MEDICAL CARE COORDINATION

Medical care coordination between Primary Care Providers and Specialists, Hospitals, Home Care Agencies, and Skilled Nursing Facilities is important to improve patient quality of care. This is achieved by providing most up to date information to providers managing patient care to improve patient outcomes and patient compliance.

*For more information, Refer to *Provider Manual, Chapter 4, Unit 7, Documentation Requirements for All Providers*

Provider Type	Best Practices
Hospital	• Establish procedure to notify PCP of Emergency Room visits and Inpatient Admission, within 48 hours of visit or admission. • Establish procedure to ensure Discharge Summaries are sent to PCP, regardless of admitting physician, within 48 hours of discharge • Provide patient or facility/agency a copy of discharge instructions
PCP	• Coordinate regular follow ups for patients with chronic medical or behavioral health conditions • Refer to specialists as needed • Request communication to be sent for any referrals made • Follow up with members after inpatient discharge within one week to reconcile medications and review discharge summary and instructions
Specialist	• Establish procedures to communicate with PCP • Notify patient of plan for follow-up
Home Health Agency	• Obtain and follow hospital discharge instructions • Provide PCP with treatment plan on a routine basis • Establish procedure to send a discharge summary of care to PCP
Skilled Nursing	• Identify PCP and communicate treatment plan and update on regular basis • Notify PCP of patient discharge from facility and send discharge summary with instructions for patient care within 48 hours of discharge