Appendix C
To the Patient Centered Specialty Care Program Participation Attachment

“Care Compact”

Patient Centered Specialty Care
Primary Care – Specialist Physician
Collaborative Guidelines

Represented Specialty Care Physicians and Provider shall use all reasonable efforts to promote, achieve and comply with (to the extent applicable) the provisions of this Care Compact.

I. Purpose

- To provide optimal health care for Provider’s and Represented Specialty Care Physicians’ patients.
- To provide a framework for better communication and safe transition of care between primary care and specialty care providers.

II. Principles

- Safe, effective and timely patient care is the central goal.
- Effective communication between primary care and specialty care is key to providing optimal patient 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.’

III. Definitions

The following definitions shall apply to this Care Compact. All other defined terms used in this Care Compact shall have the same meaning set forth in the Program Attachment or Agreement, including the PCS.

- Coordination of Care – the deliberate organization of patient care activities between two or more participants (including the patient/caregiver) involved in a patient’s care to facilitate the appropriate delivery of health care services such as management of the exchange of information including clinical data; appropriate referrals and transfer of care; shared decision-making of medically appropriate treatment options; utilization of care management and disease management programs; community resources and more. See IV. Types of Care Coordination for various care coordination scenarios.
Patient-Centered Medical Home (PCMH) – 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.

Primary Care Physician (PCP) – all of the physicians whose primary specialty is internal medicine, general pediatrics, family practice/medicine, general practice/medicine or geriatrics 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.

Technical Procedure – a clinical procedure for diagnostic, therapeutic, or palliative purposes which might require the temporary transfer of care to another provider specializing in a specific organ system, class of disease or type of patient.

IV. Types of Care Coordination

• Pre-consultation exchange – communication between the PCP and Specialist to:
  1. Answer a clinical question and/or determine the necessity of a formal consultation.
  2. Facilitate timely access and determine the urgency of referral to specialty care.
  3. 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 Specialist’s practice will 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.

• 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 PCP 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.

V. **Mutual Agreement for Care Coordination**

- Review the provisions below and determine which services you can provide.
- The Mutual Agreement section of each care segment reflects the core elements of the PCMH and medical neighborhood and outline expectations from both primary care and specialty care providers. The medical neighborhood is a system of care that integrates the PCMH with the medical community through enhanced, bi-directional communication and collaboration on behalf of the patient.
- The Expectations section of the tables provide flexibility to choose what services can be provided depending in 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 respective provider checks each box that applies to the commitment of his/her practice.
- When patients self-refer to specialty care, processes should be in place to determine the patient’s overall needs and re-integrate 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.
- Upon agreement of this Care Compact, each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this Care Compact, as well as the format and venue of this discussion.
- Optimally, this Care Compact should be reviewed every two years.
## Care Coordination

### Mutual Agreement

- Maintain accurate and up-to-date clinical records.
- When available and clinically practical, agree to standardized demographic and clinical information format such as the Patient Information Record (see Patient Information Record in Section VI, below).
- Ensure safe and timely Coordination of Care for a patient.

### Expectations

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ PCP maintains complete and up-to-date clinical records including demographics.</td>
<td>○ Determines and/or confirms insurance eligibility.</td>
</tr>
<tr>
<td>○ Transfers information as outlined in Patient Transition Record.</td>
<td>○ Identifies a specific referral contact person to communicate with the PCMH.</td>
</tr>
<tr>
<td>○ Orders appropriate studies that would facilitate the specialty visit.</td>
<td>○ When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work-up.</td>
</tr>
<tr>
<td>○ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit.</td>
<td>○ Informs patient of need, purpose, expectations and goals of hospitalization or other transfers.</td>
</tr>
<tr>
<td>○ Provides patient with Specialist contact information and expected timeframe for appointment.</td>
<td>○ Notifies referring provider of inappropriate referral and explains reasons.</td>
</tr>
</tbody>
</table>

### Additional agreements/edits:

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## Access

### Mutual Agreement

- Be readily available for urgent help to both the physician and patient via phone or e-mail.
- Provide visit availability according to patient needs.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters.

### Expectations

#### Primary Care

- Communicate with patients who “no-show” to Specialists.
- Determine reasonable time frame for Specialist appointment.
- When available and clinically practical, provide a secure email option for communication with patients and/or Specialist

#### Specialty Care

- Notifies PCP of first visit ‘no-shows’ or other actions that place patient in jeopardy.
- Provides visit availability according to patient needs.
- Be available to the patient for questions to discuss the consultation.
- Schedule patient’s first appointment with requested physician.
- Be available to PCP for pre-consultation exchange by phone and/or secure email.
- When available and clinically practical, provide a secure email option for communication with established patients and/or provider.
- Provides PCP with list of practice physicians who agree to compact principles.

### Additional agreements/edits:

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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 specialty care that best fits the patient’s needs.

