



Systems of Care/Patient Centered Medical Home Initiative

Systems of Care/PCMH Initiative
Compact Facilitation Guide
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Compact Facilitation Guide

Welcome to the Patient Centered Medical Neighborhood

The Patient-Centered Medical Home (PCMH) movement is gaining momentum. As of December 2010, NCQA has recognized 1246 PCMHs and is receiving 100 recognition applications monthly. There are now 14 major PCMH pilots demonstrating positive outcomes in quality parameters and cost reduction. Yet, the PCMH model faces significant unaddressed challenges. Several barriers exist to the successful implementation and sustainability of the PCMH and threaten the clinical and economic advantages of the model.

Effective coordination of care is an essential element in the successful PCMH and this element requires the willingness of specialists, other medical providers and health care facilities to participate in collaborative decision-making. The Medical Neighborhood is a systems model that extends the PCMH team-based care paradigm and:

- Fosters shared accountability among providers
- Improves quality
- Reduces waste
- Aligns incentives to encourage collaboration
- Includes measures to evaluate the patients' experience of care

Our health care system is not broken; it is obsolete (Jordan Cohen, M.D., Pharos magazine, winter 2011). We have a patchwork system of care that has exceeded the capacity to deliver safe, quality, coordinated and equitable care. We are trying to reach the moon fueled by gasoline and these efforts have exhausted the resources of our country. In the chaos of repair efforts, we must find a new community standard that can overcome health care's functional, social and logistical obsolescence. A system that provides innovative organizational and payment redesign that truly coordinates health care services.

The following guide provides the tools to take those first steps and make the difficult practice changes that will transform us from parallel, cooperative silos of care to collaborative care teams that can restore function to our dysfunctional system.

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Introduction

In a recent publication of the American College of Physician, “The Patient Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Sub-Specialty Practices”¹ introduces the concept of the specialist “medical neighbor” is introduced and a framework and a set of guiding principles for the interaction between a primary care medical home and their specialist partners is outlined. These principles focus on shared patient care by defining the types of management and standardizing expectations for care coordination.

The Systems of Care Initiative Care Compact (or Collaborative Care Agreement) is based on the Joint Principles of the Patient Centered Medical Home and the American College of Physicians position paper on The Patient Centered Medical Home Neighbor: The Interface of the Patient Centered Medical Home with Specialty/Subspecialty Practices. As a result, there are certain assumptions made about the roles and interactions of physicians around continuity of care that need to be addressed:

- A patient centered medical home encompasses the following elements: personal physician, physician directed medical practice, whole person orientation, care is coordinated and/or integrated across all elements of health system, quality and safety are hallmarks of the home and promoted, enhanced access is available between patients and the medical practice.²
- The PCMH operates as the central hub of patient information, primary care provision³ and is responsible for coordinating care across multiple settings, which includes:
 - Point of first contact for the patient
 - Primary care coordinator
- The patient centered medical home neighbor (PCMH-N), aka. Medical Neighborhood endorses:
 - Collaboration with specialists and sub-specialists are critical to achieve the goal of improved care integration and coordination within the patient centered medical home model.
 - Care delivery and care coordination is provided using a patient centered approach that encourages patient and family participation in referrals, diagnostics, treatment plan and self-management. The PCMH does not preclude the patient from self-referral to a specialist/subspecialist.
 - Please see Principles of the Patient-Centered Medical Neighborhood (hyperlink)
- Continuity of Care⁴: refers to the degree to which patients experience discrete components of healthcare as coherent, organized, connected and consistent with their needs.

¹ American College of Physicians position paper on The Patient Centered Medical Home Neighbor: The Interface of the Patient Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia, American College of Physicians, 2010; Policy Paper

² Joint Principles of the Patient Centered Medical Home

³ American College of Physicians position paper on The Patient Centered Medical Home Neighbor: The Interface of the Patient Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia, American College of Physicians, 2010; Policy Paper

⁴ Implementation Guide: Continuous and Team-Based Healing Relationships, Improving Patient Care through Teams. Safety Net Medical Home Initiative, December 2010.

- *Relational Continuity*: refers to ongoing caring relationships where a patient is known by his or her providers so that past care is linked with current care, usually with the expectation that the relationships will continue in the future.
- *Informational Continuity*: refers to the transfer of information from one episode of care to another, and the notion that relevant information is taken up and acted upon over time.
- *Managerial Continuity*: refers to the notion that care is coherently organized and planned and that today's care decisions take into account yesterday's care experience.

Objectives:

The purpose of the facilitation guide is to offer enhanced support to individuals or groups that are interested in convening groups of physicians to implement a care coordination guideline within their medical neighborhood by developing tools, key questions and other resources that aid in compact adoption.

The facilitation guide is organized according to the following elements:

- *Introduction: Concepts & Purpose*
- *Care Coordination Agreement: principles, definitions, areas for mutual agreement, exchange of information*
- *Implementation of agreement: tools and activities that support practices in the execution of a care compact*
- *Measurement: Monitoring and improvement*
- *Other Issues for Consideration*

Each section offers resources through:

- *Key questions*: The purpose of the key questions are to a) generate discussion about the value of care coordination agreements and b) surface and identify issues that that lead to a shared understanding if the compact between providers c) help providers think about how they might implement the compact within their own care settings.
- *First Steps: Suggested action plan*
- *Tools: Documents, tips, surveys and workflows*
- *Activities: Organized activities (facilitated and non-facilitated) that will support building and implementing compacts.*
- *Supporting Literature: evidence-based articles that support the patient centered medical home and the medical neighborhood approach.*

Introduction: Concepts & Purpose

Target Audience:

There are several circumstances where a physician compact, or care coordination agreement can be utilized. The following scenarios were taken into consideration when writing the facilitation guide.

- A primary care physician seeking to engage and build a network of medical neighborhood specialists to foster coordinated care with a comprehensive approach to referral and care management expectations (1:1 physician outreach).

- A specialist physician seeking to utilize the compact to improve bidirectional flow of relevant patient information when receiving a patient referral, and targeted at primary care or other specialists/community facilities. (1:1 physician outreach).
- A group of physicians (loosely defined) looking to identify and establish community standards for physician communication (i.e. “the Block Party”).
- A physician group (IPA or PHO) looking to utilize the compact elements as standards and expectations for participation. (Likely done through contracting model)

A significant amount of work has been done in several national pilots on care coordination from inpatient settings to outpatient settings. The National Quality Forum has developed a matrix of care coordination measures to support this work. The following scenarios are also areas where a care collaborative agreement would be useful but have not been tested; therefore, specific supporting materials have not been developed at this time.

- Physician to Hospital/Hospital to Physician standardization of medical records and protocols pertinent in transitions of care.⁵
- Facilitation of bidirectional information between primary care/specialist physician and home health services or other community resources and facilities.

Purpose/Objectives of care coordination agreements

Patients who transition between primary care and specialty care often encounter lapses in communication, duplication of diagnostic testing, and ambiguity regarding physician duties and responsibilities⁶. A care coordination agreement, or compact, facilitates the goal of improved care integration and coordination for patients through articulation of bi-directional expectations around types of care, communication of pertinent clinical information and patient preferences, access and availability, and collaborative development of care plans for shared patient care. These agreements can serve as a practical guide to enhance referrals between primary care and specialty practices, as well as, standardizing transfer of clinical information across multiple care settings.

It is acknowledged that most physicians have established referral networks and clinical partnerships with specialists, hospitals and ancillary providers (medical neighborhoods). The care compact is meant to enhance, rather than replace those relationships by offering participants an opportunity to share their preferences, clinical expertise and update communication methods to ensure that they see the right patient at the right time in a more structured framework, as well as, to facilitate implementation within the clinical practice and other care settings.

