Sample Compact: Primary Care and Specialty Care Collaborative Guidelines and Compacts for South County Patient Centered Medical Community (SCPCMC)

A. 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.

B. Principles

* High quality and timely patient care for our patients.
* Effective communication between primary care and specialty care is the key to providing optimal patient care.
* Mutual respect and care management agreement is essential to building and sustaining a professional relationship and working collaboration. (See appendix B).

C. Definitions

* Patient Centered Medical Community – A collaboration of patient centered medical homes and South County Health to ensure accessible, coordinated, comprehensive and continuous health care in the local community, using local resources when appropriate.
* Medical Neighborhood - A system of care that integrates the PCMH with the medical specialists in the **c**ommunity through enhanced, bidirectional communication and collaboration on behalf of the patient.

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| **Primary Care and Specialty Care Compact** | |
| **Name of practice, address, phone, fax** | **Name of specialty, address, phone, fax** |
| □ Provider is aware of referral. If patient self-referred to specialty and PCP is made aware a processes will be in place to determine the patients overall need and reintegrate further care with PCP as appropriate  □ Informs patient of need, purpose, expectations, and goals of service/specialty.  □ Communicates reason for referral and sends relevant information including demographics and clinical data such as: laboratory results, scans, etc. along with a current care plan (or informs of documents in EHR) (see appendix C)  □ Schedules appointments for patient or provides patient with contact information and follows up with patients who did not follow through with appointments to assist in problem solving  □ Ensures provider is informed of any change in a patient’s condition if changes are relevant to care.  □ Resumes care of patient when patient returns from specialist and acts on care plan developed by specialist provider.  □ Contacts specialist by phone for urgent problems and consultation. Transfers appropriate information as soon as possible.  □ Agrees to work with specialist to ensure shared population receives all appropriate medical evaluation before or after consultation.  □ Agrees to engage in collaborative discussion regarding future opportunities to  employ outcome measures and actionable utilization data to improve health and healthcare and reduce healthcare costs for the shared population of patients  □ Specify time frame for appointment | □ Have timely appointment availability within timely manner specified in referral to meet patient care needs    □The specialty care team will consist of a list of providers and mid- level members  □ Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX and refills    □ Informs patient of diagnosis, prognosis, and follow-up treatment recommendations, including appropriate follow up with PCP  □ Provides appropriate educational materials and resources for patient/family  □ Sends reports to PCP no later than five business days; to include a care plan, follow-up, recommendations, and results of any testing  □ Confers with PCP before referring to secondary or tertiary specialist obtains prior authorizations, if required, or notifies PCP of need to obtain authorization based on insurance benefits.  □ Agrees to work with SCPCMC to ensure that the shared population receives all appropriate medical evaluations, medication management and treatment    □ Agrees to engage in collaborative discussion with SCPCMC leadership regarding future opportunities to employ outcome measures and actionable utilization data to improve health and healthcare and reduce healthcare costs for the share population of patients |

Signatures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective date\_\_\_\_\_\_\_\_\_\_\_ Renewal date\_\_\_\_\_\_\_\_\_\_\_

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South County Health

South County Patient Centered Medical Community (SCPCMC)

J. Russell Corcoran, M.D.

Effective Date\_\_\_\_\_\_\_\_\_\_\_ Renew Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix A**

Mutual care agreement for transition of care, access, collaborative management and patient communication consistent with “Colorado Primary Care-Specialty Care Compact” and “American College of Physicians Council of Subspecialty Societies (CSS) Patient Centered Medical Home (PCMH) Workgroup”, as required by Care Transformation Collaborative Agreement

Mutual Agreement for Transition of Care

Maintain accurate and up to date clinical record

When available and clinically practical, agree to standardize demographic and clinical information format such as continuity of care record or CCD

Ensure safe and timely transfer of care

Mutual agreement for Access

Be readily available for urgent help to both 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 or portal option for communication with established patient and /or providers

Mutual Care agreement for Collaborative Care management

Define responsibilities between PCP, specialist and patient

Clarify who is responsible for specific elements of care example (drug therapy, referral; management, testing, care teams, patient calls, patient education, monitoring and follow up)

Maintain competency and skill within scope of work and standard of care

Give and accept respectful feedback when expectation, guidelines or standards of care are not met

Agree on type of care that best fits the patients’ needs

Mutual Care agreement for Patient communication

Consider patient/family choice in care management, diagnostic testing and treatment management

Provide to and obtain informed consent from patient according to community standards

Explore patient issues on quality of life in regards to their specific medical condition and shares this information with the care team

**Appendix B Patient Referral Record**

1. Practice details. PCP, contact numbers (regular, emergency)
2. Patient demographic. Patient name, contact information, insurance information, PCP designation and contact information.
3. Diagnosis-ICD-10 code
4. Query/Request a clear clinical reason for patient referral and anticipated goals of care and interventions.
5. Clinical Data

problem list

medical and surgical history

current medication

immunizations

 allergy/contraindication list

 relevant notes

 pertinent lab and diagnostics tests

 patient cognitive status if altered cognitive status

 caregiver status if appropriate

 advanced directives if available and appropriate

 list of other providers

1. Types of referral

 Pre-consultative. Advice from specialist about a non-urgent problem regarding appropriateness of the referral or when feedback is needed

 Consultation. A request for an opinion and/or advice on a question regarding a patient’s diagnosis with the intention that the care of the will be transferred back to the PCP after a few visits. The specialist 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

 Co-management. Were both PCP and specialists actively contribute to the patient care for a 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.

Specialty Medical Home Network (complete transition of care to specialist practice)

1. Visit status. Routine, urgent, emergent (specify time frame).
2. Communication and follow‐up preference (phone, letter, fax or email, etc.)
3. Specify time frame for the appointment

In addition to the above the specialists will include in their documentation back to the PCP

1. Recommendations for testing, medication changes, diagnosis changes, patient goals, care teams and community resources
2. Technical procedure- Summarizes the need for procedure risks/benefits, the informed consent and procedure details with timely communication of findings and recommendations.
3. Follow up status- Specify time frame for next PCP appointment and specialist. Define collaborative and individual responsibilities

**OHIC Cost Management Strategies**

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| **The practice must perform all of the following functions:** | | **Yr 1** | **Yr 2** | **Yr 3** | **Fully or Substantially Achieved** | **Not Achieved** |
| 1. The practice has developed referral protocols for its patients for at least two of the following:    1. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist;    2. laboratory services;    3. imaging services;    4. physical therapy services, and    5. home health agency services. | TCPI: requirement is deemed met once Phase 2 B is achieved and formal agreements are with community partners detailed in this requirement. | **X** | **X** | **X** |  |  |
| 2. Should one or more payers provide the practice with readily available, actionable data, the practice has used such data and any other sources to identify referral service providers who provide higher quality services at costs lower than or the same as their peers (i.e., “high-value referral service providers”) and prioritizes referrals to those providers. |  |  | **X** | **X** |  |  |