Care Coordination and Care Transitions
(CC- Competency C)

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Community Health Solutions

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Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

CC – Competency C

The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
CC 14 (Core)	**Identifying Unplanned Hospital and ED Visits**: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	*Documented process **AND** Report*	*5C1*
CC 15 (Core)	**Sharing Clinical Information:** Shares clinical information with admitting hospitals and emergency departments.	*Documented process **AND** Evidence of implementation*	*5C2*
CC 16 (Core)	**Post-Hospital/ED visit Follow-Up:** Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	*Documented process **AND** Evidence of follow-up*	*5C4*

CC – Competency C
(continued)

The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
CC 17 * (1 Credit)	**Acute Care After Hours Coordination**: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.	*Documented process **AND** Evidence of implementation*	*No equivalent*
CC 18 (1 Credit)	**Information Exchange during Hospitalization:** Exchanges patient information with the hospital during a patient's hospitalization.	*Documented process **AND** Evidence of implementation*	*5C5*
CC 19 (1 Credit)	**Patient Discharge Summaries:** Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.	*Documented process **AND** Evidence of implementation*	*5C3*

CC – Competency C
(continued)

The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
CC 20 (1 Credit)	**Care Plan Collaboration for Practice Transitions:** Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).	*Evidence of implementation*	*2A4*
CC 21 (Maximum 3 Credits)	**External Electronic Exchange of Information:** Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): A. Regional health information organization (RHIO) or other Health information exchange source that enhances ability to manage complex patients B. Immunization registries or immunization information systems C. Summary of care record to other providers or care facilities for care transitions	*Evidence of implementation*	*5B7 & 5C7 (align with CC 21C);* *6G7 (aligns with CC 21B);* *6G8-9 (align with CC 21A)*

CC 14 (Core) Identifying Unplanned Hospital and ED Visits:

Systematically identifies patients with unplanned hospital admissions and emergency department visits.

- The practice should develop a process for monitoring unplanned admissions and emergency department visits and states how often monitoring takes place. The practice works with local hospitals, EDs and health plans to identify patients with recent unplanned visits. The practice provides a report with the proportion of local admissions and ED visits (reported separately) to facilities where practices have an established notification exchange mechanism.

CC 15 (Core) Sharing Clinical Information

Shares clinical information with admitting hospitals and emergency departments.

- The practice demonstrates timely sharing of information with admitting hospitals and emergency departments. Shared information supports continuity in patient care across settings. The practice provides **three examples** of this exchange to meet the criteria.

CC 16 (Core) Post-Hospital/ED visit Follow-Up

Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

- The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate.
- The practice's policies define the appropriate contact period in addition to a log documenting systematic follow-up was completed. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encouraging follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs.