Collaborative Care Agreements & Care Coordination

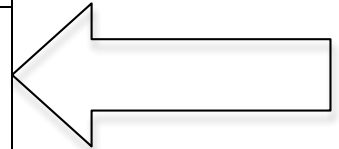
How does the collaborative care agreement fit into the larger picture of care coordination? The Agency for Health Care Research recently developed a Care Coordination Atlas and distinguishes between the activities and broad strategies that support coordinated care. The collaborative care agreement is an activity that provides the framework for an effective care hand-off by establishing accountabilities, expectations for communication and facilitating transitions. Subsequent clinical activities, listed in the table below, should be communicated in the progress note or care record and shared across the care continuum with all relevant providers.

⁵ National Quality Forum (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*, Washington, DC: NQF; 2010.

⁶ Chen, AH, Improving the Primary Care-Specialty Care Interface. *Arch Intern Med.* 2009;169: pp.1024

Care Coordination Elements:⁷

Coordination Activities – unique activities that support coordinated care
<ul style="list-style-type: none"> Establish Accountability or Negotiate Responsibility Communicate (interpersonal and information transfer) Facilitate Transitions Assess Needs and Goals Create a Proactive Plan of Care Monitor, Follow up and Respond to Change Support Self-Management Goals Link to Community Resources Align Resources with Patient and Population Needs
Broad Approaches – means of achieving coordinated care
<ul style="list-style-type: none"> Teamwork focused on care coordination Health Care Home Care Management Medication Management Health IT – enabled coordination



“Care Coordination Atlas - Version 3” AHRQ Publication No. 11-0023-EF.

The effectiveness of care coordination activities and strategies should be viewed, and subsequently measured, from the perspective of multiple stakeholders, all of whom will have different definitions of successes and failures. The grid below summarizes those perspectives in terms of the purpose and goal of care coordination and what is a perceived failure by key stakeholders.

Care Coordination Perspectives⁸

	Patient	Health Care Professional	System
<i>Purpose</i>	Ensure that a patient’s needs and preferences are met over time, regardless of people, function and sites.	Patient/Family centered, team based activity designed to assess and meet the needs of the patient while helping them navigate the system.	The system takes responsibility for care in a way that seamlessly integrates personnel, information and other resources that are required to meet patient needs.
<i>Success</i>	The delivery of high quality, high value care that are in accordance with the needs and preferences of the patient/family.	Support of the patient through complex system navigation, which includes knowing where to send the patient, what information to transfer, designating accountability and responsibility for care by providers, and identifying and addressing gaps in patient needs (medical and non-medical)	Facilitate the appropriate and efficient delivery health services within and across the system.
<i>Failures</i>	Failures may occur at transition points within the system. Patients perceive failure as anything that requires an “unreasonable” degree of effort by them or care givers in order to meet care needs.	Poor health outcomes as a result of poor hand-offs or poor information exchanges are recognized as failure points, as well as any “unreasonable” level of effort to accomplish the necessary coordination activities.	A failure is perceived in terms of cost and quality. If a patient experiences a poor outcome due to fragmentation of care, those failures have corresponding affects upon the financial performance of the system as a whole.

The patient centered medical home and the medical neighborhood

⁷ *Care Coordination Measures Atlas*. AHRQ Publication No. 11-0023-EF, January 2011. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/careatlas/>

⁸ Adapted from AHRQ Care Coordination Atlas, Perspectives on Care Coordination

The typical primary care doctor must coordinate care within an average network of 229 other physicians from 117 practices⁹. This presents several barriers to the successful implementation of the PCMH and threatens the clinical and economic advantages of the model. Effective coordination of care is an essential element in the successful PCMH model and requires the willingness of specialists and other medical providers of care to participate in collaborative decision-making¹⁰. A 2009 survey of physicians by the Colorado Medical Society revealed that while a majority of physicians (both primary care and specialty care) ranked care coordination a major area of focus within their practice, only 15% of PCPs and 21% of specialists were satisfied with their communications with other facilities. In addition, physicians noted they always or regularly received necessary information from referrals 41% (PCPs) or 36% (specialists) of the time¹¹.

Mutual Benefits:

A compact, or care coordination agreement, offers significant mutual benefits to all stakeholders on the care team. A primary care team has the confidence of knowing that they are sending patients to a trusted, high quality specialty network that shares the same values around patient care and has corresponding care processes to support patients in their treatment outside the primary care office. A relationship with a specialist network offers the opportunity for reciprocal continuing medical education on clinical conditions that are relevant to their patient population. Specialists ensure that they are seeing the right patient at the right time with the pertinent clinical information at hand. In addition, a compact offers the opportunity of a consistent and prepared patient volume from their primary care partners. Clinical information at the point of service can reduce unnecessary, duplicative testing and clear designation of management responsibilities help care teams know who's on point for critical follow up and communication. Physicians can reclaim the joy of medicine and professional camaraderie by building clinical relationships to meet their patient needs. Most importantly, successful implementation of a care compact supports the patient by having a seamless health experience across multiple care settings because providers understand and can respond to their clinical needs, communicates their preferences and encourage patient activation and engagement in a collaborative manner.

Key Questions:

Overview and Introduction:

1. What is the medical home and how does it relate to a care coordination agreement?
2. What is a compact / care coordination agreement?
3. If you are a PCP, what does it mean to be first point of contact and principle coordinator of care?
 - I. What care processes need to be in place and functional prior to working on your medical neighborhood?
 - II. What can "evolve" as you work out the referral process with your specialist partners?
 - III. What are pros/cons of each approach?
 - IV. How can I perform as a medical neighbor without being a PCMH?

⁹ Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination. Pham, H et al. Ann Intern Med 2009;150:236-242.

¹⁰ "A Toolkit for Primary Care - Specialty Care Integration", R. Scott Hammond, MD and Caitlin Barba, MPH, Medical Home News, Volume 3, Number 2, February 2011.

¹¹ "Physician Perceptions on Care Coordination", Karen Leamer, MD FAAP and Gene Sherman, MD, FACC; Colorado Medicine, January/February 2010, pp 36-37.

4. Why codify the care coordination and referral relationships between primary care and specialists and specialist to specialists?
5. What interests you about care coordination agreements?
 - I. What doesn't work within your current referral relationship?
 - II. Think about your various referring partnerships and identify what elements work well for your practice?
 - III. Are there areas within your referral relationship that you feel strongly about and/or are non-negotiable as you develop care coordination agreements with your colleagues?
 - IV. How does fragmentation of health care affect your patient's outcomes and safety?
6. How does this fit with your current practice priorities (business or clinical)? How does it not fit?
7. Does the economics of health care affect you or create concerns on how you practice in the future?

First Steps

- Develop your vision, agree to improve care coordination, and adapt/adopt Collaborative Guidelines (Compact)
- Identify a list of key specialists /PCPs that you want to invite into your medical neighborhood and send invitations to join. Initiate conversations, when needed.

Tools:

- PCMH and the Medical Neighborhood (HTW visual)
- Quick tips to setting up a community meeting
- Medical Neighborhood Invitation Letter Template
- Medical Neighborhood Community Meeting Presentation Template
- *Guide to document for PCMH application and/or MHI standards [to be developed]*

Activities:

- Hosting a medical neighborhood welcome visit or "block party" using tools listed above

Supporting Literature:

- Building a Medical Neighborhood for the Medical Home, Elliot S. Fisher, MD, PhD. New England Journal of Medicine, 359;12 www.nejm.org September 18, 2008

Care Coordination Agreement

Care coordination agreement, compact, service level agreement or standardized checklist for referrals all refer to an explicit understanding between providers that outline expectations around defining accountability for care management, the sharing of clinical information, access to care and areas of care coordination to facilitate a well orchestrated and seamless care experience for the patient. The American College of Physicians (ACP) outlines clear clinical interactions and guiding principles for the medical neighborhood in their recent position paper on the interface of the PCMH with specialty practices. Agreements can be implemented in phases or in its entirety. Full participation by providers of

care requires purposeful evaluation and redesign of care processes. A care coordination agreement is not a legal document rather it offers standardized language to describe the referral process and outlines what each provider can provide in key areas.

