POLICY AND PROCEDURE

POLICY NAME: Continuity & Coordination of ~~Medical~~ Care	**POLICY ID:** LA.QI.09
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Quality
EFFECTIVE DATE: 08/2020	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 10/20, 07/22, 6/23, 4/24, 02/25	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines the process of data collection surrounding the continuity and coordination of medical care.

PURPOSE:
To foster collaboration between all providers to demonstrate seamless, continuous, and appropriate care for members and to strengthen continuity between all elements of the medical delivery system. This includes member movement between health care practitioners such as primary care providers (PCP), specialists, and ancillary providers as well as member movement across settings of care, such as home to hospital and hospital to a rehabilitation facility. Communication between providers and across settings fosters comprehensive and all-inclusive care and facilitates positive outcomes.

SCOPE:
Louisiana Healthcare Connections (Health Plan) Quality and Population Health and Clinical Operations (PHCO) Departments.

DEFINITIONS:
Coordination of Care: Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.
Behavioral Health Provider~~Settings~~: Specialists/settings who serve people who seek help for a variety of mental health and substance abuse needs including Psychiatrists, Clinical Psychologists, Licensed Social Workers and Mental Health Counselors, Community Mental Health Centers, and Psychiatric Inpatient Facilities~~Inpatient, residential, ambulatory, or other types of locations where care may be rendered.~~
~~**Transitions in care**: Refers to members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. The organization collects data to assess coordination of care during care transitions.~~
~~**Movement of members between practitioners**: Includes the inception or cessation of patient care by a practitioner and coordination of care across practitioners who are concurrently or intermittently providing ongoing care for members.~~
~~**Member movement across settings**: Usually occurs as a member's health status changes (e.g., moving from home to hospital, moving from the hospital to a rehabilitation facility).~~
~~**Qualitative Analysis:** An examination of deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Also called a *causal, root cause* or *barrier* analysis. The analysis involves those responsible for the execution of the program.~~
~~**Quantitative Analysis:** A comparison of numeric results against a standard or benchmark trended over time using charts, graphs, or tables. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends.~~

POLICY:
The health plan annually collects data to assess, identify opportunities, and act on those opportunities to improve coordination of care~~medical care~~. The health plan analyzes results, develops interventions, and implements interventions when opportunities for improvement are identified. The health plan also assesses the effectiveness of interventions implemented to improve continuity and coordination of care. ~~Continuity and coordination of medical services involves the facilitation, across transitions and setting of care, of members getting the care or services they need, and practitioners/providers getting the information needed to provide appropriate care for members.~~

~~Data are focused on coordination of medical care across settings and/or transitions in care. A summary including qualitative and quantitative analysis of the activity is presented to the Quality Committee, or designated subcommittee, and included in the health plan's annual Quality Program Evaluation.~~

PROCEDURE:

A. Data Collection:

~~1.~~ At least annually, LHCC collects data about ~~The health plan has a systematic method for collecting data to detect~~ opportunities for ~~improvement in~~ coordination and collaboration~~ntinuity of care~~ between providers.~~actitioners and across settings~~.

~~2. Data are collected for a minimum of four (4) areas to monitor. Data are collected on member movement between practitioners *and* member movement across settings:~~

- ~~1. Member movement between practitioners who are concurrently or intermittently receiving ongoing care, which includes the start or end of care by a practitioner during the course of a chronic or acute illness (e.g., primary care to specialist, etc.)~~
  - Exchange~~amples~~ of information (between behavioral health providers and primary care providers, medical/surgical specialists, organizational providers, across medical settings or other relevant medical delivery systems). Communication between providers must be bidirectional. For example: ~~data collected on member movement between practitioners includes, but is not limited to:~~
    - Practitioner satisfaction with outside practitioners who care for member and their communication as assessed through the Annual Provider Satisfaction Survey.~~imary care provider satisfaction with the timeliness and frequency of feedback received from specialists~~
    - Evaluation of solicited or unsolicited practitioner reports on communication between practitioners and/or across settings, including protection of privacy~~Healthcare Effectiveness Data and Information Set (HEDIS®) [e.g., diabetic retinal eye exam (CDC – DRE), use of opioids facilitated by multiple pharmacies and multiple prescribers (UOP).~~
    - Data collected must measure any or all of the following:
      - Accuracy of information
      - Sufficiency of information
      - Timeliness of information
      - Clarity if information
      - Frequency of receiving information
      -
  - Demonstrating performance on Continuity and Coordination of Care Measures using the below designated HEDIS Measures and their HPR ratings:~~Member movement across settings, usually occurring as a member's health status changes (e.g., home to the hospital, hospital to a rehabilitation facility, inpatient stay to outpatient follow-up care, etc.)~~
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Medicaid

- Eye Exam for Patients With Diabetes (EED)
- Prenatal and Postpartum Care (PPC)—Prenatal Rate
- Prenatal and Postpartum Care (PPC)—Postpartum Rate
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Follow-Up After Hospitalization for Mental Illness (FUH)—7 days—Total Rate
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate
- Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate
- Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total Rate
- Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 Days—Total Rate
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- ~~Examples of data collected on member movement across settings includes, but is not limited to:~~
  - ~~Timely outpatient visit following an inpatient discharge~~
  - ~~Timely emergency department (ED) visit follow-up calls and post discharge phone calls~~
  - ~~HEDIS results [e.g., post-partum visits (PPC), all cause readmission rates (PCR), pharmacotherapy reconciliation post-discharge, transitions of care (TRC) either the Patient engagement after inpatient discharge rate or the medication reconciliation post discharge rate, use of opioids facilitated by multiple pharmacies and multiple prescribers (UOP),]~~

