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

# Physician– Hospital/SNF Collaborative Guidelines

## Overview

Effective coordination of care is an essential element in any successful health care system and this element requires the willingness of specialists, other medical providers, and health care facilities to share bi-directional information and collaborate in decision-making. The Medical Neighborhood is a systems model that extends the Patient-Centered Medical Home team-based care paradigm and:

- Fosters shared accountability among providers/facilities
- Improves quality of care
- Reduces waste
- Aligns incentives to encourage collaboration

The purpose of this Collaborative Guideline is to provide the structure and identify the key elements needed to implement a collaborative agreement between the physician and hospital.

Care coordination guidelines or compacts are service agreements between medical providers or providers and facilities that outline explicit expectations that define who is accountable for the care; how the care is delivered; what clinical information is shared; and how access to care is ensured to provide a seamless care experience for the patient. Collaborative care agreements can take many forms but standardizing definitions for care responsibility and information are critical in order to create a shared language across provider communities. The four domains of care coordination are: Transitions of Care; Access; Collaborative Care Management; and Patient Communication. Each domain identifies the elements of care, aligns responsibilities, and focuses the work to provide safe and effective care transitions. The Transition of Care Record outlines the essential items critical to bi-directional communication.

This document is organized according to the following categories:

- *Purpose & Principles*
- *Definitions of Terms*
- *Components of Care Transitions*
- *The Care Coordination Agreement:*
    - *Transition of Care*
    - *Access*
    - *Collaborative Care Management*
    - *Patient Communication*
- *Appendix - Tools:*
    - *Transition of Care Record: the core elements required for informational continuity between physician to hospital and hospital to physician transitions.*
    - *Discharge Care Plan: A sample template for post-hospital assessment and care plan*
- *References*

  This Guideline presents the concepts of collaborative care coordination and outlines the essential elements of coordinated care that are needed to make the difficult changes that will transform us from parallel, cooperative silos of care to integrated, collaborative care teams. Implementing this agreement into practice requires multiple new processes and work flows unique to the organization and community.

R. Scott Hammond, M.D., FAAFP
Bridgette Binford, CPH, CHES

## 1. Purpose

- To provide optimal health care for our patients.
- To provide a framework for better communication, coordination and safe transition of care between physicians and hospital/emergency/SNF facilities.

## 2. Principles

- Safe, effective and timely patient care is our central goal.
- Effective communication between physicians and hospital/SNF care is essential 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 ensures continuity of care and provides patients with access to the 'right care at the right time in the right place with the right team'.
- A concept of patient transfer with continuous care (as opposed to the traditional concept of non-coordinated patient discharge) is necessary to ensure informational, relational, and geographic continuity of care.

## 3. Definitions

- Patient: a person receiving medical or behavioral health care. For purposes of this agreement, the individual is treated in the context of their life circumstances and in consideration of family needs and preferences.
- Care coordination: the deliberate integration of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services (McDonald, NEJM, 2007).
- Care Coordinator (CC) – a person who assists all patients and their families by acting as a patient advocate and navigator and providing logistical and informational help to patients referred to or from outside medical practitioners or facilities. The CC ensures timely and effective transfer of patient information and coordinates continuity of care between physicians, healthcare organizations, and community resources.
- Co-management - the PCP or specialist actively coordinates care with the emergency department physician/hospitalist and hospital-based physician or SNF providers and collaborates on management of all medical disorders, drug therapy, secondary referrals, diagnostic testing, patient education, care teams, monitoring, and patient follow-up.

- Emergency care – medical or surgical care obtained on an urgent or emergent basis.

- Hospitalist – a dedicated inpatient physician who manages the inpatient care of general adult medicine patients referred by physicians in the community or for those patients without a primary physician.

- Medical Neighborhood – a system of care that integrates primary care physicians with specialists and the medical community through enhanced, bidirectional communication and care collaboration on behalf of the patient.

- 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.

- 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 and circumstances.

- Prepared Patient – an informed and activated patient who has an adequate understanding of his or her present health condition in order to participate in medical decision-making and self-management.

- Primary Care Physician (PCP) – a generalist whose broad medical knowledge facilitates first contact with patients, as well as comprehensive and continuous medical care for those patients.

