

Clinical Referral Protocol Guide

Definitions and Templates for Referrals within the Accountable Care Collaborative. Developed by RCCOs across the state of Colorado.

February 1, 2014

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I. Introduction

Most patients expect their primary care provider and specialty care providers to communicate about their diagnosis, health concerns, and reasons for a specialty care visit. However, according to recent research published in the Journal of the American Medical Association (JAMA), only 70 percent of primary care physicians reported they "always" or "most of the time" sent notification of a patient's history and reason for consultation to specialists, while 35 percent of specialists said they receive such information. The reverse is also true with 80 percent of specialists indicating they "always" or "most of the time" sent consultation results to the referring provider, but only 60 percent of primary care providers report getting back information from the specialist.¹ This communication gap can affect health outcomes, patient experience, and overall costs to the health care system.

The Accountable Care Collaborative program seeks to transform Medicaid into a system of care that engages primary care medical providers (PCMP) and specialty care providers to work collaboratively to provide patient-centered and coordinated care in order to improve health outcomes, improve patient experience, and decrease health care costs to the state of Colorado. The Department of Health Care Policy and Financing (HCPF) contracts with seven Regional Care Collaborative Organizations (RCCO) to implement the ACC program within their geographic region. Each RCCO works with PCMPs to transform health care delivery by engaging providers in activities that move their practices toward the values of Patient-Centered Medical Homes (PCMH) as defined by the Agency for Healthcare Research and Quality² (AHRQ), and to prepare PCMPs for the impending shift from a volume-driven, fee-for-service environment to an outcomes-based health care delivery system. The tenets of PCMH are:

- I. Comprehensive care such that the PCMH is accountable for meeting the majority of a member's care, including physical and mental health care, prevention and wellness, acute care, and chronic care.
- II. Patient-centered care that is relationship based (including a member's family) and oriented toward the whole person.
- III. Coordinated care such that the PCMH coordinates all elements of care across the broader health care system, including specialty care, inpatient care, home health, and community services and supports.

¹ Chen, AH, MD and Hal F. Yee, Jr., MD, PhD. Improving the Primary Care-Specialty Care Interface: Getting From Here to There. *Arch Intern Med.* 2009;169(11):1024---1025; Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. AHRQ Publication No. 11-0064. June 2011. Available from: <http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf>

² Agency for Healthcare Research and Quality [Internet]. Patient Centered Medical Home Resource Center. Available from: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_defining_the_pcmh_v2

- IV. Accessibility of services to include extended hours, shorter wait times for appointments, electronic access to the care team, alternative methods of communication, and responsiveness regarding member preference for access.
- V. Quality and safety measures, including evidence-based medicine, clinical decision support tools for shared decision-making, and the ability to undertake quality improvement activities to respond to population health management, patient satisfaction, and health outcomes.

While PCMPs can be a PCMH that provides comprehensive primary care and care coordination, specialty care is a vital part of managing a patient's overall health, particularly for patients with chronic, complex, or co-morbid health conditions. Many of the goals of the PCMH rely on improved communication and coordination between and across health care providers and institutions: in other words, they require a high functioning medical neighborhood that (1) encourages the flow of information across and between clinicians and patients, and (2) introduces some level of accountability to ensure that clinicians readily participate in that information exchange³.

In order to provide for comprehensive care, RCCOs are working to engage specialty providers in each community to create a medical neighborhood. The medical neighborhood is unique to each community and comprises the PCMH and the broader health care system including, but not limited to, clinicians providing services to the patient, state and local public health agencies, community services, and social service organizations. The medical neighborhood is a system of care that integrates the PCMP with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient⁴. The desired outcomes of a high-functioning medical neighborhood include improved patient outcomes; patient safety; patient experience; and possibly lower costs through reduced duplication of services, increased delivery of preventive services, and more evidence-based patient care (resulting in fewer readmissions, polypharmacy issues, and adverse events, for example)⁵.

RCCOs seek to create a PCMN that is functional without adding undue administrative burden for the PCMP or the specialist. Additionally, RCCOs wish to create a common language for the PCMN and for referrals between PCMPs and specialists such that all providers can work together regardless of which RCCO a practice is located in.

³ Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. AHRQ Publication No. 11-0064. June 2011. Available from: <http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf>

⁴ Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010.

⁵ Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. AHRQ Publication No. 11-0064. June 2011. Available from: <http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf>

The premise of this ACC deliverable is to provide a synthesis of terminologies and principles for use in communication between PCMPs and their medical neighborhood partners. The purpose of this document is to establish a statewide set of definitions and guidelines for use when developing referral agreements or coordinating referrals to minimize access barriers for patients and to simplify administrative complexities for providers working with multiple RCCOs. It is intentionally designed as a conceptual document based on research and best practices to allow maximum flexibility based on local community readiness and existing partnerships, templates, and referral patterns. RCCOs understand that PCMPs may already have established communication processes with specialists and vice versa. This deliverable is not intended to disrupt existing processes and is designed to support evolving communication initiatives across medical neighborhoods.

II. Definitions/Terms

Creating a common language for the medical neighborhood is important for establishing a shared understanding of roles and responsibilities of each member of the medical neighborhood. These definitions are from leading state and national medical and research organizations.

