PCMH5: Care Coordination and Care Transitions

A practice's ability to track important referrals and follow-up to obtain specialist reports is a key element of a well-functioning patient centered medical home. A quality PCMH practice has relationships with specialist practices and collaborates with them to provide coordinated care.

It may not be necessary to track every referral – only those referrals that are deemed **important for the patient care plan** by the practice. For example: a referral to a breast surgeon for a suspicious lump, a referral to a mental health provider for depression, referral to a pediatric cardiologist for a heart murmur, etc.

Element B: Referral Tracking and Follow-Up—MUST PASS:

Which of the following activities does practice perform and which ones include a system for tracking and follow-up? (Practice must satisfy at least 4-6 factors including factor 8 to obtain the minimum 50% score required for must-pass elements).

1. Considers available performance information on consultants/specialists when making referral recommendations
2. Maintains formal and informal agreements with a subset of specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers
4. Integrates behavioral healthcare providers within the practice site
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan
7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports
9. Documents co-management arrangements in the patient's medical record
10. Asks patients/families about self-referrals and requesting reports from clinicians

Documentation Requirements:

Factors 1, 5, 6, 8, 10:	Documented process and at least one example
Factor 2, 3:	For each factor, the practice provides at least one example.
Factor 7:	Report based on at least three months of data with numerator, denominator and percent
Factor 9:	The practice provides at least one example.
Factor 10:	The practice has a dated documented process and at least one example.

Recommended Links/Resources:

www.medicalhomeinfo.org

- Co-management Agreement (http://www.medicalhomeinfo.org/downloads/pdfs/CMESeries2-ComanagementAgreement.pdf)

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https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

- Webinars on all standards
- Tools/practice examples for all measures/NCQA standards
- Practical tools/resources for practice transformation
- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls)
    - Referral Tracking Form
    - Referral Tracking Policy (Example)
    - ER Visit Follow-up Log

http://www.safetynetmedicalhome.org/

- Safety Net Medical Home Initiative

Element C – Coordinate with Facilities and Care Transitions *(Included since this is a critical element for Medicaid population)*

The practice:

- Proactively identifies patients with unplanned hospital admissions and emergency department visits
- Shares clinical information with admitting hospitals and emergency departments
- Consistently obtains patient discharge summaries from the hospital and other facilities
- Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit
- Exchanges patient information with the hospital during a patient's hospitalization
- Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners
- Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+

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