- Primary management –the PCP or specialist assumes responsibility as the attending physician and directs and manages the care of the patient.

- Secondary referrals – A primary referral is from PCP to a specialist. A secondary referral occurs when a specialist refers to another specialist.

- 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.

- Technical Procedure – transfer of care to obtain a clinical procedure for diagnostic, therapeutic, or palliative purposes.

- 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.

## 4. **Components of Care Transitions** (see Continuum of Collaborative Guidelines graphic)

- Types of accountability

    1. Primary management and co-management with shared care of the patient

        - PCP or specialist assumes responsibility as the attending physician for the care of the patient by directing, managing and coordinating the patient's health care team.

    2. Co-management

- Co-management with Principal Care for the Disease (Referral) – the emergency department physician, hospitalist, hospital-based physician, or SNF provider assumes responsibility for the comprehensive management of a patient's referred medical/surgical condition. The PCP receives consultation reports and provides input on secondary referrals

- Co-management with Principal Care for the Patient– due to the nature and impact of the disease or injury, the emergency department physician, hospitalist, hospital-based physician or SNF becomes the provider for total care until the crisis or treatment has stabilized or has been completed. The PCP or specialist remains active in bi-directional information, providing input on secondary referrals, end-of-life issues and other defined areas of care.

- Types of transitions:

1. Treat and release

2. Admission to Emergency Department
   - From office (PCP or specialist referral)
   - From home or ambulance (self-referral)
   - From hospital department (diagnostic or out-patient procedure) or hospital transfer

3. Direct Admission to hospital
   - From PCP
   - From Specialist
   - From hospital department (diagnostic or out-patient procedure) or hospital transfer

4. Admission to Outpatient Department
   - Laboratory
     - From PCP
     - From specialist
   - Diagnostic testing and imaging
     - From PCP
     - From specialist
   - Procedures
     - From PCP
     - From specialist

5. Admission to Skilled Nursing Facilities

6. Transition to home
   - without home care
   - with home health care

## 5. Mutual Agreement for Care Management

- The Mutual Agreement section of the tables reflects the core elements of the Medical Neighborhood and outlines expectations for both physicians and hospital/SNF 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 physicians or hospital/SNF providers.
- 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 his or her practice.
- When patients self-refer to the hospital, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCP and specialists, as appropriate.
- During emergency care, processes should be in place to determine the patient's urgent and/or emergent needs and reintegrate further care with the PCP and specialists, as appropriate.
- 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 periodically.

## Transition of Care

### Mutual Agreements

- ☐ Maintain accurate, up-to-date and readable clinical records.
- ☐ 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.
- ☐ Identify the primary medical provider responsible for care throughout each transition.
- ☐ Provide a dedicated team member to receive information for transition of care, as well as, to provide care coordination.
- ☐ Shift perspective from that of a discrete event of patient admission or discharge to that of a patient transfer with continuous management (CCGC, n.d.).
- ☐ Develop protocols and policies to ensure safe, effective and efficient transfer of care and establishes performance standards to monitor.
- ☐ Receive all incoming calls and urgent faxes from receiving team with appreciation.

### Expectations

#### All Physicians

- ☐ Ensure safe transfer to the appropriate care facility able to handle patient needs.
- ☐ Transfer information as outlined in Patient Transition Record preferably within 30 minutes of request or notification of transition.
- ☐ Order appropriate studies that would facilitate the hospital visit, if possible.
- ☐ In cases of direct admission to the hospital, provides patient with hospital contact information and expected time frame for admission.
- ☐ Inform patient of need, purpose (specific question), expectations, and goals of the hospital admission or ED referral.
- ☐ Ensure patient/family is in agreement with hospital admission/ED referral and hospital selection.

**Primary Care Physician**

- ☐ Provides all patients with wallet cards or other identification that lists PCP name, other providers (PAs, NPs, Care Coordinator), and contact information.

**Specialist/Skilled Nursing Facility (SNF)**

- ☐ Whenever possible, confers with PCP prior to referral to hospital or ED; in urgent or emergent situations, contact is made with the PCP regarding the referral as soon as possible, preferably on the same day.