Care Coordination & Care Transitions

CC 14-16, 18-19: Example

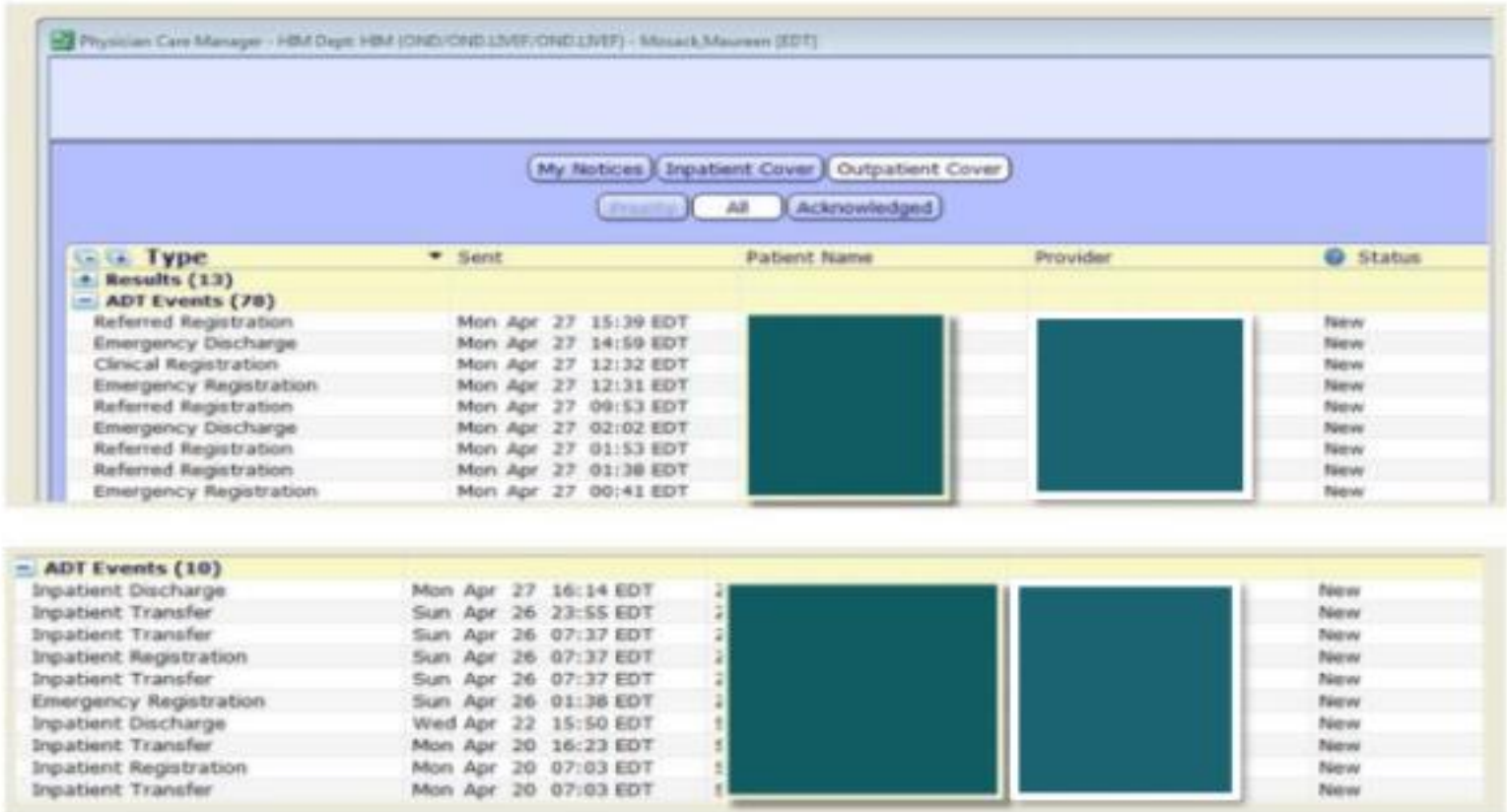
Procedure:

- CC 14 — Hospital census is obtained daily by fax or from an offsite electronic Health Information System from local hospitals by the Care Coordinator or Nurse Care Manager.
- CC 15 — Communication with local hospitals is completed daily.
- CC 19 — Discharge records are faxed to the CHCCM from the hospital or pulled from an offsite Health Information System by the Care Coordinator or Nurse Care Manager.
- CC 18 — Local hospitals are contacted if additional information is needed.
- After thorough review and obtaining hospital records the Care Coordinator will give the daily census to the Nurse Care Manager for review.
- Nurse Care Manager will be responsible for assuring the medical records were received and scanned into the chart.
- CC 16 — Nurse Care Manager or Care Coordinator (if designated) will be responsible for contacting patient's that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient's chart, schedule follow up appointment's if needed and obtain additional information as needed.

Care Coordination & Care Transitions

CC 14: Example

Referred Registration is an admission
Inpatient Discharge is a hospital discharge
Emergency Discharge is discharge from the ED.



NOTE: NCQA will no longer accept de-identified examples uploaded into Q-PASS. Any evidence of implementation that includes/included patient information should be shown during a virtual check-in.