Expectations

<table>
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<tr>
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</tr>
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<tbody>
<tr>
<td>o Follows the principles of the Patient Centered Medical Home.</td>
<td>o Reviews information sent by PCP and addresses provider and patient concerns.</td>
</tr>
<tr>
<td>o Manages the medical problem to the extent of the PCP’s scope of practice,</td>
<td>o Confers with PCP or establishes other protocol before ordering additional</td>
</tr>
<tr>
<td>abilities and skills.</td>
<td>services outside practice guidelines. Obtains proper prior authorization.</td>
</tr>
<tr>
<td>o Follows standard practice guidelines or performs therapeutic trial of</td>
<td>o Confers with PCP before referring to secondary/tertiary Specialists for</td>
</tr>
<tr>
<td>therapy prior to referral, when appropriate, following evidence-based</td>
<td>problems within the PCP scope of care and uses a preferred list to refer</td>
</tr>
<tr>
<td>guidelines.</td>
<td>when problems are outside the scope of care. Obtains proper prior</td>
</tr>
<tr>
<td>o Resumes care of patient as outlined by Specialist, assumes responsibility</td>
<td>authorization when needed.</td>
</tr>
<tr>
<td>and incorporates care plan recommendations into the overall care of the</td>
<td>o Sends timely reports to PCP and shares data with care team as outlined in</td>
</tr>
<tr>
<td>patient.</td>
<td>the Coordination of Care Record.</td>
</tr>
<tr>
<td>o Explains and clarifies results of consultation, as needed, with the</td>
<td>o Notifies the PCP office or designated personnel of major interventions,</td>
</tr>
<tr>
<td>patient. Makes agreement with patient on long-term plan and follow-up.</td>
<td>emergency care or hospitalizations.</td>
</tr>
<tr>
<td>o Shares data with Specialist in timely manner including pertinent</td>
<td>o Prescribes pharmaceutical therapy in line with insurance formulary with</td>
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<tr>
<td>consultations or care plans for other care providers.</td>
<td>preference to generics when available and if appropriate to patient needs.</td>
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<tr>
<td></td>
<td>o Provides useful and necessary education/guidelines/protocols to PCP, as</td>
</tr>
<tr>
<td></td>
<td>needed.</td>
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</table>

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

Expectations

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</tr>
</thead>
<tbody>
<tr>
<td>o Explains, clarifies, and secures mutual agreement with patient on recommended care plan.</td>
<td>o Informs patient of diagnosis, prognosis and follow-up recommendations.</td>
</tr>
<tr>
<td>o Assists patient in identifying his/her treatment goals.</td>
<td>o Provides educational material and resources to patient when appropriate.</td>
</tr>
<tr>
<td>o Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in his/her care team.</td>
<td>o Recommends appropriate follow-up with PCP.</td>
</tr>
<tr>
<td></td>
<td>o Be available to the patient to discuss questions or concerns regarding his/her care management.</td>
</tr>
<tr>
<td></td>
<td>o Participates with patient care team.</td>
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</tbody>
</table>

Additional agreements/edits:

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VI. Patient Information Record

PCP Patient Information Record

1. Practice details – PCP, PCMH level, contact numbers (regular, emergency)
2. Patient demographics – Patient name, identifying and contact information, insurance information, PCP designation and contact information.
3. Diagnoses/diagnoses codes
4. Query/Request – a clear clinical reason for Coordination of Care and anticipated goals of care and interventions.
5. 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
6. Type of care coordination
   - Consultation
   - Technical Procedure
   - Co-management
   - Principal care
   - Consuming illness
   - Shared care
7. Visit status – routine, urgent, emergent (specify time frame)
8. Communication and follow-up preference – phone, letter, fax or e-mail

This physician compact has been created based on the Creating Medical Home Communities: Colorado Systems of Care/Patient Centered Medical Home Initiative’s Primary Care-Specialist Physician Collaborative Guidelines (12/8/2011 version).
Specialist Patient Information Record - Initial

1. Practice details – Specialist name, contact numbers (regular, emergency)
2. Patient demographics – Patient name, identifying and contact information, insurance information, PCP designation
3. Communication preference – phone, letter, fax or e-mail
4. Diagnoses/diagnoses codes
5. Clinical Data – problem list, medical/surgical history, current medication, labs and diagnostic tests, list of other providers
6. 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
7. Technical Procedure – summarize the need for procedure, risks/benefits, the informed consent and procedure details with timely communication of findings and recommendations.
8. Follow-up status – Specify time frame for next appointment to PCP and Specialist. Define collaborative relationship and individual responsibilities.
   - Consultation
   - Co-management
     a. Principal care
     b. Shared care
     c. Consuming illness
   - Technical Procedure

This physician compact has been created based on the Creating Medical Home Communities: Colorado Systems of Care/Patient Centered Medical Home Initiative’s Primary Care-Specialist Physician Collaborative Guidelines (12/8/2011 version).
Specialist Patient Information Record – Follow-up

1. Practice details – Specialist name, contact numbers (regular, emergency)
2. Patient demographics – Patient name, identifying and contact information, insurance information, PCP designation
3. Communication preference – phone, letter, fax or e-mail
4. Diagnoses/diagnoses codes: note new or changes diagnoses and any new or current secondary diagnoses
5. Clinical Data – interval history and pertinent exam, current medication and allergies list, new labs and diagnostic test
6. Recommendations –
   - 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
   - Develop an evidence-based care plan that clearly specifies responsibilities and expectations of the Specialist and PCP:
     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 (Home Health, Social Services, Physical Therapy, etc)
     d. Patient Goals – Outline education and consultation provided to patient on medical/surgical condition, prognosis and management. Summarize patient’s desired outcome/needs/goals/expectations and understanding. Patient goals are 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.
   - Specify follow-up status:
     a. Specify Coordination of Care status: Consultation, Co-management (shared care, principle care, consuming illness), Technical Procedure
     b. Specify preference for bi-directional communication (phone, letter, fax, or e-mail) – how does Specialist prefer to send information to PCP and does Specialist want to be contacted by PCP
     c. Specify time frame for next appointment to PCP
     d. Specify time frame for next appointment to Specialist