- Specialty Care Compact

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.***
- ***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

- ***Generalist – a primary care physician (PCP) whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients across a lifetime.***
- ***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.***

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- ***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.***

- ***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 Care Management Transition

- ***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 generalist 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.***
    - ***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.**

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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 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 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.
- Upon signing this agreement, each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, the format and venue of this discussion.
- This agreement is effective for 2 years and then should be renewed.

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Transition of Care	
Mutual Agreement	
• Maintain accurate and up-to-date clinical record. • 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. ☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit ☐ Provides patient with specialist contact information and expected timeframe for appointment.	☐ Determines and/or confirms insurance eligibility ☐ Provides single source referral contact person ☐ When needed, be ready to communicate with the PCP prior to the appointment to assist in the preparation of patient and appropriate pre-referral work-up

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	Specialty Care
☐ Communicate with patients who "no-show" to specialists. ☐ Determines reasonable time frame for specialist appointment. ☐ Provide a secure email option for communication with patient and specialist.	☐ Notifies PCP of 'no-shows' ☐ Provides visit availability according to patient needs. ☐ Be available to the patient for questions to discuss the consultation. ☐ Schedule first patient appointment with physician. ☐ Be available to PCP for pre-consultation exchange by phone and/or secure email. ☐ Provide a secure email option for communication with patient and 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

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. ☐ Reviews and acts on care plan developed by specialist. ☐ Resumes care of patient when patient returns from specialist care. ☐ Explains and clarifies results of consultation, as needed, with the patient. Makes agreement with patient on long-term treatment plan and follow-up.	☐ Reviews information sent by PCP ☐ Addresses referring 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 or establishes other protocol before refers to secondary or tertiary specialists. Obtains proper prior authorization. ☐ Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions. ☐ Notifies the PCP 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	
• Engage and utilize a secure electronic communications platform for high risk patients such as ReachMyDoctor or CORHIO. • Prepare the patient for transition of care. • 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
☐ Informs patient of the reason for care transfer and expectations. ☐ Determines appropriate time frame for visit to specialist. ☐ Provides specialist name and contact information. ☐ Explains specialist results and treatment plan to patient, as necessary. ☐ 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. ☐ Recommends appropriate follow-up with PCP. ☐ Will be accountable to address patient phone calls/concerns regarding their 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. **Communication preference – phone, letter, fax or e-mail**
4. **Diagnosis -- ICD-9 code**
5. **Query/Request – a clear clinical reason for patient transfer and anticipated goals of care and interventions.**
6. **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**
7. **Type of transition of care.**
8. **Visit status -- routine, urgent, emergent (specify time frame).**
9. **Follow-up request**

PCP	Date	Date	Initial	Date	Initial
Specialist	Date	Date	Initial	Date	Initial

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- **Specialist Patient Transition Record**

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 specialist and primary care physician that clearly outline:**
    1. **new or changed diagnoses**
    2. **medication or medical equipment changes, refill and monitoring responsibility.**
    3. **recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.**
    4. **secondary diagnoses.**
    5. **patient goals, input and education provided on disease state and management .**
    6. **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.**
    1. **Consultation**
    2. **Co-management**
        - **Principal care**
        - **Shared care**
    3. **Specialty Medical Home Network (complete transition of care to specialist practice)**
    4. **Technical procedure**

PCP	Date	Date	Initial	Date	Initial
Specialist	Date	Date	Initial	Date	Initial

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