#### Hospital

**Emergency Department (ED)**

- ☐ Makes all attempts to identify PCP and/or specialist.
- ☐ For self-referred patients, notifies PCP or specialist and obtains pertinent medical information.
- ☐ Contacts the PCP/specialist to determine if admission is necessary or if outpatient workup is appropriate.
- ☐ Informs patient of need, purpose, expectations, and goals of hospitalization or other transfers.
- ☐ Notifies referring provider of secondary referrals.
- ☐ Attempts to honor established provider's referral patterns.
- ☐ Sends the Patient Transition Care Record to PCP/specialist within 24 hours.

**Hospitalist and hospital-based physicians**

- ☐ Informs patient of need, purpose, expectations and goals of hospitalization or other transfers.
- ☐ Obtains pertinent medical information from PCP/specialist at admission.
- ☐ Determines and/or confirms insurance eligibility.
- ☐ Attempts to honor established provider's referral patterns.
- ☐ Reviews documentation sent by PCP and utilizes information for making care decisions.
- ☐ Confers with PCP before making difficult care decisions when possible.
- ☐ Sends a faxed or emailed discharge notification/summary at the time of discharge and the complete Patient Transition Record to PCP and/or specialist within 48 hours of discharge.

| | |
|---|---|
| | **Discharge Advocate/Care Coordinator for ED and Hospital**<br>☐ Determines and/or confirms insurance eligibility on admission and for transfers.<br>☐ Aids in any insurance/billing concerns.<br>☐ Ensures that appropriate transition documentation is sent from hospital/ED to PCP/specialist or other facility.<br>☐ Communicates with care coordinator at PCP or other facility on care and transition planning.<br>☐ Assesses patient's functional status, preferences, and determines any care coordination needed to assist with safety and activities of daily living (ADLs) upon transition or discharge.<br>☐ Arranges for community resources needed by patient, including transportation, assistance with activities of daily living (ADLs), etc. |

Additional edits/agreements/notes:

## Access

### Mutual Agreement

- ☐ When available and clinically practical, provide a secure email option for communication with established patients and/or providers.
- ☐ A health care team member is made available to the patient, caregiver, and receiving health care team for 72 hours after the transfer to discuss any concerns regarding the care plan.
- ☐ Use the preferred mode of communication (phone, fax, email).
- ☐ Provide contact information for urgent/ emergent situations.
- ☐ Provide a list of physicians, hospitalists, and/or providers who agree to compact principles.

### Expectations

| All Physicians | Hospital |
|---|---|
| ☐ Are readily available to physicians, hospitals, and patients.<br>☐ Are prepared to respond to urgencies.<br>☐ Provide adequate visit availability.<br>☐ Provide alternate back-up when unavailable for urgent matters.<br><br>**Primary Care Physician**<br>☐ Arranges on-call provider to be available 24/7; provides single point of contact for on-call provider.<br>☐ Follows-up with patients who "no-show" to ED or hospital. | **Emergency Department/ Hospitalist and hospital-based physicians**<br>☐ When referred from the office, notifies PCP of 'no-shows'.<br>☐ Provides patient with reasonable wait time before being evaluated by a medical provider.<br><br>**Hospital**<br>☐ Ensures transition and admittance to the hospital is coordinated and as timely as possible.<br>☐ Allows PCP access to necessary treatment information outside of the transition care record, if requested.<br><br>**Discharge Advocate/Care Coordinator**<br>☐ Arranges convenient hours and contact information for patient and physician.<br>☐ Facilitates access to necessary patient information. |

Additional edits/agreements/notes:

# Collaborative Care Management

## Mutual Agreement

- ☐ Define responsibilities between PCP, specialist, hospital/SNF, 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 and preferences.
- ☐ Share data/reports with patient care team (Primary Care Physician, Hospital, Specialist/SNF) providers in a timely manner including pertinent consultations or care plans from other care providers.

## Expectations

### All Physicians

**Primary Care Physician**

- ☐ Manages the medical problem to the extent of the physician's scope of practice, abilities and skills.
- ☐ Follows standard practice and evidence-based guidelines.
- ☐ Resumes care of patient as outlined by hospital/SNF provider, assumes responsibility and incorporates care plan recommendations into the overall care of the patient.