CC 15 – Sample Consulting Physician Letter

TO:
Subspecialist (Group)

As you are probably aware, our practice is involved in a Pilot Project which revolves around Patient-Centered Care and the concept which has been referred to in the literature as the Patient Centered Medical Home ("PCMH") We are remodeling how our practice works in an effort to become more Patient centered and focused as part of this effort.

Coordination of Care for our mutual patients is critically important for good patient care and improved outcomes. It is our goal to improve our communication with our consultants in an effort to prevent unnecessary duplication of services and to practice both cost-effective and evidenced based care for our patients. In doing so, we hope to align ourselves most closely with sub-specialist consultants who are focused on the same improved and coordinated care for our patients.

We feel that an important first step is to improve the communication between us (as Primary Care Physicians) and you as our sub-specialty consultants who are also seeing and caring for our mutual patients. We would ultimately like to actually develop a written and agreed upon set of guidelines and expectations between our practice and yours . (what you can expect and anticipate from us in this effort and vice-versa.)

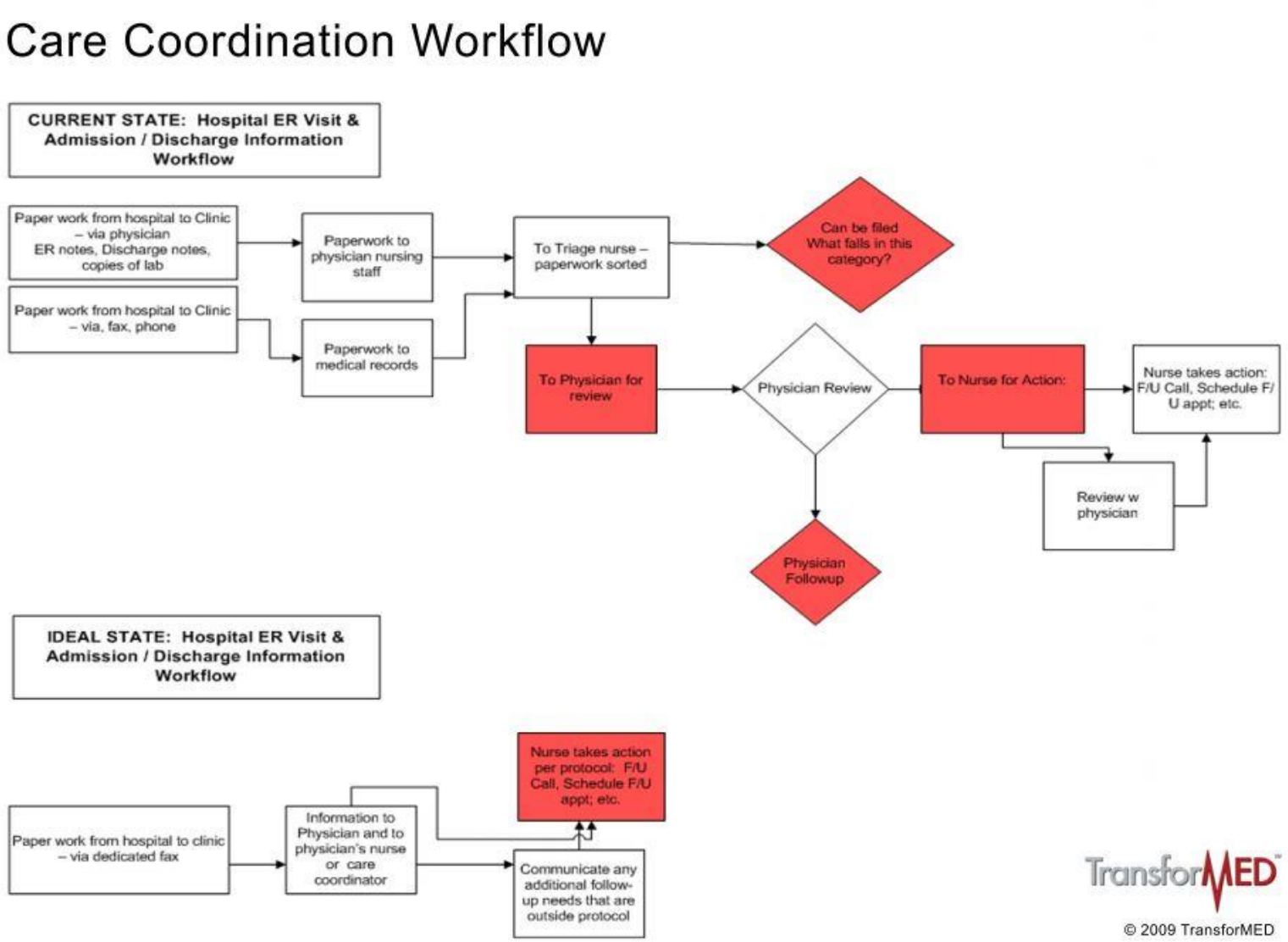
To start this process in motion, we would invite you to have a representative or representatives from your practice spend an hour or so with a couple of us to discuss some of these issues in more detail and to consider how we can move forward in the best interest of our patients in the future.