Collaborative care agreements can take many forms but standardizing definitions for care responsibility and information are critical in order to create a shared language across provider communities. *For the purposes of this facilitation guide, we highly recommend that any collaborative care agreement developed maintain the ACP care management role definitions and include a section that outlines clinical records.* Several examples are listed in the appendix: a full scale collaborative care agreement, a one page document outlining expectations, and a standardized checklist for both primary and specialty care.

A PCMH-N is a subspecialty practice that engages in processes that:

- Ensure effective bidirectional communication, coordination, and integration with PCMH practices
- Ensure appropriate and timely consultations and referrals
- Ensure efficient, appropriate, and effective flow of necessary patient care information
- Effectively determine mutual responsibility in co-management situations
- Support patient-centered care, enhanced care access, and high levels of care quality and safety
- Support the PCMH practice as the provider of primary care to the patient and as having overall responsibility for ensuring the coordination and integration of all care.

Phase 1: Agreement on care management roles and clinical information sharing

The most important components of a care coordination agreement are identifying areas for mutual agreement on care transition, management definitions and accurate transfer of clinical information across the continuum of care. By knowing who's on point for clinical services and follow-up and having the clinical information at the point of service, each provider of care is prepared to care for the patient within their scope of expertise. In addition, care teams are equipped with specific knowledge about patient preferences and care plans.

Defining the care management roles. The ACP defines the following types of care management roles:

- Pre-Consultation Exchange: communication between primary care and specialist to answer a clinical question and/or determine the necessity of a formal consultation; facilitate timely access and determine the urgency of referral to specialty care; or facilitate the diagnostic evaluation of the patient prior to a specialty assessment. A pre-consultation exchange is intended to expedite/prioritize care or clarifies need for referral.¹²
- Formal Consultation: Referral of a patient to a specialist for a discrete diagnosis, diagnostic test, results, procedure, treatment or prognosis. Care is transferred back to the medical home for management and ongoing monitoring.
- Co-Management:

¹² American College of Physicians position paper on The Patient Centered Medical Home Neighbor: The Interface of the Patient Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia, American College of Physicians, 2010; Policy Paper

- With Shared Care for the Disease: a referral to a specialist where they provide expert advice, guidance and follow up of the patient for one specific condition. The medical home will manage the illness with support from the specialist.
- With Principle care for the disease: both the medical home and the specialist are concurrently active in the patient's treatment plan. The specialist assumes responsibility for the long-term, comprehensive management of the patients referred medical/surgical condition. The medical home receives reports and follows the patient for all other aspects of care, as well as offering input on quality of life/treatment decisions.
- With Principle care for a consuming illness: The specialist assumes primary care for the patient for a limited time due to the nature and impact of the clinical condition(s). The medical home continues to receive on-going treatment information and retains input on secondary referrals.
- Transfer of a patient to specialty care: This refers to a situation where a specialist assumes the role of the medical home by mutual agreement with the primary care provider and patient/family. The specialist agrees to provide care according to the Joint Principles and would be expected to meet the recognition/certification requirements as a medical home. Examples of this type of care would include end stage renal disease patient on dialysis or an infectious disease practice caring for an HIV/AIDs patient with complex medical and treatment issues.

As more practices join the information super-highway, health information technology becomes an increasingly important tool in care coordination. The ease with which clinical information can be extracted and shared will continue to evolve as standards, protocols and rules for communities adopt meaningful use and health data exchange.

The *transitions of care record, or minimum data set*, outlines the recommended clinical information that should be exchanged in the course of a patient transition through the care continuum. Groups implementing a collaborative care agreement can develop their own required clinical data sets or use/modify the PCP and Specialist Patient Transition Record in the Systems of Care Agreement. These data elements should become embedded in any measurement system put in place.

Phase 2: Care Coordination Agreement Elements:

Systems of Care Agreement

The particular elements of any care coordination agreement should be mutually agreed upon expectations that correspond to a physician or practice setting, ability to provide that service or information. Care coordination will likely be included in upcoming versions of meaningful use and payment reform. Individual physicians, physician communities or organized groups will benefit from having candid discussions about referral and information standards.

- i. Review and discuss Domains/Elements of Compact and PCP & Specialist patient transition record
- ii. Review and discuss mutual agreement for care transition (if applicable)
 1. Identify what is personal to physician approach (i.e. area of interest is sports medicine & rehab, only refer patients when ready for surgical intervention, etc.)

Key Questions:

Compact details

- I. If you could change one thing about the design of the care coordination agreement, what would it be and why?
- II. Referrals
 - a. Are there existing referral guidelines (formal or informal) within your specialty or within the community that offer guidance on seeing the right patient at the right time?
 - b. Is there an interest to develop condition specific educational guidelines between PCPs/Specialists to support the referral process?
 - c. How will secondary referrals to another specialist work? (i.e. exchange of clinical information, contact with primary care physician, patient preparation and development of shared care plan)
- III. Types of Management
 - a. Are there additional types of management that you think are not covered?
 - b. How do you currently express clear designation of care responsibility and accountability in your current progress notes? Are there changes that you will need to make in order to sync up and speak the same “language” about care responsibility and accountability?
 - c. Are there areas within the types of care management that you do not feel comfortable with and/or cannot agree to? If so, why?
- IV. Collaborative Care Domains: Transitions of Care, Access, Collaborative Care Management
 - a. Are the expectations something that you can provide in the course of a referral?
 - b. How will you be able to distinguish a patient’s level of urgency for an appointment and be able to respond to it within an appropriate and agreed upon time frame.
 - c. What changes will you need to make in your office processes or care notes in order to deliver that information?
- V. Patient Communication
 - a. Does the patient have a specific agenda, set of needs or plan for the visit? What are the techniques that you employ to understand the patient’s agenda?
 - b. Do you have a system in place to identify if there are issues or barriers that prevent the patient from following through on care recommendations? (i.e. language or cognitive issues, family or community support not available, etc) How or is it appropriate to share with other providers of care?
 - c. How will you prepare the patient for their next visit or service (whether that care is provided by you or another provider)?
 - d. What is the role of the primary care physician or specialist in communicating patient wishes that are expressed within a visit while respecting patient confidentiality?
- VI. Patient Transition Record
 - a. Are you consistently sending patient information and medical records to your colleagues? What elements of the Patient Transition Record are missing? What information transfer system will work for your practice? How do you need to change your work flow?

- b. Do you have the resources to capture the essential elements of the Report in an effective and consistent way?
- c. How will you track and measure your performance? What tracking system is most appropriate for your system?

First Steps:

- Review each item of the Compact **and determine action plan**
- Choose a Quality Improvement model that will be most successful in your practice?

Tools:

- 6 Steps to Becoming a Medical Neighbor
- Types of Care Transitions Quiz
- PCMH –N Specialty List Template
- Practice Survey Questionnaire (practice self assessment) [need scoring tool from Perry]
- Diabetes Case Study (Carol Greenlee, MD)
- Sample ACP Checklist
- Sample 1 Page Compact

Activities:

- Compact Table Top Exercise: Ideal Referral State
- Action Planning: Building Your Medical Neighborhood

Supporting Literature:

- Chen, AH, Improving the Primary Care-Specialty Care Interface. Arch Intern Med. 2009;169:1024-1025
- Forrest, CB, A Typology of Specialists' Clinical Roles. Arch Intern Med. 2009;169:1062-1006
- American College of Physicians position paper on The Patient Centered Medical Home Neighbor: The Interface of the Patient Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia, American College of Physicians, 2010; Policy Paper

Implementation of Collaborative Care Agreement

The 2011 NCQA Patient Centered Medical Home Standards places greater emphasis on care coordination, both in tracking results of testing done outside the medical home, referral tracking and follow-up and coordination with facilities and care transitions.

Operational execution is probably the most challenging component of the agreement, as it will require an evaluation and redesign of current care processes for both the medical home and the medical neighbor. The ability of a practice to consistently and reliably follow through on the associated tasks and activities below will need to be assessed and modified whether implementing the agreement as a medical home or as a medical neighbor.

