Developing Provider Collaborative Care Agreements

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Healthcare Intelligence

Objectives

- Define a care compact and its role in optimal care outcomes
- Identify steps involved in developing an effective care compact
- Include the patient in care compact

Care Compacts

Why?

- Provide a framework for better communication and safe transition of care between primary care and specialty providers
- Result is optimal health care outcomes for patients

Definition

Care Compact, Collaborative Care Agreement

- Care compacts bring together primary and specialty care for the benefit of the patient
  - Formalized agreement between PCPs and specialists, or between specialists
  - Designates referral protocols, care transition expectations and care management responsibilities
  - Critical for ACO and population health risk contracting

Care Compact Benefits

Care Compact or Collaborative Care Agreement

- Effective communication between providers to eliminate waste and excess costs of health care
- Mutual respect is essential to building and sustaining a professional relationship and work collaboration
- A high functioning medical system of care provides patients with access to the *right care at the right time in the right place*

Care Compact Benefits

Care Compact Role

- Patients experience coordinated care that adheres to their needs
- Patients are more likely to avoid unnecessary, or duplicative testing
- Providers are able to collaborate and share information
- Care compacts facilitate improved efficiency and development of tighter networks of trusted, high-quality partners, which is important in risk bearing ACO environments

Types of Care Compacts

Pre-consultation Exchange: Communication between two providers to:

- Answer clinical questions and determine the necessity of a formal consultation
- Facilitate timely access and determine the urgency of referral to specialty care
- Facilitate the patient diagnostic evaluation prior to a specialty assessment

Types of Care Compacts

Formal Consultation

- Request for an opinion on a discrete question regarding a patient's diagnosis, diagnostic results, procedure or treatment
- Specialty practice would provide a detailed report on the diagnosis along with care recommendations
- Patient care can transfer to the specialty practice
- Examples?

Types of Care Compacts

Co-Management Shared Care

- Primary and specialty care providers actively contribute to patient care
- Responsibilities include:

First visit with patient	Care teams
Drug therapy	Patient follow-up
Referral management	Monitoring
Diagnostic testing	Management of other medical conditions
Patient education	

Types of Care Concepts

Complete Transfer of Care to Specialist

- Due to complexity of the patient's condition and diagnosis, the specialist assumes total care, providing:
  - full contact
  - ready access
  - continuous care
  - comprehensive and coordinated medical services
  - links to the community resources
- Examples?