- *Accountable Care Collaborative (ACC)* – HCPF program designed to affordably optimize client health, functioning and self-sufficiency with the primary goal to improve Medicaid client health outcomes and control cost.
- *Patient Centered Medical Home (PCMH)* – “operates as the central hub of patient information, primary care provision, and care coordination. Within a PCMH, the concept of the care team is expanded to include health care professionals including nurses, pharmacists, care managers, and others. Care delivery places a high priority on patient involvement and recognition of patient needs and preferences – it is patient-centered. Population management processes are incorporated into the practice workflow that facilitates the delivery of evidence-based disease management and patient self-management services.” (American College of Physicians, 2010)
- *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”. (Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010)
- *Primary Care Medical Provider (PCMP)* – A primary care provider who serves as a Medical Home for Members. A PCMP may be a FQHC, RHC, clinic or other group practice that provides the majority of a Member’s comprehensive primary, preventive and sick care. A PCMP may also be individual or pods of PCMPs that are physicians, advanced practice nurses, or physician

assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology. (HCPF RCCO Contract)

- PCMP Role in Medical Neighborhood – understand the comprehensive health care needs of a patients/members and development of processes and tools to assure these needs are met in a timely, effective, equitable, efficient, safe, and patient-centered manner. (IOM; Crossing the Quality Chasm; 2001)
- PCMP Accountabilities in a Medical Neighborhood—
 - Comprehensive patient/member care
 - Coordination and integration of care with all patient/member providers in a bidirectional manner to provide high-quality and efficient care
 - Ensure appropriate and timely consultations and referrals that complement the aims of the PCMH practice
 - Ensure the efficient, appropriate, and effective flow of necessary patient and care information
- RCCO Accountabilities—
 - Overall health outcomes of enrolled clients
 - Provider network development and practice support
 - Medical management and care coordination
 - Accountability/reporting for quality and financial outcomes
- RCCO Role in Medical Neighborhood - understand the gaps and challenges PCMPs, specialists and patients/members face when referrals are needed and support the identification and development of tools and solutions that support evolution of Medical Neighborhood communication and reduce administrative burden for providers when making referrals or transition a patient/member back to the PCMP provider.
- 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.” (Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010)
- Specialist Role in Medical Neighborhood – “support the goal of the PCMH model to promote integrated, coordinated care throughout the health care system, but also recognize that the effectiveness of the PCMH care model to achieve this goal is depending on the cooperation of the many subspecialists, specialists, and other health care entities (e.g., hospitals, nursing homes) involved in patient care.” (American College of Physicians, 2010)
- Specialist Accountabilities in Medical Neighborhood:

- “Ensure effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care
 - Ensure appropriate and timely consultations and referrals that complement the aims of the PCMH practice
 - Ensure the efficient, appropriate, and effective flow of necessary patient and care information
 - Effectively guides determination of responsibility in co-management situations
 - Support patient-centered care, enhanced care access, and high levels of care quality and safety
 - Support the PCMH practice as the provider of whole person primary care to the patient and as having overall responsibility for ensuring the coordination and integration of the care provided by all involved physicians and other health care professionals.” (American College of Physicians, 2010)
- 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”. (Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010)
 - Whole-person orientation – “the personal physician is responsible for providing all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals”. (American College of Physicians, 2010)

III. PCMP and Medical Neighborhood Relationships

A literature review was performed to identify best practices in promoting strong communication between PCMPs and specialists, to maximize each provider’s time spent with patients, and supporting member experience of the health care system. The literature review demonstrated value for PCMPs and for specialists when a functional PCMN framework is created.

Value of Medical Neighborhood Relationships

PCMPs benefit from a medical neighborhood as specialists support the central role of the PCMP as the hub of whole, patient-centered care. Specifically, a medical neighborhood allows PCMPs to:

- Experience partnership from specialists and community resources in caring for patients to address their whole person needs
- Leverage support structure of care managers and practice supports to increase accessibility and integrated care initiatives

- Support from RCCO in identifying specialist availability/engagement and willingness to participate in medical neighborhood

Specialists benefit from the medical neighborhood by allowing the specialist to focus on treating the patient based on their area of expertise in partnership with a PCMP who can address the patient’s other health care and psycho-social needs. Specifically, a medical neighborhood benefits allows specialists to:

- Experience a prepared patient as guided by PCMP
- Gain support from care management teams in reducing no-show rates
- Support from RCCO in resolving PCMP or patient concerns in serving ACC patients
- Opportunity to grow practice by establishing relationships with more PCMPs for referral of other patients, including patients with commercial insurance
- More effective interactions with PCMPs and more appropriate referrals
- Opportunity to help ACC develop payment reform around these best practices

Patients benefit from the medical neighborhood as well. In the medical neighborhood, care is less fragmented and the health care system becomes more coordinated to address their health needs. Benefits for patients include:

- Maximum possible wellness, quality of life and empowerment to manage health conditions
- Whole person centered care from primary care physician
- Receive value of specialists unique knowledge in caring for specific health conditions
- Understanding of how to use health care system
- Understanding of their multiple medical conditions and the importance of treatment compliance with both primary and specialty care treatment recommendations

