I. **Policy Statement**

The PCMH model develops relationships between primary care providers, their patients and their patients’ families. In the PCMH model, primary care promotes cohesive coordinated and continuity of care by integrating the diverse, collaborative services a member may need. This coordination and continuity of care approach allows primary care providers to work with their patients in making healthcare decisions. These decisions are based on the fullest understanding of information in the context of a patient’s values and preferences.

II. **Requirements**

The health plan has written policies and procedures to ensure timely coordination with any of a member’s other providers of the provision of Covered Services to its members and to ensure:

- Attention to individual needs
- Continuity of care to promote maintenance of health and maximize independence
III. **Procedures**

1. The medical home team; which may consist of nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioral health therapists, social workers, care coordinators, and others will take the lead in working with the patient to define their needs, develop a plan of care, and update a plan of care as needed. Care Coordination, with KPCO’s PCMH model, includes the following activities:

   1.1 **Determine and update care coordination needs:** Coordination needs are based on a patient’s health care needs and treatment recommendation, which reflect physical, psychological and social factors. Coordination needs are also determined by the patient’s current health and health history; functional status, self-management knowledge and behaviors; and needs for support services.

   1.2 **Create and update a proactive plan of care:** Establish and maintain a plan of care, jointly created and managed by patients, their families, and their health care team. The plan of care outlines the patient’s current and long term needs and goals for care, identifies coordination needs, and addresses potential gaps. The care plan anticipates routine needs and tracks current progress towards patients’ goals.

   1.3 **Communication:** Communication allows for the exchange of information, preferences, goals, and experiences among participants in a patient’s care. Communication may take place in person, by phone, in writing, and electronically. Communication is especially critical during transitions of care. Primary care providers must be included in the transfer of information during transitions in care. Examples of transition include from the inpatient hospital or skilled nursing facility (SNF) to the ambulatory setting (i.e. physician’s office), as well as transitions from acute episodes of care to chronic disease management.

   1.4 **Connect with community resources:** Provide and coordinate services as needed with additional resources in the community to help support patients’ health and wellness or meet their care goals. Community resources may include financial resources, social services, educational resources, support groups, or support programs (i.e. Meals on Wheels).

2. Communication between care coordination teams and the PCMH are critical to proper functioning of care coordination programs and optimal patient outcomes. The goal is awareness of the PCMH of the specific healthcare needs and gaps of their empaneled patients and an awareness at the care coordination program level of actions taken and performance on the populations of patients for whom each PCMH is responsible. Kaiser Permanente’ electronic health record KP HealthConnect (KPHC) enhances communication between care coordination teams and the PCMH (Refer to attachment: Coordinating Care Communication Process with PCMH).
3. The overall performance goal is to improve health care quality, service and affordability for members with complex chronic conditions, as well as those without chronic conditions. To achieve this goal, it is the expectation of the PCMH to manage these members. The health plan is responsible for identifying the patients who qualify for its care coordination programs, notifying the PCMH about the identification, and maintaining a tracking mechanism that includes these members. Notification to the PCMH is conducted for each patient when they are identified as being qualified for the care coordination programs. The care coordinator routes this information via KPCO’s electronic health record (KP HealthConnect), or a letter is faxed to the practitioner and expects feedback from the practice on whether they intend to engage the patient on the lists.

IV. Review or Revision

This policy and procedure is to be reviewed annually and revised as needed.

V. Archiving

All final versions will be archived within a central repository, i.e. shared drive, as well as, stored on [http://coweb.co.kp.org/pp/](http://coweb.co.kp.org/pp/).
VII. Signatures

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VIII. Attachments

1. Coordinating Care Communication Process for PCMH 2013.02.27