Steps to Set Up Care Compact

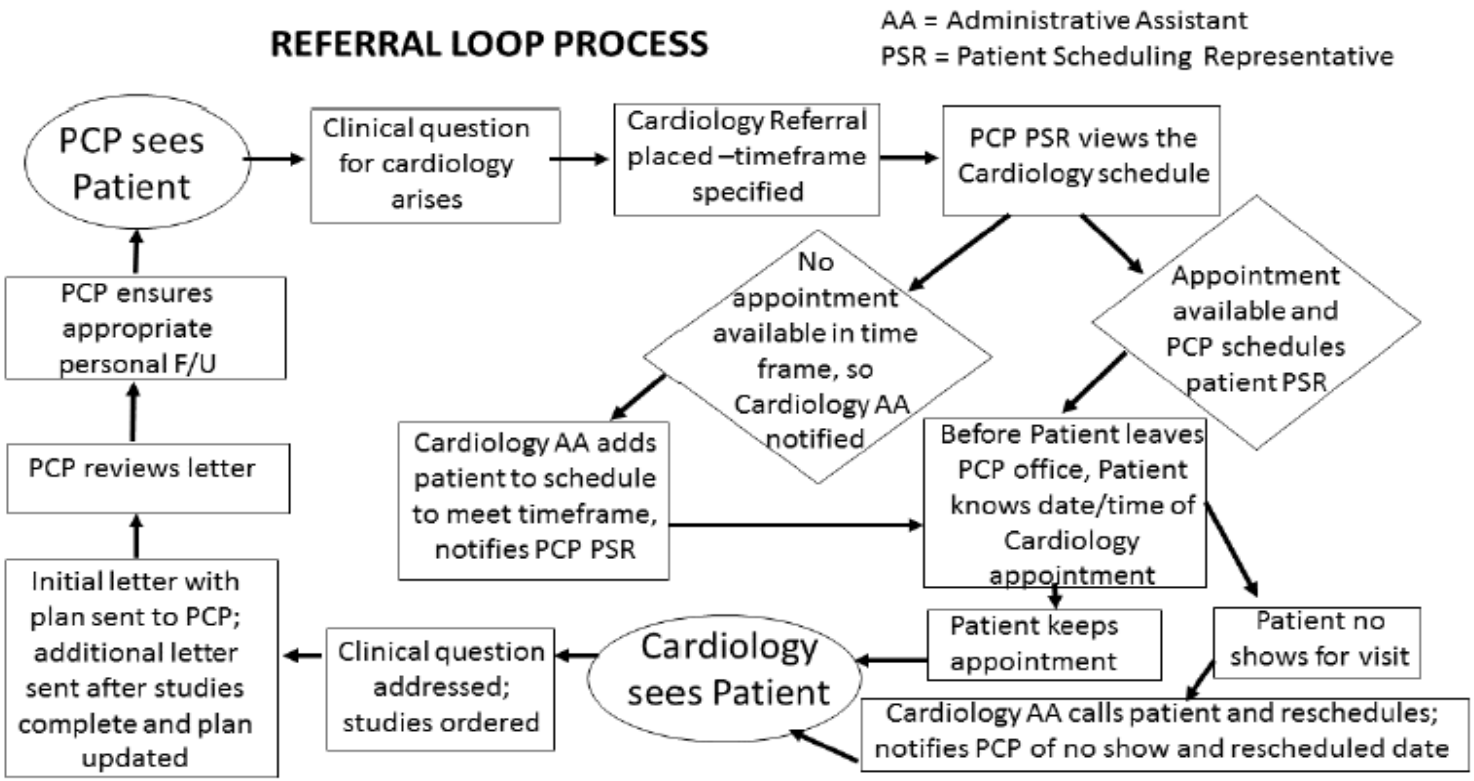
- **Identify communication gaps** - Align objectives by identifying collaboration challenges, and how a care compact will address the challenges
  - Not every patient needs a care compact
- **Articulate measurable care compact goals** - Enhance provider accountability by establishing clear short- and long-term goals for compact implementation
- **Create** care compact template(s)

Steps to Set Up Care Compact

- **Inform and include patient:** Educate patient on the purpose of care compact, and overlapping care
- **Educate and train staff:** Foster commitment by training staff on the goals of compacts (e.g. clearer documentation standards, more efficient task distribution), agreement details and their responsibilities
- **Audit change: A**ssess progress to compact adherence, pinpoint improvement opportunities and refine existing metrics

Map Workflow for Care Compact

Referral Flow:



Provider Collaborative Care Agreement

PROVIDER COLLABORATIVE CARE AGREEMENT

Practice name *values its partnership with* ***[Insert Specialty Group Name]*** in providing patients with collaborative, streamlined, quality care.

The purpose of this agreement is to provide a framework for better communication and safe transition of care between our primary care and specialty providers, resulting is optimal health care outcomes for our patients.

