Care Compact Guide
Patient-Centered Specialty Care (PCSC)

A Component of Medical Neighborhood Initiatives

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Section 1: Overview

As health care becomes more complex and diverse, patients, families and providers are increasingly tasked with navigating a health care system that is disconnected, fragmented and offers little to no coordination of the health care services a patient receives. This fragmentation of care poses a significant risk to patient safety as well as increasing costs through needless or duplicate services.

Care coordination is described as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.” (AHRQ, 2007). Care coordination can reduce fragmentation and improve overall patient experience and safety.

Patients transition across settings, across providers and throughout the stages of their lives. The visual below offers insight into the diversity and challenges of care coordination. Each of these stages offers different touch points and different players that require careful planning and follow up to avoid fragmented care.

Care Compacts, or collaborative care agreements, are bidirectional agreements that aim to enhance communication between providers and patients. By sharing preferences and expectations around the referral process, a Care Compact facilitates effective care management and coordination across the continuum.

This document provides guidelines regarding the Care Compact and coordination of care. It serves as a reference for Specialty Care Providers (SCPs) to support the adoption of Care Compacts and facilitate optimal care coordination activities.

Many of the goals of the patient-centered medical home (PCMH) rely on a high functioning medical neighborhood that shares the goals of effective, two way communication, appropriate and timely care, effective management of patients and a patient-centered approach to care delivery.

Care Coordination Ring

- Transitions involving entities
  - Among members of one care team (receptionist, nurse, physician)
  - Between patient care teams
  - Between patients/informal caregivers and professional caregivers
  - Across settings (primary care, specialty care, inpatient, emergency department)
  - Between health care organizations
- Transitions over time
  - Between episodes of care (i.e., initial visit and follow up visit)
  - Across lifespan (e.g., pediatric developmental stages, women’s changing reproductive cycle, geriatric care needs)
  - Across trajectory of illness and changing levels of coordination need

(AHRQ, Care Coordination Measures Atlas, 2011)
A. Introduction

The Patient-Centered Specialty Care program (alternatively “PCSC” or the “Program”) is aimed at extending support for primary care-focused initiatives by adopting the principles of “The Patient-Centered Medical-Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices,”1 as published by the ACP in 2010. ACP’s concept of a Patient-Centered Medical-Home Neighbor (PCMH-N) strives to define the role of specialists within the broader medical neighborhood.

Characteristics of a good medical neighbor include:

- Supporting the PCMH practice as the “hub” of care and provider of whole-person primary care to the patient
- Communicating, coordinating and integrating bidirectionally with the PCMH, as well as with patient
- Ensuring appropriate and timely consultations and referrals
- Ensuring accurate and effective flow of information
- Addressing responsibility in co-management situations
- Supporting patient-centered care

1 http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf

Care Compact

Many of the elements listed above can be addressed systematically with the implementation of Care Compacts. The Care Compact, or collaborative care agreement, is a mutual agreement between the SCP and the primary care physician (PCP), regarding co-management responsibilities, referral coordination, expectations, and information exchange. It provides a framework for better communication and safe transition of care and defines various types of care episodes in order to set roles and responsibilities.

The Care Compact:

- supports the concept of providing the patient with access to the right care, at the right time, in the right place
- provides a foundation and set of standardized processes that providers can modify and customize to ensure the success of the Medical Neighborhood model within their organizations
- is not a prescription for how SCPs and PCPs must interact and engage with each other, but rather a guide for effective communication and shared management of patients
- should be considered a “living document” that will evolve over time as SCPs and PCPs build upon existing coordination processes and identify new areas for improvement

Healthy Hand-Offs and Coordination of Care

Care coordination serves to clearly define the role of the PCPs and SCPs and potentially other providers within the care team who serve a given patient. We like to refer to this as a healthy hand-off. Providers must be jointly committed to patient-centered care transformation and agree on key interactions and responsibilities that support comprehensive sustained care coordination. Communication between specialists, PCPs, other providers, and patients/family/caregivers needs to encompass more than just an exchange of information.

