

Dear Medical Provider,

It is increasingly clear that clinical outcomes suffer and costs rise when healthcare is not coordinated. Delivering care within silos, with incomplete information and without continuity of care, is suboptimal -- and less satisfying to both patients and providers. Primary care practices are ideally positioned to be the hub for coordinating care.

Historically, primary care physicians (PCPs) have not been compensated for the extra work involved in coordinating care. That is changing. Both the Patient-Centered Medical Home (PCMH) and Comprehensive Primary Care Plus (CPC+) initiatives include care management fees (CMF) specifically intended to incentivize care coordination. QualChoice participates in both of these innovative programs.

Care coordination is ideally focused on those patients with greater needs. This means developing care plans for at-risk patients and including agreed-upon goals and timelines for follow-up. However, there are often barriers to following through on recommendations. Barriers may be socioeconomic, or related to the complexity of the healthcare maze. Perhaps the main challenge is getting patient engagement for needed behavioral changes.

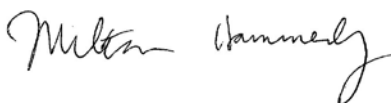
A good care plan recognizes barriers that can prevent success. Even though you've recommended lifestyle changes, prescribed appropriate antidiabetic medications, ordered the indicated blood tests and made a referral for diabetic eye screening, it may be hard to track whether these things actually happen. Reminder calls to patients, tickler files or EMR alerts are all opportunities to help improve adherence and success with care plans. But information should also flow to the primary care office. Our intent in assigning members to PCPs is to help specialists know who they should be communicating with. How can you coordinate what you're unaware of?

QualChoice is taking steps to improve coordination of care. We're launching a program to notify PCPs when their patients are hospitalized. This will allow scheduling of a follow-up visit after discharge and coordination of care during the vulnerable period when readmission is likely. We are also developing care gap reports for providers participating in the CPC+ program, indicating which patients may need evidence-based interventions.

Coordinated care requires collaboration, communication and the flow of patient information to the PCPs who are committed to planning and overseeing their care. At QualChoice, we're committed to partnering with you to enhance your ability to coordinate care. Working together, we can improve patient outcomes!

If you have ideas or suggestions on how QualChoice can help you coordinate patient care, please let us know at: [collaboration@qualchoice.com](mailto:collaboration@qualchoice.com)

Sincerely,



Dr. Milton Hammerly  
Chief Medical Officer