

American College of Physicians
Council of Subspecialty Societies (CSS) Patient-Centered Medical Home (PCMH)
Workgroup

**PRINCIPLES OF SERVICE AGREEMENTS BETWEEN PATIENT CENTERED
MEDICAL HOMES (PCMH) AND SPECIALTY PRACTICES SERVING AS
PCMH-NEIGHBORS (PCMH-N) WITHIN AMBULATORY SETTINGS**

1) A service agreement will define the types of referral and co-management agreements available

The agreements regarding scope of patient care management should clearly define the types of consultation and /or co-management elements and specifics. These should be fluid (dynamic) to adapt to changes in patient or disease status and should be clearly communicated and understood by all parties including the PCMH and the specialty practice as well as patients and their families and caregivers. The agreements may include the following arrangements:

- **Pre-consultation exchange – intended to expedite/prioritize care.** It is envisioned that a pre-consultation exchange would either answer a clinical question without the necessity of a formal specialty visit and/or better prepare the patient for specialty assessment. This category includes the establishment of general referral guidelines to help expedite timeliness and appropriateness of referrals and also provides guidance on what defines an “urgent” consult and how these should be specifically addressed. Several national specialty societies have already developed referral guidelines and these should be utilized when appropriate.
- **Formal Consultation – to deal with a discrete question / procedure.** It is envisioned that a formal consultation would be limited to one or a few visits that are focused on answering a discrete question. A detailed report and discussion of management recommendations would be provided to the PCMH. The specialty practice would not manage the problem. It is also envisioned that this may include a particular service request by a PCMH for a patient.
- **Co-Management**
 - **Co management with Shared Management for the disease.** The specialty practice will provide guidance and ongoing follow up of the patient for one specific condition. Both the PCMH and specialty practice are responsible for clear delineation of expectations for the other. Within this model, the specialty practice will typically provide expert advice, but will not manage the illness day to day.
 - **Co management with Principal care for the disease.** Both the PCMH and specialty practice are concurrently actively involved in the patient’s treatment, but the specialty practice’s responsibilities are limited to a discrete problem group or set of problems. The PCMH maintains control

over all other aspects of patient care, and remains the first contact for the patient.

- **Co management with Principal care of the patient for a consuming illness for a limited period of time:** Because of the significant nature and impact of the disorder, the specialty practice needs to temporarily become the first contact for care for the patient. However, the PCMH still receives on-going treatment information, retains input on secondary referrals and may provide certain, well-defined areas of care.
- **Transfer of patient to specialty PCMH for entirety of care.** This refers to situations in which the specialty practice assumes the role of the PCMH. Thus, the specialty practice would be expected to meet the requirements of an approved third-party PCMH recognition process (e.g. the NCQA PPC-PCMH recognition), and affirm the willingness to provide care consistent with the “Joint Principles,” including the delivery of first contact, whole person, comprehensive care. This situation is best represented by a specialty practice that is seeing a patient frequently over a relatively long period of time for the treatment of a complex condition that affects multiple aspects of their physical and general functioning.

2) The service agreement will specify who is accountable for which processes and outcomes of care within (any of) the consultation or co-management arrangements.

The specific elements of care that should be addressed and assigned accountability include:

- Recommended pre-referral testing
- Pharmacologic therapy and equipment
 - Prescribing, monitoring, refills, prior authorization
- Referral management
 - Additional specialists or services
- Diagnostic testing
 - Ordering, communication of results, tracking
- Patient education on disease management
- Addressing secondary diagnoses
- Care teams/ community support
- Patient phone calls/concerns/disease and medication issues
- Monitoring/surveillance/follow up

Responsibility for specific elements will vary based on the consultation or co-management arrangement. These accountability arrangements will be affected by such factors as geographic location of the practices and related practice patterns, the preferences of the collaborating physicians/practices, and the needs and preferences of the patient, and when appropriate, their family.

3) The Service agreement will specify the content of a patient transition record/core data set which is to go with the patient in all care transitions. This will be established as mutually agreeable to all involved.

Elements of the transitions record/core data set should ideally include the following:

- Clearly identifies medical home and/or transferring coordinating physician/institution
- Emergency plan and contact number and person
- Patient’s cognitive status
- Assessment of caregiver status
- Advance directives, power of attorney, consent
- Principle diagnosis and problem list
- Surgical and procedure history
- Medication list (reconciliation) including immunizations, OTC/ herbals, allergies and contraindications
- Prognosis and goals of care
- Ongoing treatment and diagnostic plan
- Test results/pending results
- Planned interventions, DME, wound care etc
- List of all Providers(and preferably the disorder they help co-manage

The transitional record used should take the form of a national standard, when and if such a standard is developed and approved by the majority of healthcare stakeholders.