B. Opportunities for Improvement

1. The health plan conducts an ~~quantitative and qualitative~~ analysis of product specific HEDIS data at least annually and ~~compar~~identifies ~~the~~ root causes/barriers when the goals are not met and identifies opportunities for at least one measure.~~esults against a defined goal or benchmark.~~
2. The health plan must select a measure from the designated HEDIS measure list with a HPR score of 0 or 1 during the most recent rating cycle. ~~identifies root causes/barriers when the goals are not met and identifies and selects a minimum of four (4) opportunities, at least one (1) opportunity for each area monitored to address.~~
3. The health plan documents the improvement plan for at minimum one selected measure. The improvement plan must include~~Opportunities for improvement are prioritized and may include, but are not limited to the following~~:
    - All actions the organization plans to take to improve the measure's rating.
    - Specify how the organization will monitor progress.
    - Specify how frequently the organization will monitor progress.
    - Identify the parties responsible for performing improvement plan tasks (e.g., staff, department, committee)

~~2.~~

- ~~Unavailability of medical records in a large practice, which can result in poor continuity when a patient sees multiple providers~~
- ~~Inability of members to follow up with the same provider/no established relationship with a PCP~~
- ~~No visits to specialist provider following PCP referrals~~
- ~~Discharge planning instructions for follow-up care not being followed~~
- ~~Lack of specialist feedback documented in PCP's medical records~~
- ~~Cultural barriers that prevent patient access (stigma, faith healers etc.)~~
- ~~Frequent visits to the ED~~
- ~~Multiple requests to change PCP~~

~~**C. Interventions**~~

~~1. When areas for improvement have been identified, the health plan acts on a minimum of three (3) of the identified opportunities for improvement. Actions are prioritized and may include, but are not limited to the following possible interventions:~~

- ~~Prompt members to return to primary care after a visit or episode of care from an urgent care or emergency department~~
- ~~Prompt specialists to send summaries of recommendations to PCPs~~
- ~~Encourage providers to enhance their appointment system to maximize members' access to the same provider for continuity~~
- ~~Educate hospital discharge planners or home health agencies on use of discharge instructions~~
- ~~Educate PCPs, use incentives, and disseminate diagnosis and referral guidelines to promote early case finding referrals at the appropriate stage~~
- ~~Provide pharmacy data to treating providers or notification to practitioners of patients with prescriptions from multiple practitioners~~
- ~~Monitor care during transition from outpatient, inpatient, and skilled nursing facility and educate members on their discharge plan and the importance of compliance with the treatment plan~~
- ~~Encourage practitioners to establish a relationship with newly enrolled members within 90 days of enrollment~~
- ~~Provide online tool kits and communicate their availability to practitioners~~

~~**D. Measuring Effectiveness**~~

~~1. The health plan measures the effectiveness of the interventions at least annually on a minimum of the three (3) identified opportunities, comparing the result of each measure to the pre-established goal to determine if the measure will be continued or retired. If the goal is not met, the effectiveness of each intervention is analyzed and additional interventions identified, as appropriate. The health plan must measure the effectiveness of the actions (i.e., re-measure) twice, and analyze the results of each re-measurement. A baseline measurement, analysis, and interventions must precede the first measurement. For each opportunity, two (2) full cycles of measurement are included with analysis and intervention. The analysis is presented to the health plan Quality Committee, or designated subcommittee, for review, discussion, and input from participating practitioners and identification of follow-up actions. A summary of the analysis is also included in the health plan annual Quality Program Evaluation.~~

~~2. Quantitative analysis is completed using valid methodology; the health plan defines the following for each of the four (4) areas monitored:~~

- ~~Numerator/denominator~~
- ~~Sampling methodology~~
- ~~Sample size calculation if a sample is used~~

~~• Measurement periods and any seasonality effects~~

~~3. Qualitative analysis is completed if the defined goals/benchmark are not met. Barrier/root cause analysis is completed, and opportunities/actions are identified, as noted above.~~

~~E.~~C. Transition to Other Care

The Continuity and Coordination of Services policy (CC.UM.20) provides a detailed explanation as to how the health plan assists members with transitioning to other care when their covered benefits have been exhausted.

REFERENCES:
Current NCQA Standards and Guidelines for the Accreditation of Health Plans
CC.UM.20 - Continuity and Coordination of Services

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
La R.S. 46:460.54 applies to material changes of this policy

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Converted corporate to local policy	10/2020
Annual Review	Reviewed against the 2022 NCQA Health Plan Accreditation Standards and Guidelines. Minor changes made for clarification	07/28/22
Annual Review	Converted to new policy template	06/13/23
Annual Review	HEDIS measures updated to align with Plan QI 3 report data collection section, Updated Intervention section to align with corporate policy and minor grammatical change.	4/09/24
Annual Review	Updated to reflect changes to the 2025 NCQA Health Plan Accreditation Standards and Guidelines. Large scale changes made to combine LA.QI.09 and LA.QI.10 policies to align with the new standards. All changes to policy align with the updated QI 3 standard and NCQA removal of QI 4 standard.	02/11~~01~~/2025

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.