Care Coordination

Care coordination involves deliberately organizing care activities collaboratively, and, with the patient's permission, sharing information among all participants of a patient's care team. The goal is to ensure timely and appropriate coordination of services and support for the patient's healthcare. It calls for, among other things, becoming aware of the patient's needs, values, and preferences ahead of time and communicating those to the right people at the right time.

Effective care coordination requires:

- Regular communication among care providers, with standardized guidelines for referrals, transitions, and follow-up
- Collaboration through shared clinical information and decision making
- Clear care coordination agreements (roles, responsibilities, protocols)
- Care teams that can develop individualized care plans for patients with complex needs
- Well-designed and -executed continuity-of-care plans during patient transitions
- Collaboration among care coordinators, care managers, and the PCP to facilitate the care of patients with complex or chronic conditions
- Development of strong relationships between providers, patients, families, care managers, and those representing community resources

Provider responsibility checklist

Blue Cross® Blue Shield® of Arizona (AZ Blue) requires network providers to take the following actions for effective care coordination for our members:

- **Provide coordination of care for members with complex conditions.**
  - ✓ Refer members to specialists considered in-network for the member's benefit plan, unless the needed type of service, availability of service, or sound medical practice dictates otherwise. If out-of-network care is required, be sure to obtain prior authorization.
  - ✓ Follow up with members to be sure they're adhering to the providers' treatment plan.
  - ✓ Assess barriers to adherence and care, and intervene as needed.
- **Coordinate medical team communications between specialists and PCPs.**
  - ✓ Reduce duplication of services (lab, radiology, etc.) across PCPs and specialists by communicating with each other via EMR, phone, etc.
  - ✓ Address comorbidities, including behavioral health (mental health and substance use issues).
- **Provide proactive follow-up post-discharge.**
  - ✓ Call members to schedule a seven-day follow-up appointment.
  - ✓ Perform medication reconciliation.
- **Review notifications you've received about gaps in care** for AZ Blue members.
  - ✓ Assess potential care gaps.
  - ✓ Schedule member appointments and tests, and follow up as needed to close gaps.
- **Document condition persistency** to facilitate appropriate claim coding for each member encounter.
- **Schedule annual appointments** with members to review their medical plan.
- **Refer members to** our health and wellness programs and to our Care Management program for support (1-877-475-8449).

Care Coordination

Guidelines for effective referrals and transitions

- **Safe:** Avoids harm resulting from medical or administrative errors
- **Effective:** Is evidence-based
- **Timely:** Avoids unnecessary delays
- **Patient-centered:** Is responsive to unique patient needs, values, and preferences (includes referring to providers considered in network, according to the member's benefit plan, unless the needed type of service, availability of service, or sound medical practice dictate otherwise)
- **Efficient:** Avoids duplication and unnecessary utilization
- **Equitable:** Avoids bias