Beyond the Care Compact, we will make additional tools available in a Provider Toolkit to assist practices with integrating and implementing the Care Compact, transforming the practice, and coordinating care effectively.
Section 2: Assessment

Understanding provider capabilities is a key component of the PCSC program. This section provides additional information to guide the SCP and the PCP in assessing their infrastructure. An evaluation of their landscapes will help to determine staffing needs, roles and responsibilities, capabilities, referral patterns, processes, commonalities, and changes that may be needed for patient-centered transformation and sustained coordination of care with Medical Neighbors.

Below is an outline of a pathway to assess current infrastructure and supports around care coordination and the implementation of Care Compacts, or collaborative care agreements. This assessment pathway includes evaluating the following elements:

<table>
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<tr>
<th>Care Compact</th>
<th>Identify the characteristics of any agreements between providers</th>
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<tr>
<td>Care Team</td>
<td>Understand characteristics of the care team within your practice</td>
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<tr>
<td>Care Planning and Patient Supports</td>
<td>Determine the practice processes in place that support care planning and patient communication</td>
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<td>Care Plan Documentation</td>
<td>Identify processes in place for coordination of sharing information</td>
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<td>Pre-Visit Planning</td>
<td>Outline steps practice takes to prepare for patient visits</td>
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<tr>
<td>Tracking Clinical Information</td>
<td>Define systems and processes in place to track appropriate clinical information and activities</td>
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Assessing the current state of each of these elements will help all parties understand and meet the needs of specialty practices and provide targeted resources to facilitate Care Compact implementation.

Section 3: Implementing the Care Compact

The PCSC program aims to enhance care coordination through the implementation of Care Compacts between primary care and specialty care with the following goals:

- **Identify** priority PCPs to collaborate with for Care Compact establishment and connect SCPs with PCPs who are committed to patient-centered care transformation
- **Assess** current care coordination capabilities with PCP partners. Capabilities may vary by PCP partner
- **Adapt** the Care Compact elements to existing referral processes and procedures. The Care Compact should be customized to serve the unique needs, technological capabilities and organization of specific provider practices
- **Share** best practices related to Care Compact implementation and general care coordination activities

One of the components of care coordination is a patient-centered referral process. The examples below highlight referral differences:
The “Nightmare” Referral Process

Primary Care
- PCP makes urgent referral to specialist unknown to them in-network on patient insurance panel
- Patient record sent to specialist office, but it gets misdirected via fax
- PCP has no tracking system in place to ensure patient followed through visit

Patient
- Patient responsible for making appointment
- Patient uncertain about referral reason
- Patient is the historian of own health status

Specialist Provider
- Physician unclear about referral reason
- No clinical information available at time of appointment
- Orders complete work-up and baseline diagnostic tests
- Specialist consults with patient and makes care recommendations
- Refers patient to additional specialist for further consultation

Key Changes Needed
- Clear and mutual expectations between clinicians (Care Compact)
- Information available at the point of care
- Organization of staff around care coordination activities
- Accountability for next steps clearly identified for all stakeholders
- Ensure patient is an active participant in care

The “Dream” Referral Process

Medical Home
- PCMH makes referral to a specialist they work closely with using compact guidelines
- PCMH conducts work-up based on agreement with specialist
- PCMH sends over relevant clinical record, diagnostics, current care plan, referral reason, and level of appointment urgency
- PCMH Care coordinator tracks status of appointment and follow up
- PCMH incorporates specialist recommendations into comprehensive care plan

Patient
- Patient is prepared for specialist consultation by PCP
- Patient makes appointment and is seen based on urgency of condition
- Roles & responsibility of PCP and Specialist are clearly explained
- Patient medications are reconciled at each transition
- Patient has a robust, comprehensive care plan that includes PCMH, Specialist and their own input to manage at home
- Patient is provided appropriate educational and community resources

Specialist Provider
- Care coordinator tracks referral. Ensures all agreed upon information is received prior to visit
- Care team reviews information in huddle before visit
- Assess the necessity for an office visit based on the presented information/call with referring provider
- Assess the necessity for an office visit based on the presented information/call with referring provider
- Specialist consults with patient and makes recommendations that aligns with PCMH care plan and patient goals
- Consult summary and care plan recommendations sent back to PCMH per compact standards
- Consult with PCP before secondary referral to a specialist per compact standards
Our dedicated associates are trained in quality improvement and practice redesign, and are ready to guide specialty practices in the journey towards their “dream” referral process.