**Specialist/SNF**

- ☐ Confers with PCP before referring 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.
- ☐ Notifies the PCP office or designated personnel of major interventions, emergency care or re-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

### Hospital

**Emergency Department/ Hospitalist and hospital-based physicians**

- ☐ Reviews information sent by PCP and addresses provider and patient concerns.
- ☐ Clarifies with the patient of their relationship as part of their care team with the PCP or specialist
- ☐ Confers with PCP before ordering additional services outside practice guidelines when possible. Obtains proper prior authorization.
- ☐ Confers with PCP before refers to secondary/tertiary specialists for problems and, when appropriate, uses a preferred list to refer when problems are outside PCP scope of care.
- ☐ Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations.
- ☐ Prescribes pharmaceutical therapy on discharge 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.

**Discharge Advocate/Care Coordinator**

- ☐ Coordinates information between hospital and PCP and/or specialist or other facilities and facilitates collaboration in preparation of care plan.
- ☐ Assesses functional status, needs of and support for the patient prior to discharge and provides written care plan to patient, family and providers according to their preferences.
- ☐ Ensures primary medical provider has knowledge of and access to needed support systems.
- ☐ Provides PCP care coordinator with updates on patient status when major changes occur or other

| | |
|---|---|
| | care needs present.<br>☐ Performs hand-off phone call with PCP care coordinator. |

Additional edits/agreements/notes:

# Patient Communication

## Mutual Agreement

- ☐ Consider patient/family preferences and choices in care management, diagnostic testing and treatment plan.
- ☐ Provide to and obtain informed consent from patient according to community standards.
- ☐ Explore patient issues on quality of life in regards to their specific medical condition and share this information with the care team.
- ☐ Participate with patient care team as needed.

## Expectations

| Physician | Hospital |
|---|---|
| **Primary Care Physician**<br>☐ Explains, clarifies, and secures mutual agreement with patient on recommended care plan.<br>☐ Assists patient in identifying his or her treatment goals.<br>☐ Identifies whom the patient wishes to be included in his or her care team.<br>☐ Educates patient on importance of notifying hospital/SNF providers of PCP designation (through use of wallet card, etc.).<br><br>**Specialist/SNF**<br>☐ Informs patient of diagnosis, prognosis and follow-up recommendations.<br>☐ Provides educational material and resources to patient when appropriate.<br>☐ Recommends appropriate follow-up with PCP.<br>☐ Is available to the patient to discuss questions or concerns regarding the consultation or their care management. | **Emergency Department**<br>☐ Informs patient of diagnosis, prognosis, and follow-up recommendations.<br>☐ Provides educational material and resources to patient and educates patient of the importance to communicate with PCP regarding the ED visit.<br>☐ Provides procedures to follow if a problem arises with discharge plan.<br>☐ Recommends appropriate follow-up with PCP and/or specialist.<br><br>**Hospitalist and hospital-based physicians**<br>☐ Informs patient of diagnosis, prognosis, and follow-up recommendations.<br>☐ Provides educational material and resources to patient when appropriate.<br>☐ Recommends appropriate follow-up with PCP.<br>☐ Is available to the patient or family to discuss questions or concerns regarding the consultation or their care management.<br>☐ Provides procedures to follow if a problem arises with discharge plan<br>☐ Educates patient of importance of communication with PCP regarding hospital visit.<br><br>**Discharge Advocate/Care Coordinator**<br>☐ Ensures that patient communication preferences are known by providers.<br>☐ Ensures that patient cultural considerations are ascertained and known by providers; provide assistance and education to provider on cultural considerations, if needed.<br>☐ Monitors and improves transition process through satisfaction surveys of patients and physicians. |

Additional edits/agreements/notes:

# 6. Appendix

## A. Physician to Hospital Transition Care Record

1. Demographics:
   - Patient --Patient name, DOB, contact and insurance information
   - Practice -- PCP designation, referring provider and contact information.
2. Clinical Note:
   - Primary complaint and a clear clinical reason for patient transfer
   - Key physical findings and relevant notes and test results
   - Assessment/Diagnosis -- ICD-9 code
3. Clinical Data:
   - problem list
   - medical and surgical history
   - current medication
   - immunizations
   - allergy/contraindication list
   - pertinent labs and diagnostics tests
   - patient cognitive status
   - patient functional status
   - caregiver status
   - advanced directives
   - list of other providers, specialists, care team
4. Admission/Treatment or Transfer Orders
5. Type of transitions of care.
   - Primary management
   - Co-management
     - Principal care of the Disease
     - Principal care of the Patient
     - Technical procedure

