POLICY AND PROCEDURE

DEPARTMENT: Quality	**DOCUMENT NAME:** Continuity & Coordination of Medical Care
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APPROVED DATE: 08/2020	**RETIRED:**
EFFECTIVE DATE: 08/2020	**REVIEWED DATE:** 10/20; 7/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.QI.09

SCOPE:
Louisiana Healthcare Connections and health plan Quality and ~~Medical Management~~Population Health and Clinical Operations Department~~s~~.

PURPOSE:
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.

POLICY:
The health plan annually collects data to assess, identify opportunities, and act on those opportunities to improve coordination of medical 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. The health plan has a systematic method for collecting data to detect opportunities for improvement in coordination and continuity of care between practitioners 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:
   a. 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.) ~~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.)~~
   b. Examples of data collected on member movement between practitioners includes, but is not limited to:
      - Primary care provider satisfaction with the timeliness and frequency of feedback received from specialists

- Healthcare Effectiveness Data and Information Set (HEDIS®) ~~results for Comprehensive Diabetes Care (CDC) - Eye Exam rate~~ [e.g., diabetic retinal eye exam (CDC – DRE), use of opioids facilitated by multiple pharmacies and multiple prescribers (UOP).

c. - 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)

~~c.~~d. 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
- Neonatal Intensive Care Unit (NICU) discharge follow-up
- Newborn care follow-up visit after inpatient discharge
- HEDIS results [e.g. post-partum visits (PPC), all cause readmission rates (PCR), pharmacotherapy reconciliation post-discharge (TRC – MRP), follow-up for people with multiple chronic conditions after emergence department visit (FMC)] ~~MRP)]~~

B. Opportunities for Improvement

1. The health plan conducts a quantitative and qualitative analysis of data at least annually and compares the results against a defined goal or benchmark.
2. The health plan 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. Opportunities for improvement are prioritized and may include, but are not limited to the following:
   a. Unavailability of medical records in a large practice, which can result in poor continuity when a patient sees multiple providers
   b. Inability of members to follow up with the same provider/no established relationship with a PCP
   c. No visits to specialist provider following PCP referrals
   d. Discharge planning instructions for follow-up care not being followed
   e. Lack of specialist feedback documented in PCP's medical records
   f. Cultural barriers that prevent patient access (stigma, faith healers etc.)
   g. Frequent visits to the ED
   h. 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:
   a. Prompt members to return to primary care after a visit or episode of care from an urgent care or emergency department
   b. Prompt specialists to send summaries of recommendations to PCPs
   c. Encourage providers to enhance their appointment system to maximize members' access to the same provider for continuity
   d. Educate hospital discharge planners or home health agencies on use of discharge instructions
   e. Educate PCPs, use incentives, and disseminate diagnosis and referral guidelines to promote early case finding referrals at the appropriate stage
   f. Provide pharmacy data to treating providers or notification to practitioners of patients with prescriptions from multiple practitioners
   g. 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
   h. Encourage practitioners to establish a relationship with newly enrolled members within 90 days of enrollment

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:
   a. Numerator/denominator
   b. Sampling methodology
   c. Sample size calculation, if a sample is used
   d. 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. Transition to Other Care

~~3.~~ 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..~~exhausted.

REFERENCES:

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

ATTACHMENTS:

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.

Settings: inpatient, residential, ambulatory or other types of locations where care may be rendered.

Transitions in care: ~~include changes in management of care between practitioners, changes in settings or other changes in which different practitioners become active or inactive in providing ongoing care for a patient.~~ 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~~ 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.

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REVISION LOG:	**DATE**
Converted corporate to local policy.	10/2020
Reviewed against the 2022 NCQA Health Plan Accreditation Standards and Guidelines. Minor changes made for clarification.	**7/22**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer and is considered equivalent to a physical signature.