Principles:

- 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.'*

KEY PERSONNEL	
Practice Name:	Specialist Name:
Physician Lead: Dr.	Physician Lead:
Practice Leadership:	Practice Leadership:
Administrative Lead:	Administrative Lead:
Mailing Address:	Mailing Address:
Email Address:	Email Address:
P:	P: (000) 000-0000 F: (000) 000-0000
EMR: EPIC	EMR:

Epic access available for specialist team to view clinical documentation? Yes/No

Is the Specialist able to send an EPIC staff message to the PCP? Yes/No

MUTUAL AGREEMENT
• Agree to standardized demographic and clinical information exchange and mode of record sharing (fax, electronic, etc.)
• Maintain accurate and up-to-date clinical records.
• Offer reasonably convenient office hours of operation, providing an alternative when unavailable for urgent matters.
• Educate office staff on care compact and its purpose.
• 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 and education, monitoring and follow-up.)
• Give and accept respectful feedback when expectations, guidelines or standards of care are not met.
• Consider patient/family choices in care management, diagnostic testing, and treatment plan.
• Explores patient issues and quality of life with regard to their specific medical condition and shares this information with the care team.
• Phone communication to primary contact person preferred if electronic communication isn't effective

1

PRIMARY CARE RESPONSIBILITIES	SPECIALTY CARE RESPONSIBILITIES
Transition of Care	
• PCP maintains complete and up-to-date clinical records • Orders appropriate studies that would facilitate 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 in agreement with specialty referral, including copayment.	• Provides PCP with specialty requirements that will assist with referrals. [Example] • Send most recent office note to PCP. Routes notes through EPIC when applicable, otherwise via fax to provided number. • Informs patient of need, purpose, expectations and goals. • Contacts patient to schedule appointment • Notifies referring provider of inappropriate referrals and explains reasons. • Completes referral authorization, if required
Access	
• Determines reasonable time frame for specialist appointment based on patient care needs.	• Notifies PCP of first visit 'no-shows' or other actions that place patient in jeopardy. • Schedule patient's first appointment with requested physician.
Collaborative Care Management	
• 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.	• Reviews information sent by PCP and addresses provider and patient concerns. • Confers with PCP or establishes other protocol before referring to secondary/tertiary specialists for problems within the PCP scope of care. When appropriate, use a preferred list of specialists. • Sends reports to PCP and shares data with care team within (48-72 business hours/5-7 business days.) • Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and appropriate.
Patient Communication	
• Explains, clarifies and secures agreement with patient on recommended care plan and reason to refer to specialist. • Assists patient in identifying their treatment goals. • Encourages understanding of preventative health requirements.	• 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 to discuss questions or concerns regarding the consultation of their care management. • Communicates to patient that their results will be sent to the PCP.

PROVIDER ENTITY:

Signature: _____

Name: _____

Title: _____

Date: _____

SPECIALIST ENTITY:

Signature: _____

Name: _____

Title: _____

Date: _____

Ideal Hand Off

Practice	Patient	Specialist
Practice makes referral to specialist, using compact agreement	Patient is prepared to see specialist by the primary practice	Specialist works with primary provider on work up prior to visit
Practice conducts work-up based on agreement with specialist	Patient makes appointment based on urgency	Specialist office ensures all documents are received prior to patient visit
Patient sends specialist medical record data, referral reason, urgency and testing results	Roles and responsibilities of primary and specialist are CLEARLY explained to patient at their activation level	Specialist office schedules patient appointment based on urgency noted
Practice tracks status of appointment and follow-up	Patient is aware of recommendations and sees them as part of the care plan	Specialist consults with patient referring to compact, and makes recommendations based on findings
Practice incorporates specialist recommendations into the patient care plan	Patient is provided with education and resources based on activation level	Consult summary and plan returned to primary provider per compact agreement

Summary

A Compact is:

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

Summary

A compact is NOT

- An agreement between the specialist and his/her patients
- A replacement for health plan medical management guidelines
- A defined set of specific clinical measures
- Defining reimbursement

Resources

- Colorado Systems of Care/Patient Centered Medical Home Initiative: Colorado Primary Care - Specialty Care Compact https://www.integration.samhsa.gov/operations-administration/Colorado_Primary_Care_-_Specialty_Care_Compact.pdf
- Care Compact Guide Patient-Centered Specialty Care https://www11.empireblue.com/provider/noapplication/f1/s0/t0/pw_e224533.pdf?refer=ehpmember

Questions?

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