Please give one of us a call at your convenience - We look forward to working with you!

Sincerely,

Dr_____
Phone contact #

CC Competency C – Sample Care Coordination Workflow



Care Coordination & Care Transitions

CC 16: Example

10:26 AM Telephone

Description: **45 year old female**
Provider:
MRN
Department:

Reason for Call

Follow-up since

Call Documentation

10:32 AM Signed

Following up with patient after visit to ER for abdominal Pain. Pt states that she was discharged and that her CT Scan and labs were fine. Still c/o some slight pain today but that overall it is better. Was told last night that it could be because of her nerves. The ER MD increased zoloft for this and pt states that she has made the changes recommended. Would like to follow up with PCP to make sure that dose will work for her. Schedule F/U in 1 week. Pt voices no further needs at this time.

Encounter Messages

No messages in this encounter

Contacts

	Type	Contact	Phone
10:26 AM	Phone (Outgoing)		

Created by

10:26 AM

Patient Instructions

None

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Frequently Asked Questions

Do health plan hospitalization and ED visit data meet the requirements of CC14?

A practice may use timely (provided at least weekly) health plan data to identify patients if at least 75 percent of the patient population is represented by the health plan. The practice may use data from more than one health plan as long as the plans collectively represent at least 75 percent of the practice population.

Frequently Asked Questions

Are practices required to show they can identify all patients who have been admitted to the hospital and treated in the ED? (CC14)

No, practices are not required to identify all patients admitted to the hospital or ED, but they must have a process for identifying patients admitted to target facilities used most often by their population. In addition to a documented process, practices must also submit a log or report demonstrating that patients were identified.

Frequently Asked Questions

If the clinic and hospital share EHR, how do you document examples for CC-Competency C? CC 15

If the primary care practice shares an EHR with the hospital, the practice should submit a documented process that describes how the hospital and ER are able to access the patient data via the shared EHR. In addition to the documented process, the practice could demonstrate de-identified examples that show the ability of the hospital to view the patient's medical record. Please note that the practice should also have a process in place for sharing patient information in the case that a patient is admitted to an ER or a hospital outside of the system.