- Preparing the referral and the clinical record:

- Ensuring that all elements of the transition of care record are available at the next scheduled point of service (primary care referral to a specialist office, specialist office hands back to primary care office, ancillary provider, hospital)
- Clearly identifying type of care management and responsibility for specific elements of care and follow up.
- Alters consult templates (written or electronic) to capture and communicate critical clinical and care management information.
- Preparing and meeting the needs of the patient:
 - Referral contact information readily available to share with patients
 - Establishes purpose, expectations and goals of the visit and/or shares diagnosis, prognosis and treatment plan.
 - Communicates appropriate time frame for specialist appointment and/or follow up appointment
 - Designs treatment interventions with a sensitivity to patients' needs and preferences (i.e. culturally sensitive, education materials in primary language, meets relevant insurance requirements, provides training and education for complex issues, assess patient confidence for self care)
- Being a good partner
 - Administrative:
 - Identification of single point of contact for referrals within office for questions
 - Be accessible to patient with reasonable office hours and timeframes for next available appointment based on urgency of clinical need.
 - Provide and accept respectful feedback from staff, physicians and patients in the spirit of improvement.
 - Obtains appropriate prior authorization
 - Understands and acts upon preferences for secondary/tertiary referrals
 - Clinical:
 - Availability of (number that will be answered for clinical issues) physician to answer physician or patient calls to facilitate care such as, discussion of treatment plan, assist in appropriate work-up or follow up, and for urgent matters
 - Offer ongoing clinical expertise to support shared care plan

The Systems of Care Initiative has developed, and continues to evolve, a comprehensive medical neighborhood toolkit to support the patient centered medical home implementation of the Primary Care-Specialist Physician Collaborative Guidelines. Many of these tools are referenced and utilized throughout the facilitation guide. The toolkit follows the 5 A's format (Ask, Advise, Assess, Assist, Arrange). This comprehensive approach walks practices through the process of identifying, establishing and monitoring the medical neighborhood on a monthly or quarterly basis. Practices typically spend about 5-8 hours for initial set up of their medical neighborhood and approximately 2 hours for each new medical neighbor. Routine monitoring and feedback is approximately 1-2 hours, depending on the frequency of your measurements. Please see appendix for the complete set of tools.

This Care Collaborative Agreement Facilitation Guide has been developed for general distribution with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative. Please reference the initiative in any reprints or revisions May 2011

Key Questions:

Implementation Discussion Items

- I. What are challenges that you see to implementation?
- II. What are the benefits to implementing this kind of process?
- III. How well do you think your practice performs on care coordination? How do you know? Please describe that process. Is it documented?
- IV. Why go to the effort to formalize care processes and care coordination at your practice?
- V. Who needs to be brought into this discussion at your practice in order to make this agreement work?
- VI. Are there improvement projects that your practice has undertaken in the past few years that have been successful? What are the elements that made that project successful?
- VII. How will you communicate this new effort to your staff? What are things that you can communicate to them that will help them understand why you are changing the current process? (i.e. How/why this is important in improving patient care? What will this effort require of them? What is their role? What is the time commitment?)

First Steps:

- Audit your referral notes to be sure they satisfy the Transition Record core elements
- Develop a QI plan and timeline to implement changes
- Create 'breathing space' for transformation champions to work on the change process.

Tools:

- Primary Care Checklist by Roles
- Specialist Office Workflow for Compact Implementation [to be developed]
- Sample Consult Forms
- PCMH-N Fax Cover Sheet
- Specialist Transition Record Checklist
- Sample Consult Note

Activities:

- Test Tracking Rapid Improvement Activity (Health TeamWorks)
- Building a Medical Neighborhood: Implementation Guide (5 A's)

Supporting Literature:

- "A Toolkit for Primary Care - Specialty Care Integration", R. Scott Hammond, MD and Caitlin Barba, MPH, Medical Home News, Volume 3, Number 2, February 2011.
- Care Coordination: Reducing Care Fragmentation in Primary Care and Implementation Guide, Safety Net Medical Home Initiative, April 2011.

Measurement: Monitoring and improvement

An important component of undertaking any new initiative that can impact patient care is to understand if your intervention had the anticipated impact. Whether you are using a formal scorecard system or using a Plan-Do-Study-Act format, measuring performance is a critical feedback loop to ensuring accountability and offers insight into opportunities for improvement and communication going forward. Your group needs to define up front what it wants to measure in the implementation of the collaborative care agreement. In order to support patient safety and practice efficiency, we recommend that at minimum you measure a) clear identification of care management roles outlining responsibility for care (ie. do you know who is on point for what components of care based on the progress note) b) completeness of the clinical data set transferred between primary care and specialists.

The Systems of Care Initiative Medical Neighborhood toolkit developed a scorecard for both the primary care physician and the specialist to ensure that the compact is measurable and accountable for all parties. The scorecard mirrors the four domains of the SOC compact (Transitions of Care, Access, Collaborative Care Management, and Patient Communication) as well as the transition of care record (TCR) and has qualitative and quantitative measures. An excel spreadsheet has been developed with embedded formulas to track and report outcomes. It is recommended that scoring is conducted quarterly during the initial phases of implementation to identify and correct any issues that may arise.

Key Questions:

I. Measurement

- a. What is your overall aim in implementing a collaborative care agreement? How will you know if you have achieved that aim?
 - i. Are you measuring acceptance and participation in the collaborative care agreement? What elements indicate adherence? [process measurements]
 - ii. Are you measuring improved care coordination? What measurable elements exist that help you understand improvement? [outcomes measurements]
- b. What are your data sources to determine measurement?
- c. How will you determine whether the care coordination agreement is working?
- d. What are your specific expectations for:
 - i. Receipt of clinical information prior to patient visit? Results of patient visit?
- e. Have you designated “Must Haves”, “Important to Have” and “Nice to Have” elements of your the collaborative care agreement?
 - i. What will you do if a practice does not meet the Must Have elements?

II. Monitoring & Improvement:

- a. How often will you audit your results? The results of other providers
- b. How will you share your findings with other providers?
- c. If you opt to put a practice on an Action Plan, what will that look like? How will you communicate that? How often will you re-visit that practice’s performance?

- III. Agreement going forward: Are you keeping in pace with changes with new technology and policy in the health care system?
- IV. What mechanisms can be put in place that provides regular review and evaluation of the agreement? Who's responsibility is it?
- V. How often should this agreement be re-visit?
- VI. What steps can you take if you feel that the care coordination agreement is not working for your patients or your practice?

First Steps:

- Score your practice and determine if you satisfy all 'Must haves'. As your first priority, create an action plan to ensure that your practice fulfills these criteria.

Tools:

- PCP Medical Neighborhood Score Card
- Specialist Medical Neighborhood Score Card
- Score Card Tracking (Excel Spreadsheet)
- Patient Satisfaction Survey Sample
- PDSA Template
- Online tutorial completing the score card excel spreadsheet (to be developed)

Activities:

- If you are developing your own measurement approach, the following link at the ARHQ Care Coordination Atlas provides a methodology to map your activity to validated care management assessment tools. <http://www.ahrq.gov/qual/careatlas/careatlas4.htm>
- *Care Coordination Measures Atlas*. AHRQ Publication No. 11-0023-EF, January 2011. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/careatlas/>

Supporting Literature:

- McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, and Malcolm E. "Care Coordination Atlas - Version 3" AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.
- National Quality Forum (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*, Washington, DC: NQF; 2010.
- www.IHI.org

Other Issues for Consideration

Key Questions:

- I. How do you ensure that the patient is at the center of care?
- II. What is the role of HIE in a care coordination agreement?
- III. How does something like a care coordination agreement align with efforts within your community?

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IV. How do you identify, address, and communicate patient goals?

