Title:	Continuity and Coordination of Medical Care				
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LINE OF BUSINESS

This document applies to the following line(s) of business:
All SWHP & ICSW

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

Continuity of Care – process for assuring that care is delivered seamlessly across a multitude of delivery sites and transitions of care throughout the course of the disease process.

Electronic Medical Records (EMR) – should be more than a collection of scanned paper charts. They should have the capability to do index search and retrieval of records, labs or procedures.

Transitions in Care – movement of individuals between care settings (e.g., from home to hospital) as their condition and needs changed during the course of a chronic or acute illness.

Primary Care Physician - is a physician who practices on any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (OB/GYN); Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under the Medicaid contract).

Patient-Centered Medical Home (PCMH) – a health-care setting that facilitates partnerships between patients and their personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, the exchange of health information and by other means, to ensure that patients get care necessary, when and where they need and want it, in a culturally and linguistically appropriate manor.

POLICY

Scott and White Health Plan (SWHP) monitors and takes appropriate action(s), as necessary, to improve continuity and coordination of care across the health care network. SWHP uses information at its disposal to facilitate continuity and coordination of care across its delivery system. SWHP uses valid data collection and analysis methodologies to both identify opportunities for improvement as well as to measure the effectiveness of changes and subsequent results. This policy applies to all providers providing care to SWHP members, including Baylor Scott and White Clinics and contracted providers.

PROCEDURE

SWHP encourages members to establish a relationship with a primary care physician (PCP) as part of a Patient-Centered Medical Home (PCMH). The PCP will then lead a team of clinicians that are collectively responsible for providing health care needs and arranging for appropriate care with other clinicians and specialists as appropriate. As such, SWHP collaborates with all providers providing care to SWHP members including Baylor Scott & White Healthcare (BSWH) clinics and contracted practioners for the continuity and coordination of patient and family centered medical care.

Medicaid members can utilize Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics; physicians serving members residing in Nursing Facilities; and specialist physicians who are willing to provide Medical Home to selected members with special needs and conditions as their PCP.

SWHP collects data on member movement between practioners and across settings to assess coordination of care. SWHP then uses quantitative and qualitative analysis of the data to compare the results against goals and conducts causal analysis if goals are not met. The analyses are presented to the SWHP Quality Improvement Sub-Committee for review and oversight.

SWHP selects and implements a minimum of three different activities to improve and measure the effectiveness of continuity and coordination of medical care based on issues or sources of problems that are found in the analyses. SWHP takes action to improve coordination of medical care and measures the effectiveness of the improvement activities taken through the use of defined variables to meaure performance of identified issues and collects data on one of the following:

- Activites
- Events
- Occurrences
- Outcomes

SWHP measures and monitors data to analyze the effectiveness of the improvement activities basd on standards of care or practice guidelines that include objective clinical criteria from authoritative sources, such as:

- Clinical literature
- Consensus panels
- HEDIS® measures
- Measures that are part of SWHP's ongoing monitoring

Measures may be designed for a focus study or for an activity targeted to improve a process of care. Measurements of these activities requires evidence of explicit defined variables that allow the organization to measure its performance regarding the clinical issues identified. BSWH uses a fully integregrated electronic medical record (EMR) system that facilitates communication flow and provides medical practitioner's access to each other's notes.

An annual report of Continuity and Coordination of Medical Care is submitted to the Quality Improvement Sub-Committee (QIS). The report will identify interventions, barriers, and outcomes for continuity and coordination of medical care. Any measure(s) not meeting goal will receive an action/recommendation by the Quality Improvement Coordinator and reported to the QIS for further action and/or follow-up. Therefore, as an integral part of the improvement process, it is vital that collaboration efforts of medical care practitioners are duly documented to sustain compliance with applicable federal, state, and NCQA guidelines.

ATTACHMENTS

None.

RELATED DOCUMENTS

Continuity of Care/Transition of Care (SWHP.HSD.32900.P)

REFERENCES

2017 NCQA Health Plan Standard, QI 8: Continuity and Coordination of Medical Care
Texas Medicaid Managed Care Contract, Section 8.1.15.4 Coordination between the BH Provider and the PCP