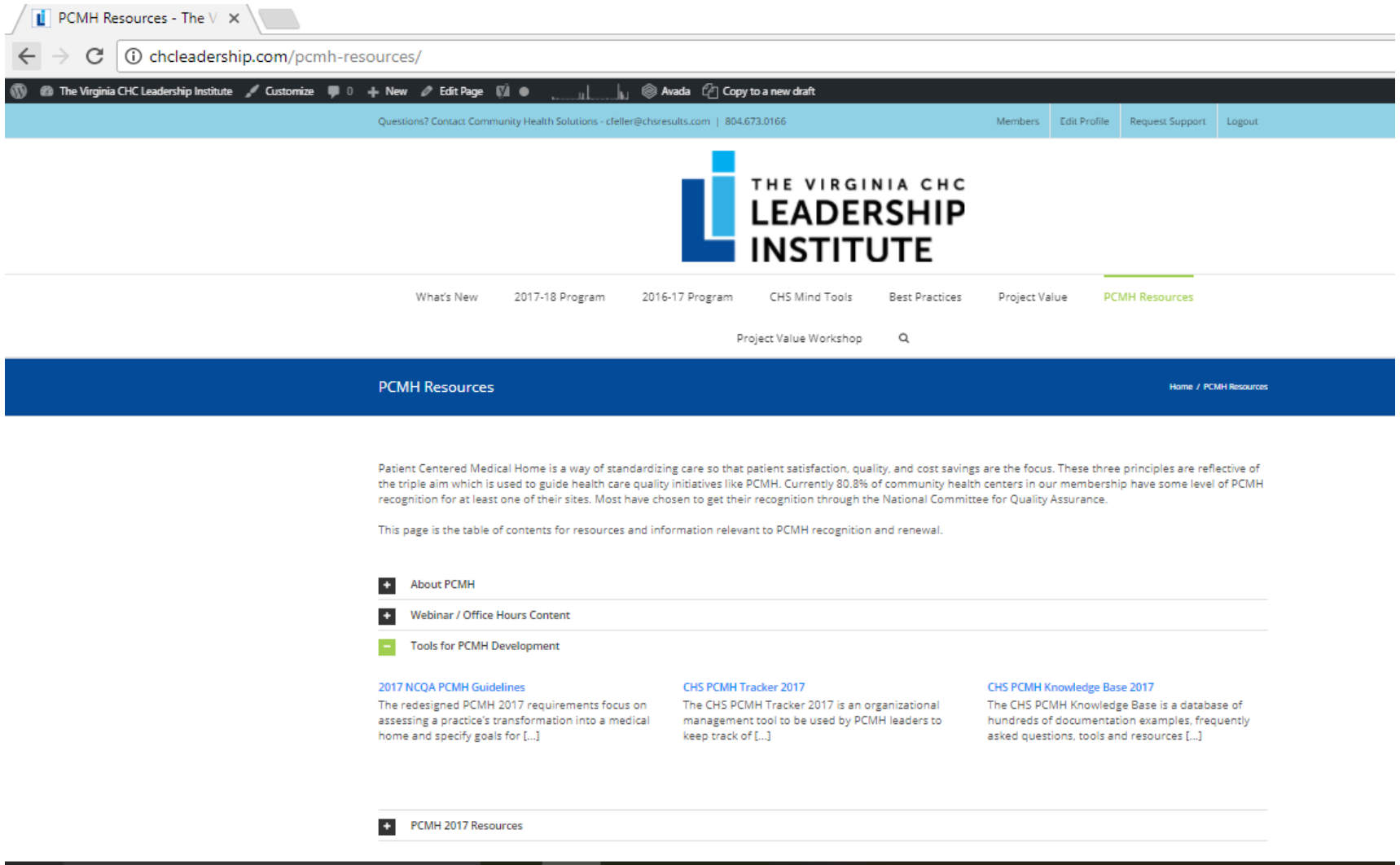
Frequently Asked Questions

Can you provide more clarification on the requirements of CC 15? We are concerned about the requirements as it relates to our relationship with local facilities.