Tools:

- Patient Activation Assessment Form: <http://www.ipro.org/index/cms-filessystem-action/care/cti/ptactivationassess1.pdf>
- Partnering in Self-Management Support: *A Toolkit for Clinicians*: Institute for Healthcare Improvement; 2009: <http://www.newhealthpartnerships.org/provider.aspx?id=1544>
- The Care Transition Program, Eric Coleman, M.D.: <http://www.caretransitions.org/>
- Web Technology for Patient Referrals;
<http://www.chcf.org/%7E/media/Files/PDF/B/PDF%20BridgingTheCareGap.pdf>

Activities:

- Contact your State REC provider (CO – Health TeamWorks, Physician Health Partners,...)

Key Issues to Track & Trend with groups utilizing some form of a care compact:

2. What interests you about care compacts? Why did you opt for a formalized agreement?
3. How are care coordination agreements being implemented? (1:1 outreach, group meetings, IPA/PHOs, other) Why this format?
4. What activities have you undertaken to provide education about the compact? How effective were those activities?
5. What activities have you undertaken to support the implementation of the compact within physician practices?
6. What were the biggest barriers/obstacles to achieve implementation?
7. How are you measuring adherences to the compact?
8. What practice redesign was necessary to implement the agreement?
9. What resources would be needed to spread this program?
10. How many physicians are impacted by the care collaborative agreements?
11. Are there any strategic learnings that you feel are important to share with other groups that are considering implementing compacts?

Key Findings:

Westminster Medical Clinic experience:

2. Interest in and agreement to the compact was not a barrier; ability of specialty practices to effectively operationalize compact seems to be significant challenge.
 - a. Specialists have interest in working on increasing efficiency and improving patient satisfaction
 - b. Agreement with physician leaders doesn't always translate to prioritization with office manager so find resistance to investing staff time in working on practice improvement
 - c. Specialists have the belief that they are doing higher-level quality tracking/improvements in office but this is not reflective of their practice operations.
 - d. Operational challenges in identifying medical home patients and directing them to correct physician (in large practices) and receipt back of correct clinical information are poor.
3. See PCMH as another "gatekeeper model" or term not known/understood
 - a. Specialty offices perceive PCMH patients as VIP
 - b. Question necessity of communicating with other team players (i.e. PCP or allied health) unless directly referred or questioned
4. Specialist practices do not have experience with practice improvement value and techniques and oftentimes lack infrastructure (such as population based reporting tools) to facilitate quality improvement:
 - a. Lack of access to published evidence-based guidelines that lend themselves to broad implementation
 - b. Lack of access to nationally endorsed performance measures (needs additional research, PQRI is a good place to start)

Appendix

Principles of the Patient-Centered Medical Neighborhood

Table. American College of Physicians' Position Paper on PCMH-Ns: Summary Points¹³

Collaboration between specialty and subspecialty practices is important to achieve improved care integration and coordination within the PCMH care delivery model.

A PCMH-N is a subspecialty practice that engages in processes that

- Ensure effective bidirectional communication, coordination, and integration with PCMH practices
- Ensure appropriate and timely consultations and referrals
- Ensure efficient, appropriate, and effective flow of necessary patient care information
- Effectively guide determination of responsibility in co-management situations
- Support patient-centered care, enhanced care access, and high levels of care quality and safety
- Support the PCMH practice as the provider of primary care to the patient and as having overall responsibility for ensuring the coordination and integration of all care.

Interaction between PCMHs and PCMH-Ns can take the following forms:

- Pre-consultation exchange: intended to expedite or prioritize care, or clarify need for a referral
- Formal consultation: to deal with a discrete question or procedure
- Co-management with shared management for a disease, with principal care for a disease, or with principal care of the patient for a consuming illness for a limited period
- Transfer of patient to a specialty PCMH (that meets the same requirements as the primary care PCMH) for the entirety of care

Care coordination agreements between PCMH and PCMH-N practices should aspire to

- Define the types of referral, consultation, and co-management arrangements available
- Specify who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements
- Specify the content of a patient transition record or core data set, which travels with the patient in all referral, consultation, and co-management arrangements
- Define expectations regarding the information content requirements, as
- Specify how secondary referrals are to be handled
- Maintain a patient-centered address for situations of self-referral by the patient to a PCMH-N practice
- Clarify inpatient processes, including notification of admission, secondary referrals, data exchange, and transitions into and out of hospital
- Contain language emphasizing that in the event of emergencies or other circumstances in which contact with the PCMH is not practical, the specialty or subspecialty practice may act urgently to secure appropriate medical care for the patient
- Include mechanisms for regular review of the terms of the care coordination agreement and for evaluation of cooperation and quality of joint care.

¹³ Laine, C. Welcome to the Patient-Centered Medical Neighborhood. *Ann Intern Med.* 2011;154:60.



Creating
Medical Home Communities

Systems of Care/Patient Centered Medical Home Initiative

Primary Care – Specialist Physician Collaborative Guidelines

Purpose

- To provide optimal health care for our patients.
- To provide a framework for better communication and safe transition of care between primary care and specialty care providers.

Principles

- Safe, effective and timely patient care is our central goal.
- Effective communication between primary care and specialty care is key to providing optimal patient care and to eliminate the waste and excess costs of health care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- A high functioning medical system of care provides patients with access to the ‘right care at the right time in the right place’.

Definitions

- Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients.
- Specialist – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.
- Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.
- Transition of Care – an event that occurs when the medical care of a patient is assumed by another medical provider or facility such as a consultation or hospitalization.
- Technical Procedure – transfer of care to obtain a clinical procedure for diagnostic, therapeutic, or palliative purposes.
- Patient-Centered Medical Home – a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.
- Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment options, and expectations taking into consideration the patient’s psychosocial and personal needs.

- Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

Types of Transitions of Care

Pre-consultation exchange – communication between the generalist and specialist to:

Answer a clinical question and/or determine the necessity of a formal consultation.

Facilitate timely access and determine the urgency of referral to specialty care.

Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.

Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient’s diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.

Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient’s health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources as outlined by the “Joint Principles” and meeting the requirements of NCQA PPC-PCMH recognition.

Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.

Co-management with Shared management for the disease -- *the specialist shares long-term management with the primary care physician for a patient’s referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the PCMH and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.*

Co-management with Principal Care for the Disease (Referral) – *the specialist assumes responsibility for the long-term, comprehensive management of a patient’s referred medical/surgical condition. The PCMH continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The generalist continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.*

Co-management with Principal Care for the Patient (Consuming illness) – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The PCMH remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.

Emergency care – medical or surgical care obtained on an urgent or emergent basis.

Mutual Agreement for Care Management

- Review tables and determine which services you can provide.
- The *Mutual Agreement* section of the tables reflect the core elements of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The *Expectations* section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or specialist.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to specialty care, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCMH, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.
- Each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

Transition of Care

Mutual Agreement

- *Maintain accurate and up-to-date clinical record.*
- When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD]
- Ensure safe and timely transfer of care of a prepared patient.

Expectations

Primary Care

- PCP maintains complete and up-to-date clinical record including demographics.*
- Transfers information as outlined in Patient Transition Record.
- Orders appropriate studies that would facilitate the specialty visit.
- Provides patient with specialist contact information and expected timeframe for appointment.
- Informs patient of need, purpose (specific question), expectations and goals of the specialty visit
- Patient/family in agreement with referral, type of referral and selection of specialist

Specialty Care

- Determines and/or confirms insurance eligibility*
- Identifies a specific referral contact person to communicate with the PCMH
- When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up.
- Informs patient of need, purpose, expectations and goals of hospitalization or other transfers.
- Notifies referring provider of inappropriate referrals and explains reasons.

Additional agreements/edits: _____

Access

Mutual Agreement

- *Be readily available for urgent help to both the physician and patient.*
- Provide adequate visit availability.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters.
- When available and clinically practical, provide a secure email option for communication with established patients and/or providers.

Expectations

Primary Care

- Communicate with patients who “no-show” to specialists.
- Determines reasonable time frame for specialist appointment.