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

## B. Hospital to Physician Transition Care Record

1. Demographics
   - Patient-- name, identifying and contact information, insurance information, PCP designation.
2. Facility details – Hospital name, attending physician with contact numbers and communication preference – phone, letter, fax or e-mail,
3. Date(s) of hospitalization or Emergency Department visit
4. Diagnoses (ICD-9 codes)
   - Admitting diagnosis
   - Discharge and secondary diagnoses.
5. Care team - list of consultants and community resources involved in hospital care or referral after hospital discharge
6. Discharge summary
   - Course of illness or treatment
   - Clinical Data – problem list, complete medication list noting new medications, immunizations given, labs and diagnostic tests with list of pending results.
   - Procedures – summarize procedure details, findings and recommendations.
   - Condition on discharge (including cognitive level)
   - Disposition (LTC, Home Health, Home, etc.)
7. Recommendations – communicate recommendations for further diagnostic testing/imaging, additional referrals and/or treatment. Develop an evidence-based care plan with responsibilities and expectations of the hospital and responsible physician that clearly outline:
   - Medication or medical equipment changes, and monitoring responsibility.
   - Recommended timeline of future tests, procedures, secondary referrals and coordination of community resources and who is responsible to institute, coordinate, follow-up and manage the information.
   - Patient goals, functional status, level of activation, support issues, input and education provided on disease state and management
8. Follow-up status – Specify time frame for next appointment to primary physician and/or specialists.

## C. Discharge Care Plan

Patient: _____ PCP: _____ Date:_____
Diagnosis: _____
Hospitalization Dates: _____ Transition to: _____
Care Team: _____

☐ Discharge Summary sent:
To: _____
Date: _____
Physician appointment: Date: _____

☐ Laboratory/Diagnostic tests pending:
Test: _____
Test: _____
Test: _____

| Status | Information Needed | Short Term Goal | Long term goal |
|---|---|---|---|
| Functional Status | • ADL assessment<br>• Transportation issues | | |
| Medical Status | • Diagnosis<br>• Co-morbid conditions<br>• Prognosis<br>• Medication Review<br>• Allergy Review<br>• Advance Directives | | |
| Self-care Ability | • Current Ability and confidence<br>• Educational needs | | |
| Social Support | • Primary Caregiver<br>• Ability/willingness to give care<br>• Community support | | |
| Disposition | • Prior residence<br>• Current residence<br>• Future residence | | |
| Communication | • Language needs<br>• Health beliefs | | |
| DME | • Current needs<br>• Vendor | | |
| Referral | • Name, specialty and date recommended | | |
| Lab orders | • Hospital orders and date recommended | | |

| Current Functional Status | | | | |
|---|---|---|---|---|
| Cognitive | Dress | Bathing | Toileting | Bathing |
| ☐ Independent<br>☐ Requires assist<br>☐ Unable | ☐ Independent<br>☐ Requires assist<br>☐ Unable | ☐ Independent<br>☐ Requires assist<br>☐ Unable | ☐ Independent<br>☐ Requires assist<br>☐ Unable | ☐ Independent<br>☐ Requires assist<br>☐ Unable |

# 7. References

1. American Academy of Family Physicians. (2009, April). *Hospitalists.* Retrieved January 13, 2010, from AAFG Guidelines for Interaction in "Hospitalist" Models - Communication Between the Receiving Inpatient Care Management Physician and the Referring Primary Care Physician: www.aafp.org.

2. Bodenheimer, Thomas. (2008, March). Coordinating Care – A Perilous Journey Through the Health Care System. New England Journal of Medicine.

3. California Healthcare Foundation. (2010, October). The Post-Hospital Follow-up Visit: A Physician Checklist to Reduce Readmissions.

4. Colorado Clinical Guidelines Collaborative. (n.d.). Hospital Sub-Group Overview. Patient-Centered Medical Home .

5. HMO Workgroup on Care Management. (2004, February). One Patient, Many Places: Managing Health Care Transitions. Washington, DC.

6. Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. (2011, June). Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality.