Creating Medical Home Communities Systems of Care/Patient Centered Medical Home Initiative

Primary Care – Specialist Physician Collaborative Guidelines

I. 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.*

II. 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'.*

III. 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*

SAMPLE

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:*

  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 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*

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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.

- *<u>Co-management with Principal Care for the Disease (Referral)</u> – 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.*
- *<u>Co-management with Principal Care for the Patient (Consuming illness)</u> – 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.*

- *<u>Emergency care</u> – medical or surgical care obtained on an urgent or emergent basis.*

IV. 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.

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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	Specialty 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	☐ 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: _____

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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	Specialty Care
☐ Communicate with patients who "no-show" to specialists. ☐ Determines reasonable time frame for specialist appointment.	☐ 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: _____

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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 care that best fits the patient's needs.

Expectations

Primary Care	Specialty 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.	☐ Reviews information sent by PCP and addresses provider and patient concerns. ☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. ☐ 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. ☐ Sends timely reports to PCP and shares data with care team as outlined in the Transition of Care Record. ☐ 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. ☐ Provides useful and necessary education/guidelines/protocols to PCP, as needed

Additional agreements/edits: _____

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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	Specialty 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.	☐ 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: _____

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V. Appendix

- **PCP Patient Transition 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. Diagnosis -- ICD-9 code

4. Query/Request – a clear clinical reason for patient transfer 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 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

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

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

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- **Specialist Patient Transition 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 (ICD-9 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 BHP and primary care physician that clearly outline:
    1. **A-** ssessment:
       New/changed primary and secondary diagnoses with ICD 9/10 codes, controlled vs. uncontrolled.
    2. **D-** ecision-making:
       Supportive evidence and logic for diagnosis, differential diagnosis and rationale for medication treatment or cognitive therapies.
    3. **A-** dvice to patient and patient goals:
       Summarize information, patient education and community resources provided to patient. Specify patient goals and methods to activate/engage patient in their care.
    4. **P-** lan:
       Recommended treatment plan and expectations with timeline of future tests or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
    5. **T-** ask List:
       Outline next steps in treatment and who is responsible for each task; specify when does patient return to the PCP.
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.
    1. Consultation
    2. Co-management
       - Principal care
       - Shared care
       - Consuming illness

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3. Specialty Medical Home Network (complete transition of care to specialist practice)
4. Technical procedure

- **Specialist Patient Transition Record -- Follow-up**

2. Practice details – Specialist name, contact numbers
3. Patient demographics -- Patient name, DOB, PCP designation.
4. Clinical Data –interval history and pertinent exam, current medication and allergies list, new labs and diagnostic tests.
5. Diagnoses (ICD-9 codes)
    1. Note new or changed diagnoses
    2. New or current secondary diagnoses.
6. Care Plan Recommendations –
    1. Communicate opinion and recommendations for diagnosis, further diagnostic testing/imaging, additional referrals and/or treatment.
        1. 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:
        1. Medication or medical equipment changes, refills and monitoring responsibility.
        2. Recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
        3. Community or medical resources obtained or needed such as Home Health, Social Services, Physical Therapy, etc.
        4. Patient goals –
            - Outline education and consultation provided to patient on med/surgical condition, prognosis and management and summarize their desired outcome/needs/goals/expectations and understanding.

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3. 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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