Specialty Care

- Notifies PCP of first visit ‘no-shows’ or other actions that place patient in jeopardy.
- Schedule patient’s first appointment with requested physician.
- Provides PCP with list of practice physicians who agree to compact principles.

Additional agreements/edits: _____

Collaborative Care Management

Mutual Agreement

- *Define responsibilities between PCP, specialist and patient.*
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met
- Agree on type of care that best fits the patient's needs.

Expectations

Primary Care

- Follows the principles of the Patient Centered Medical Home or Medical Home Index.*
- Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills.*
- Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines.*
- Resumes care of patient as outlined by specialist, assumes responsibility and incorporates care plan recommendations into the overall care of the patient.
- Shares data with specialist in timely manner including pertinent consultations or care plans from other care providers.

Specialty Care

1. *Reviews information sent by PCP and addresses provider and patient concerns.*
2. *Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization.*
3. Confers with PCP before refers to secondary/tertiary specialists for problems within the PCP scope of care and , when appropriate, uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization when needed.
4. Sends timely reports to PCP and shares data with care team as outlined in the Transition of Care Record.
5. Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations.
 - Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs.*
6. Provides useful and necessary education/guidelines/protocols to PCP, as needed

Additional agreements/edits: _____

Patient Communication

Mutual Agreement

- Consider patient/family choices in care management, diagnostic testing and treatment plan.
- Provide to and obtain informed consent from patient according to community standards.
- Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team.

Expectations

Primary Care

- Explains, clarifies, and secures mutual agreement with patient on recommended care plan.
- Assists patient in identifying their treatment goals.
- Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team.

Specialty Care

- Informs patient of diagnosis, prognosis and follow-up recommendations.*
- Provides educational material and resources to patient when appropriate.*
- Recommends appropriate follow-up with PCP.
- Be available to the patient discuss questions or concerns regarding the consultation or their care management.
- Participates with patient care team.

Additional agreements/edits: _____

Appendix

PCP Patient Transition Record

Practice details – PCP, PCMH level, contact numbers (regular, emergency)

Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation and contact information.

Diagnosis -- ICD-9 code

Query/Request – a clear clinical reason for patient transfer and anticipated goals of care and interventions.

Clinical Data --

- problem list
- medical and surgical history
- current medication
- immunizations
- allergy/contraindication list
- care plan
- relevant notes
- pertinent labs and diagnostics tests
- patient cognitive status
- caregiver status
- advanced directives
- list of other providers

Type of transition of care.

- Consultation
- Co-management
- Principal care
- Consuming illness
- Shared care
- Specialty Medical Home Network (complete transition of care to specialist practice)
- Technical procedure

Visit status -- routine, urgent, emergent (specify time frame).

Communication and follow-up preference – phone, letter, fax or e-mail

Specialist Patient Transition Record --Initial

- Practice details – Specialist name, contact numbers (regular, emergency)
- Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation.
- Communication preference – phone, letter, fax or e-mail
- Diagnoses (ICD-9 codes)
- Clinical Data – problem list, medical/surgical history, current medication, labs and diagnostic tests, list of other providers.
- Recommendations – communicate opinion and recommendations for further diagnostic testing/imaging, additional referrals and/or treatment. Develop an evidence-based care plan with responsibilities and expectations of the specialist and primary care physician that clearly outline:
 - new or changed diagnoses
 - medication or medical equipment changes, refill and monitoring responsibility.
 - recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
 - secondary diagnoses.
 - patient goals, input and education provided on disease state and management .
 - care teams and community resources.
- Technical Procedure – summarize the need for procedure, risks/benefits, the informed consent and procedure details with timely communication of findings and recommendations.
- Follow-up status – Specify time frame for next appointment to PCP and specialist. Define collaborative relationship and individual responsibilities.
- Consultation
- Co-management
- Principal care
- Shared care
- Consuming illness
- Specialty Medical Home Network (complete transition of care to specialist practice)
- Technical procedure

Specialist Patient Transition Record -- Follow-up

- Practice details – Specialist name, contact numbers
- Patient demographics -- Patient name, DOB, PCP designation.
- Clinical Data –interval history and pertinent exam, current medication and allergies list, new labs and diagnostic tests.
- Diagnoses (ICD-9 codes)
- Note new or changed diagnoses
- New or current secondary diagnoses.

Care Plan Recommendations –

- 1.** Communicate opinion and recommendations for diagnosis, further diagnostic testing/imaging, additional referrals and/or treatment.
 - a.** Technical Procedure – summarize the need for procedure, risks/benefits, with timely communication of findings and recommendations.
- 2.** Develop an evidence-based care plan that clearly specifies responsibilities and expectations of the specialist and primary care physician:
 - a.** Medication or medical equipment changes, refills and monitoring responsibility.
 - b.** Recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
 - c.** Community or medical resources obtained or needed such as Home Health, Social Services, Physical Therapy, etc.
 - d.** Patient goals –
 - e.** Outline education and consultation provided to patient on med/surgical condition, prognosis and management and summarize their desired outcome/needs/goals/expectations and understanding.

Specify Follow-up status –

- 1.** Specify Transition of care status – Consultation, Co-management (shared care, principle care, consuming illness), Technical procedure
- 2.** Specify preference for bi-directional communication (phone, letter, fax or e-mail) – how does specialist prefer to send information to PCP and how does specialist want to be contacted by PCP.
- 3.** Specify time frame for next appointment to PCP
- 4.** Specify time frame for next appointment to specialist.

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- Primary Care – Specialty Care Master Service Agreement CPMG - Kaiser Permanente. June 2008
- Care Coordination and Care Collaboration between PCP and Specialty Care template from TransforMed Delta Exchange
- Coordination Model: PCP to Specialist process map– from Johns Hopkins Bloomberg School of Medicine. The development and testing of EHR-based care coordination performance measures in ambulatory care (current study).
- Direct Referrals Model - Quality Health Network communication
- Principles of Service Agreements for PCMH and PCMH-N, American College of Physicians internal document 10-09.
- Dropping the Baton: Exploring what can go wrong during patient handoffs and reducing the risk. COPIC Insurance Company. Sept 2009 (151)

Physician Health Partners Primary Care-Specialty Care Collaborative Guidelines

Transition of Care	
<i>Mutual Agreement</i>	
Maintain accurate and up-to-date clinical record.	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Clarify type of transition: co-management, advice, complete transfer and be clear about the question being asked <input type="checkbox"/> Transfer detailed baseline information, including methods tried to date and tests performed (including copies of labs and other studies) <input type="checkbox"/> Provides patient with specialist contact information <input type="checkbox"/> Review information sent from the specialist 	<ul style="list-style-type: none"> <input type="checkbox"/> Provide single source contact person to coordinate services with specialist or primary care practice and easy access to PCP for coordination of care <input type="checkbox"/> When PCP uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up <input type="checkbox"/> Review information sent from the PCP
Access	
<i>Mutual Agreement</i>	
Be readily available for urgent help to both the physician and patient via phone. Be prepared to respond to urgencies. Provide alternate back-up when unavailable for urgent matters.	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Determines reasonable time frame for specialist appointment <input type="checkbox"/> Be open to preferences about location of admit <input type="checkbox"/> Provide specialist easy access to discuss case by phone if need be. 	<ul style="list-style-type: none"> <input type="checkbox"/> Have timely consultation appointments available to meet patient and referral source requests <input type="checkbox"/> Be open to preferences about location of admit <input type="checkbox"/> Discuss special arrangements, as needed
Collaborative Care Management	
<i>Mutual Agreement</i>	
Define responsibilities between PCP, specialist and patient. Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up). Give and accept respectful feedback when expectations, guidelines or standard of care are not met	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Review information sent by Specialist and follows-up on questions <input type="checkbox"/> Resumes care of patient when patient returns from specialist care and acts on care plan developed by specialist. <input type="checkbox"/> If surgery needs to be done, performs pre-operative evaluation <input type="checkbox"/> Order labs, radiological studies, etc., as applicable 	<ul style="list-style-type: none"> <input type="checkbox"/> Reviews information sent by PCP and follows-up on questions <input type="checkbox"/> Sends timely reports to PCP to include a care plan, follow-up, test results and studies and provides clear recommended next steps <input type="checkbox"/> If surgery needs to be done, performs pre-operative evaluation <input type="checkbox"/> Order labs, radiological studies, etc., as applicable <input type="checkbox"/> Returns care to PCP once patient is stable
Patient Communication	
<i>Mutual Agreement</i>	
Consider patient/family choices in care management, diagnostic testing and treatment plan. Provide to and obtain informed consent from patient according to community standards.	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Explains specialist results and treatment plan to patient, as necessary <input type="checkbox"/> Identifies whom the patient wishes to be included in their care team 	<ul style="list-style-type: none"> <input type="checkbox"/> Informs patient of diagnosis, prognosis and follow-up recommendations <input type="checkbox"/> Recommends appropriate follow-up with specialist and PCP