Available Support

- Dedicated staff to provide assistance to participating practices in the implementation of the Care Compact
- Structured virtual Learning Collaborative that will support the step-by-step implementation of care compacts
- Individualized coaching and support to help the practice achieve implementation of the Care Compact
- Medical Neighborhood Care Compact Toolkit – such as a Referral Preparedness Tool, among others
- NCQA Patient-Centered Specialty Physician (PCSP) Recognition Program discount available
- Free license to the ACP Practice Advisor – Specialty Care Practice Recognition

Practice Objectives

- Outreach to primary care practices to establish and fully implement Care Compacts within your practice during the PCSC measurement period
- Designate a physician champion and administrative champion that will lead this effort and provide visible leadership to this program
- Attend and fully participate in Learning Collaborative sessions
- Commit to undertaking small tests of change to implement Care Compacts
- Access and utilize available reports to support care coordination
- Provide feedback on program design and practice progress on goals

Learning Collaboratives

The Learning Collaborative approach is a means of delivering technical assistance, tools and resources through an interactive curriculum. This curriculum will include key change concepts, a web and action-based learning collaborative that focuses on the practice’s application of skills, and a toolkit that offers tools, resources and literature to support the implementation of care compacts, or collaborative care agreements, to improve care coordination.

The curriculum is designed in a three part approach for each module: sessions to teach core skills and key concepts, breakout sessions, which focus on the practical application of the skill within the practice setting and homework using small tests of change (such as PDSA cycles – Plan, Do, Study, Act) that build upon one another. Testing change by developing a plan to test the change, carrying out the test, observing and learning from the consequences, and determining what modifications should be made can be useful in transforming to the Medical Neighborhood concept.
Section 4: Feedback

This program will help identify best practices in care coordination and develop an effective program design that supports optimal outcomes. As part of a continuous improvement approach, participating practices are expected to participate in formal and informal feedback to enhance both the program design and their effectiveness in implementing the Care Compact.

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<td>• What makes this effective?</td>
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<th>What’s Not Working</th>
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<td>• What are we trying to improve?</td>
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<td>• Is change an improvement?</td>
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<td>• What changes can we make that will result in an improvement?</td>
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<th>Identify Improvements</th>
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<td>• Data Driven</td>
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<td>• Engage staff &amp; PCP partners</td>
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<td>• Rapid test of change</td>
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<th>Re-Assess</th>
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<td>• Adapt</td>
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<td>• Spread</td>
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<td>• Re-measure</td>
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Section 5: Common Misconceptions and Other General Information

This section contains additional information that might be helpful in understanding various aspects and ideas about the Care Compact and coordination of care.

**What the Compact is:**

- Actively promoted by national entities such as ACP, AHRQ, NCQA and medical neighborhood thought leaders nationally
- An agreement that outlines the guidelines for providers to coordinate care in order to ensure the safe transition of care for members
- Promotes mutual trust while improving communication by furthering the care exchange between providers
- Outlines and defines the various types of care episodes in order to set expectations for roles responsibilities and data exchange standards
- Provides a set of standardized processes for referrals and care coordination by outlining data requirements for status updates and patient profiles

**What the Compact is not:**

- The compact is not intended to be an agreement between the specialist and his/her patients. An agreement is not needed for each individual patient
- The compact does not replace health plan medical management guidelines
- The compact does not define specific clinical measures
- The compact does not define reimbursement

Note: Defined terms used in this Care Compact Guide shall have the same meaning set forth in the Care Compact, Program Description, Program Attachment, or Agreement, including the PCS (Plan Compensation Schedule).