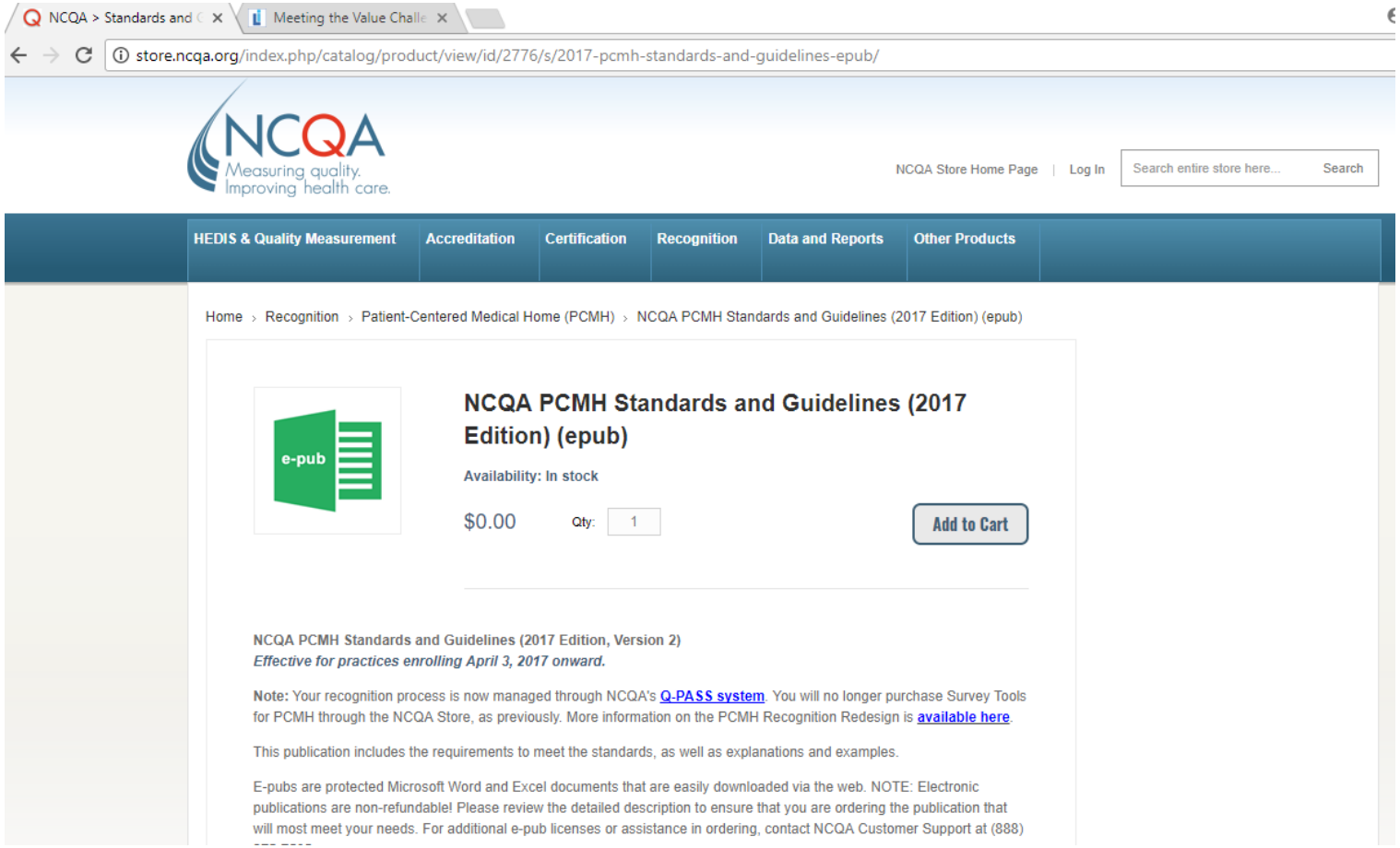
The intent is to evaluate whether practices have a process in place to send patient information from the practice to the admitting hospital or emergency department when the practice is aware of an admission or on request. Keep in mind that a practice does not need to have a process for every facility in the area. The practice should focus on facilities most frequently used by the practice's patient population. Also, we are not looking that this must done electronically. The practice provides its documented process that staff follow to send information to the facility, as well as three de-identified or demonstrated patient examples of the information sent to the facility.