Specialty Referral Request Checklist:

(This information can be communicated through any of several means including a paper-based referral form, detailed clinical note from last appointment or abstraction from an Electronic Medical Record)

- Patient name and demographics.
- Contact person (if not the patient) and appropriate numbers.
- Any special considerations required such as loss of vision, hearing loss, language preference, cognitive deficits, or cultural factors.
- Insurance company name/type of coverage.
- Referring provider name and contact information including number for direct contact for urgent issues (could be a specified staff person, physician cell phone or back office line).
- Indicate if urgent or routine (if urgent please call or directly contact the physician or referral coordinator for the specialty practice).
- Indicate type of referral requested:
 - _____ **Pre-visit Preparation/Assistance**
 - _____ **Consultation (Evaluate and Advise)**
 - _____ **Procedure**
 - _____ **Please assume Co-Management with Shared Care***
 - _____ **Please assume Co-Management with Principal Care****
 - _____ **Please assume full responsibility for complete transfer of all patient care**
- Provide detailed reason for referral, including the clinical question you want answered and a brief summary of case details pertinent to the referral including significant co-morbidities.
- Attach core data set/ clinical summary / continuity care record (reconciled problem list with chronic conditions, medication list; medical allergies; pertinent surgical history, family history, habits/social history; list of providers (care team); advance directive; current care plan).
- Attach pertinent data including office notes or care summaries, lab and imaging results, or anything else felt to be helpful to the evaluation and /or management of the patient (i.e., data showing a pattern over time provided in an organized manner).
- Ensure patient is aware of and in agreement with the referral. Ask patient to call for appointment or let specialty practice know if special scheduling arrangements are required.

*Shared care indicates that the care of the referred patient for a specified condition or set of conditions is shared between the PCMH and the Neighbor with the PCMH assuming responsibility for most or all of the elements of care for the specified condition, unless other arrangements agreed upon.

**Principal care indicates that the care of the referred patient for a specified condition or set of conditions is managed by the Neighbor with assumption of the elements of care for that condition, unless other arrangements or agreed upon.

Referral Response Critical Elements Checklist*:

(This information can be communicated through any of several means including a paper-based referral form, detailed clinical note from last appointment or abstraction from an Electronic Medical Record)

Patient Name: _____ Date Of Birth: ____/____/____
Referring Provider: _____ Specialist's Name/Practice: _____

Reason for Referral/Clinical Question: _____

- Acknowledge acceptance of referral and indicate any recommended changes in referral type and why (i.e., requested consultation but actually need "Shared Care" for this problem).
- Diagnoses (include confirmed, new, changed or suspected diagnoses as well as any ruled-out diagnoses pertinent to the reason for referral/clinical question).
- Secondary Diagnoses (include any new identified or suspected disorders not directly related to referred disorder but which may need further evaluation and/or management. Clarify who should take primary responsibility for that follow up).
- Medication changes (include new medications, samples provided, changes in dosage or form (i.e., solid to liquid), and any medications discontinued. Indicate whether any changes have already been instituted or need to be instituted by PCMH).
- Equipment changes (include new, changed or discontinued items and indicate whether any changes have already been instituted or need to be instituted by PCMH).
- Diagnostic testing (include results of testing already completed, tests that have results pending and tests that have been scheduled and clarify whether Neighbor or PCMH needs to follow up).
- Patient Education (include education completed, scheduled or recommended as well as patient information provided)
- Procedures (include procedures completed with results/outcomes; list other procedures scheduled/recommended)
- Referrals: (include other referrals completed, scheduled or recommended and reason for those referrals)
- Follow up (list any further follow up that is recommended with specialist or PCMH, specify time frame and indicate whether that has already been scheduled or not).
- Indicate any special requests or other recommendations:

*The above should be presented as a stand-alone document or as the first page of a complete response note that includes a history and physical (H&P), full evaluation and other relevant information. This should reach the referring and other pertinent providers that are part of the patient's care team, in a timely fashion, such as within one week of the referral visit if not sooner.

This Care Collaborative Agreement Facilitation Guide has been developed for general distribution with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative. Please reference the initiative in any reprints or revisions May 2011

Synopsis of Medical Home/Medical Neighbor Responsibilities based on Type of Care Management

Adopted from American College of Physicians Sub-Specialty Committee on PCMH-N

Patient Centered Medical Home Responsibilities	Medical Neighbor Responsibilities
All Patients: Referrals, Consults, Co-Management:	
<ul style="list-style-type: none"> • Prepare the patient: <ul style="list-style-type: none"> ○ Use of referral guidelines where available ○ Patient/family aware of reason for referral and type of referral ○ Patient/family in agreement with referral, type of referral and selection of specialist ○ Expectations for events and outcomes of referral • Provide appropriate and adequate information: <ul style="list-style-type: none"> ○ Demographic and insurance information ○ Reason for referral, details ○ Core medical data on patient ○ Clinical data pertinent to reason for referral • Indication of urgency <ul style="list-style-type: none"> ○ Direct contact with specialist for urgent cases • Contact number for additional information or urgent matters <ul style="list-style-type: none"> ○ Needs to be answered by responsible contact 	<ul style="list-style-type: none"> • Review referral requests and triage according to urgency <ul style="list-style-type: none"> ○ Maintain schedule to allow for urgent care ○ Notify referring provider of inappropriate referral ○ Work with referring provider to expedite care in urgent cases ○ Verify insurance status ○ Anticipate special needs of patient/family • Notify referring provider of no-shows and cancellations • Notify referring provider of changes in care plan: recommended interactions, diagnosis, medication, equipment, testing, procedures, education, referrals, follow-up recommendations or needed actions.
Co-Management with Shared Care	
<ul style="list-style-type: none"> • Assume responsibility for elements of care unless special arrangements are agreed upon with specialist and patient/family • Share data with specialist in timely manner • Communicate directly with specialist in any matter that requires change to care plan • Ensure appropriate follow up with specialist 	<ul style="list-style-type: none"> • Develop care plan with input from patient • Share care plan with referring provider • Review data on patient as received from PCMH and incorporate into patient chart • Communicate with PCMH on any matters of concern regarding data received on patient • Coordinate any secondary referral or treatment of secondary disorders with the PCMH or pre-specify terms • Communicate with PCMH regarding any interim issues that arise • Communicate follow up findings and any changes to care plan/critical elements to PCMH

Co-Management with Principle Care of Disorder

- | | |
|--|---|
| <ul style="list-style-type: none">• Review care plan and incorporate it into overall patient care plan• Share data with principle care provider, including pertinent consultations or care plans from other care providers. | <ul style="list-style-type: none">• Assume responsibility for the elements of care unless special arrangements are agreed upon by the PCMH and patient/family• Share data with the PCMH and other pertinent care team providers• Respond to data from other providers as needed for the care of the patient and incorporate into patient record• Maintain a chronic disease registry if appropriate for the condition and appropriate follow up of condition(s)• Respond to patient and family questions• Communicate with other providers to integrate care as needed• Manage secondary diagnoses that pertain to disorder of principle care and refer others back to PCMH• Make secondary referrals if appropriate to management of disorder of principle care and coordinate others with PCMH• Communicate follow up findings and changes in care/critical elements with PCMH and other pertinent care providers |
|--|---|