4) The service agreement will define expectations regarding the information content requirements, as well as, the frequency and timeliness of information flow within the referral process. This is a bidirectional process reflecting the needs and preferences of both the referring and consulting provider.

In addition to the “transition record /core data set)” that should accompany the patient in any transition of care, the request from the PCMH for consultation or referral should indicate a clear clinical question, and reflect whether a service or procedure or request for co-management is being sought. It should also include a clinical summary of the issues necessitating the referral and /or the pertinent medical records and test results. Any urgent consultation requests should be communicated in an agreed upon manner that allows the specialty practice to be aware of the situation directly.

The report back from the specialty practice should clearly address the referral request, indicate the diagnostic and/ or treatment plan and specify what components of that plan are the responsibilities of the specialty practice and which are to be completed by the PCMH. Certain items critical to the safety and care co-ordination of the patient need to be directly specified and include any new or changed diagnoses, changes to medications or medical equipment, any diagnostic study ordered (with results or pending status) or recommended (with an indication of who is to order), any procedure performed and outcome of the procedure or planned/scheduled procedure, any secondary referrals made or recommended, any patient education provided (or recommended) and/or self – management expectations and recommended follow up by the specialty practice and/or PCMH.

The service agreement should also address mutually agreed upon timeline expectations for receipt of reports and the manner in which the report will be sent (mail, fax, email, EMR etc). Communication arrangements for emergencies or situations requiring expedited contact should be developed. Notification guidelines for those patients who “no show” for their appointments or procedures should also be part of the response process. The importance of responsible and agreed upon communication processes among treating providers to the safe and effective care of patients cannot be overstated.

5) The service agreement will specify how secondary referrals are to be handled

Secondary referrals are those referrals that arise from a referral to a specialty practice for consultation, procedures or co-management in the outpatient setting. It needs to be established who is responsible for instituting and coordinating these secondary referrals and how the information from these referrals is shared and communicated. In some instances the referral for special services may require some specialty knowledge and may best be managed by the specialty practice. There needs to be clear expectations as to when the PCMH wishes to be involved in secondary referrals and when it is preferable for the specialty practice to proceed without conferring with the PCMH. In all cases the PCMH needs to be included in the communication regarding the secondary referral and the outcomes of that referral and a process for ensuring this communication connection needs to be established.

6) The service agreement will maintain a patient centered approach including consideration of patient/family choices and ensuring explanation/clarification of reasons for referral, the subsequent diagnostic or treatment plan and responsibilities of each party, including the patient/family

Both the PCMH and specialty practice establish processes to deliver care in a patient –centered manner that fosters increased patient involvement and responsibility. This should include providing information sensitive to level of health literacy, allowing time for questions and explanations, and providing clear guidelines for when and how to utilize the specialty services. A written guide about the practice operations (such as contact numbers for help with scheduling, billing issues or medical/medication questions as well as how prescriptions, diagnostic test results and follow up will be handled) is recommended. Development of treatment plans should include patient input and acknowledgement of goals and responsibilities. Resources for education about the disease state as well as disease self –management should be made available to patients/ families. Openness to and facilitation of additional expert opinion for difficult diagnoses should be part of the patient-centered approach.

Consistent with the patient centered approach of the PCMH care model, patients may engage in self-referrals. For example, they may contact a PCMH-N specialty or subspecialty practice without referral from their PCMH practice. When a patient self-referral is made, it should be handled in a thoughtful and considerate manner. There should be processes in place to ascertain that the referral is appropriate and if not, to help guide the patient to the appropriate specialist. Furthermore, after receiving appropriate

patient consent, processes should exist for the patient's PCMH to provide relevant background information to facilitate the self-referred appointment and the Neighbor should provide information back to the PCMH so treatment can be coordinated and integrated with the patient's overall healthcare plan.

7) The service agreement will clarify in-patient (e.g. acute hospital, rehabilitation facility, nursing home) processes including notification of admission, secondary referrals, data exchange and transitions into and out of hospital.

The specific elements of inpatient care that should be addressed include:

- Responsibilities of the PCMH and specialty practice regarding notification of an inpatient admission.
- Processes to facilitate the determination of service assignments for the PCMH and specialty practice in the management of the patient during inpatient care.
- Processes to delineate the responsibilities for the PCMH and specialty practice regarding the transition of the patient from the inpatient setting.
- Processes to delineate the responsibilities for the PCMH and specialty practice regarding post discharge care.

8) The service agreement will contain language that emphasizes that in the event of emergency or other circumstance in which contact with the PCMH cannot be practicably performed that the specialty practice may act urgently to secure appropriate medical care for the patient.

9) Service agreements will include:

- **The term of the agreement and mechanisms for renewal.**
- **Period for regular review of the terms of the service agreement by the PCMH and specialty practice.**
- **Mechanism for documentation and communication of real or perceived breaches of the service agreement.**