Questions?

http://chcleadership.com/pcmh-resources/

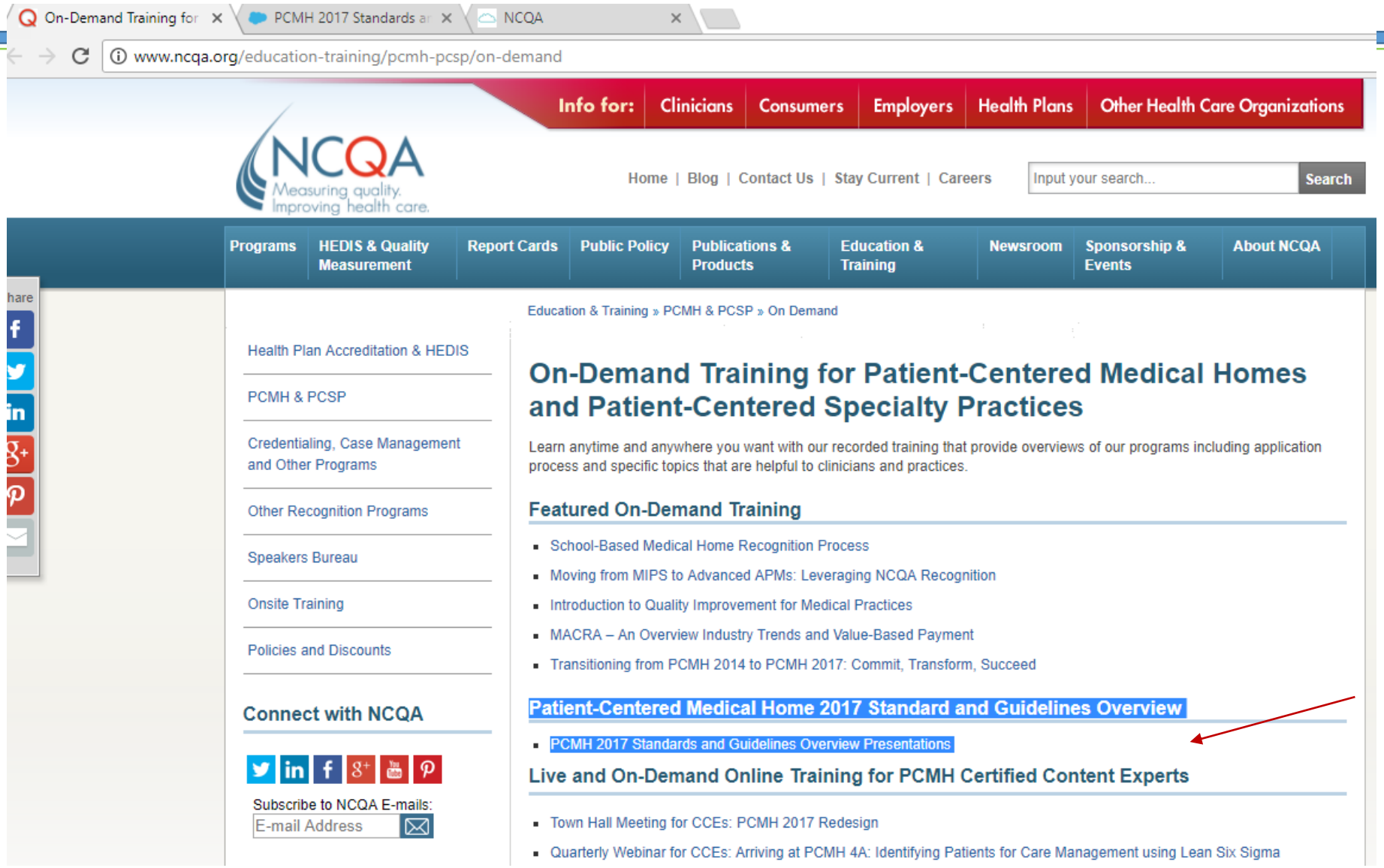


http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/



http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

http://www.ncqa.org/education-training/pcmh-pcsp/on-demand



New resource from NCQA

Request Support

Your PCMH Support Team:

Caitlin Feller, Terry Laine, Sherrina Gibson

Online:

http://chcleadership.com/support/

Phone:

804-673-0166