PDSA Template (Plan-Do-Study-Act)

Project Name: _____

Responsible: _____

Date: _____

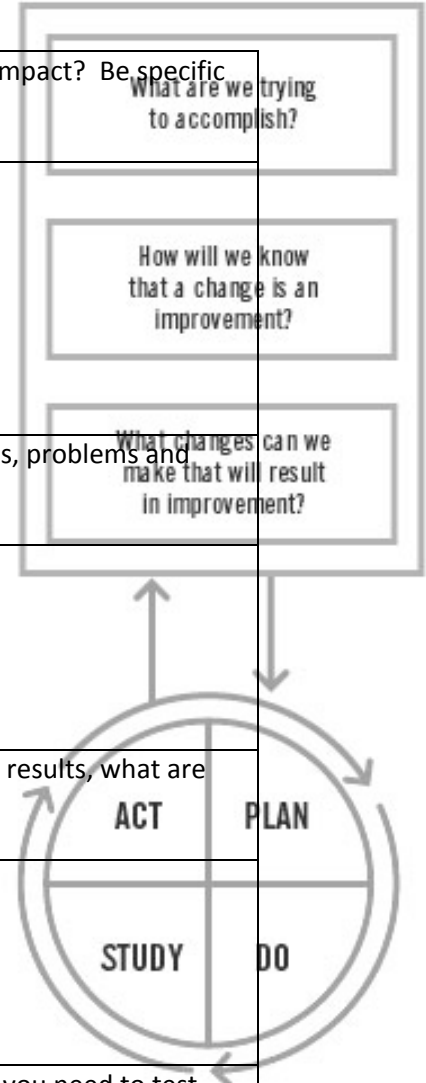
Aim Statement: **(Aim statement should be specific, measurable and concise)**

Plan: What test of change are your proposing, what do you think is the potential impact? Be specific about who, what, where and when

Do: Carry out the small test of change and document what you found (experiences, problems and surprises)

Study: Analyze the results of the test, how did this compare with your anticipated results, what are your learnings?

Act: Are there refinements or adjustments that need to be made to the plan? Do you need to test again prior to implementation?



Ideal State Referral Process

Compact Table Top Exercise

Purpose:

Facilitate a group discussion around continuity of care through a “future” state exercise on the referral process and identify focus areas to improve coordination of care.

Objectives:

- Highlight the value and utility of implementing a care compact through gap analysis. (ie. back into the need for a care compact)
- Group defines what the compact elements (types of management, transition of care, access, collaborative care management, patient communication, and transition record) mean with their own language and examples.
- Group develops an action plan to improve referral process and is introduced to tools that will support that improvement (ie. Rapid Improvement Activity, Implementation of Care Compact, Compact Score Card).

Introduction (15 minutes):

1. Patient story on care coordination – hosting physician relates patient story about why care coordination needs to be a priority between PCPs and specialists. – make is personal!
2. Continuity of Care: refers to the degree to which patients experience discrete components of healthcare as coherent, organized, and connected and consistent with their needs.
 - a. *Relational Continuity*: refers to ongoing caring relationships where a patient is known by his or her providers so that past care is linked with current care, usually with the expectation that the relationships will continue in the future.
 - b. *Informational Continuity*: refers to the transfer of information from one episode of care to another, and the notion that relevant information is taken up and acted upon over time.
 - c. *Managerial Continuity*: refers to the notion that care is coherently organized and planned and that today’s care decisions take into account yesterday’s care experience.¹⁴
3. *How effective do you think the continuity of care is for your patients? How do you know? How effectively do you think your “community” is at realizing continuity? If the goal is to see the right patient at the right time, what can you do differently to ensure that happens? What is happening within your community that might impact the referral process?*
4. Introduce exercise: see if we can find better ways to work together, let’s not assume that our current process works,

Group Exercise (30 – 45 minutes):

Gap Analysis:

1. In a perfect world, how does a good referral look? Take the next 5 minutes to describe the elements of a good referral handover/return between a PCP and a Specialist. Think about: information, timing, patient interaction, communication and coordination with other providers
2. Facilitator writes down and categorize feedback into the following areas:
 - a. Transition of Care
 - i. Information/Timing/Accuracy
 - ii. Clinical work-ups prior to referral (opportunity for specialists to offer continuing education on targeted clinical issues)
 - iii. Contact information

¹⁴ Implementation Guide: Continuous and Team-Based Healing Relationships, Improving Patient Care through Teams. Safety Net Medical Home Initiative, December 2010.

- b. Access
 - i. Appointment Availability
 - ii. Respond to urgent issues
 - c. Collaborative Care Management
 - i. Plan of Care
 - ii. Feedback loops for future plans, interim issues and urgent issues
 - d. Patient Communication
 - i. Patient Preparation
 - ii. Patient Self Mgmt Goals
 - iii. Privacy
 - e. Transition Record
 - i. Minimum data set
 - ii. Specific clinical information by condition
 - f. Types of Care Management
 - i. Clarity of referral request
 - ii. Role of PCP in managing condition vs role of specialist
3. How do referrals currently flow? What works? What doesn't work? How does that compare to the ideal state?
- a. Facilitator documents current state and documents feedback using process mapping and categorizes feedback using elements listed above.
 - b. Highlight and prioritize the "gaps".
 - c. What issues are condition-specific versus general referral issues?
 - i. Parking lot the condition specific issues to focus on the high-level referral process to keep discussion moving. Develop an action plan to address those issues during the wrap up phase OR;
 - ii. If this is a discussion between a PCP and one specialist, use this section to outline specific clinical expectations on targeted conditions.
 - d. Score current process according to compact elements (1-5, 1 being poor and 5 being excellent)
 - i. Score overall process
 - ii. Score your practice's ability to deliver on elements
 - iii. Score your referring practice's ability to deliver on elements

Improvement & Action Plan:

1. What are suggestions to you have to improve the referral process?
 - a. What can you do tomorrow at your practice to improve the referral process?
 - b. What do you need to work on either within your practice or with your medical neighborhood in the next 1-3 months?
 - c. What are more long-term solutions? (ie. HIE)
2. Map suggestions on quadrants of high/low priority vs. easy/difficult to implement
 - a. Identify whose responsibility it would be to make improvement. Break down specifically into physician responsibility vs. practice operations responsibilities and referring physician vs. specialist.
 - b. Assign timelines and responsibilities to improvements
3. Physicians create a personal report card outlining your practice's strengths/weakness based on your own assessment and the feedback from your peers. Think about the following:
 - a. Who needs to be brought into this process to make it successful?
 - b. How will you communicate this new effort to your staff? What are things that you can communicate to them that will help them understand why you are changing the current process? (ie. How/why this is important in improving patient care? What will this effort require of them? What is their role? What is the time commitment?)
 - c. Are you doing this for all patient referrals or just those being referred from / to targeted physicians?
 - d. How will you know whether there is an improvement?
 - i. Feedback from peers and/or patients
 - ii. Discrete measurement of process components (ie. % of time transition record sent/received, streamlining process)

Next Steps and Follow Up (30 minutes):

1. How will you know when things have improved? What are the areas of mutual accountability? Is it appropriate to meet again?
2. Introduce tools:
 - a. Care Compact,
 - b. Compact Score Card
 - c. Rapid Improvement Activity

Facilitator Notes:

- Format: can be written on sticky notes or can be verbal exercise)
- Tools
 - Grid for compact elements – step 1
 - Report Card
- “Plug In” Considerations:
 - HIE / HIT abilities and local initiatives
 - Role of hospitals in referrals and specialist network
 - Resources for support (ie. Health TeamWorks, Hospital, IPA, Beacon, other)