Types of Medical Neighborhood Relationships

Understanding each provider’s role in the medical neighborhood helps create continuity of care for patients and reduces duplication of effort by PCMPs and specialists. The Colorado Medical Society has endorsed the following roles and relationships as defined in a project funded by the Colorado Health Foundation:

- “Pre-consultation exchange – communication between the PCMP 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.
- 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.
 - Co-management with Principal care 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.” (Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010)

Best Practices for Effective Communication in the Medical Neighborhood

By establishing clear communication principles, both PCMPs and specialists will be able to focus on what they are trained to do and, in the end, reduce the impact of a fragmented system of care and

administrative burdens. The Colorado Medical Society has adopted the following guiding principles for PCMP and specialist collaboration:

- Safe, effective and timely patient care is the 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'.

The American College of Physicians approves the following aspirational guiding principles for the development of care coordination agreements between PCMPs and specialists in the medical neighborhood.

- A care coordination agreement will define the types of referral, consultation, and co-management arrangements available.
- The care coordination agreement will specify who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements available.
- The care coordination agreement will specify the content of a patient transition record/core data set, which travels with the patient in all referral, consultation, and co-management arrangements.
- The care coordination 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 physician or other health care professional.
- The care coordination agreement will specify how secondary referrals are to be handled.
- The care coordination 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.
- The care coordination agreement will address situations of self-referral by the patient to a specialist practice.
- The care coordination agreement will clarify in-patient processes, including notification of admission, secondary referrals, data exchange, and transitions into and out of hospital.
- The care coordination agreement will contain language emphasizing that in the event of emergencies or other circumstance in which contact with the PCMP cannot be practicably performed, the specialty/subspecialty practice may act urgently to secure appropriate medical care for the patient.
- Care coordination agreements will include:

- A mechanism for regular review of the terms of the care coordination agreement by the PCMP and specialty/subspecialty practice.
- A mechanism for the PCMP and specialty/subspecialty practices to periodically evaluate each other’s cooperation with the terms of the care coordination agreement, and the overall quality of care being provided through their joint efforts.

IV. Templates and Tools

The templates below were shared in the presentation conducted by the Colorado Medical Society “Creating Medical Home Communities- System of Care/Patient Centered Medical Home Initiative.”

Transition of Care	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • 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 	
<i>Expectations</i>	
Primary Care	Specialty Care

<ul style="list-style-type: none"> <input type="checkbox"/> PCP maintains complete and up-to-date clinical record including demographics. <input type="checkbox"/> Transfers information as outlined in Patient Transition Record. <input type="checkbox"/> Orders appropriate studies that would facilitate the specialty visit. <input type="checkbox"/> Informs patient of need, purpose (specific question), expectations and goals of the specialty visit <input type="checkbox"/> Provides patient with specialist contact information and expected timeframe for appointment. 	<ul style="list-style-type: none"> <input type="checkbox"/> Determines and/or confirms insurance eligibility <input type="checkbox"/> Identifies a single referral contact person to communicate with the PCMH <input type="checkbox"/> When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral work- up
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Access	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • 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. 	
<i>Expectations</i>	
Primary Care	Specialty Care

<ul style="list-style-type: none"> <input type="checkbox"/> Communicate with patients who “no-show” to specialists. <input type="checkbox"/> Determines reasonable time frame for specialist appointment. <input type="checkbox"/> Provide a secure email option for communication with <input type="checkbox"/> patient and specialist. 	<ul style="list-style-type: none"> <input type="checkbox"/> Notifies PCP of first visit ‘no-shows’ or other actions that place patient in jeopardy. <input type="checkbox"/> Provides visit availability according to patient needs. <input type="checkbox"/> Be available to the patient for questions to discuss the consultation. <input type="checkbox"/> Schedule patient’s first appointment with requested physician. <input type="checkbox"/> Be available to PCP for pre-consultation exchange by phone and/or secure email. <input type="checkbox"/> When available and clinical practical provide a secure email option for communication with established patients and provider. <input type="checkbox"/> Provides PCP with list of practice physicians who agree to compact principles.
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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

- 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.

Specialty Care

- Reviews information sent by PCP
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- 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 before refers to secondary/tertiary specialists for problems within the PCP scope of care and 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 to include a care plan,
- 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

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

- 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.

Specialty Care

- 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 before refers to secondary/tertiary specialists for problems within the PCP scope of care and 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 to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions.
- 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

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

- 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.

Specialty Care

- 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.

V. References and Resources

- 1) American College of Physicians. The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices. Philadelphia: American College of Physicians; 2010: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)



ACP Position Paper
Med Neighborhood

- 2) Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010.



PCMH-Primary-Care-
Specialty-Care-comp

- 3) Karen Frederick Gallegos, Building out the Medical Neighborhood using care compacts. Colorado Medical Society presentation supported by Systems of Care/Patient Centered Medical Home Initiative and funded by the Colorado Health Foundation.



Systems of Care
Initiative

- 4) Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepare by Mathematica Policy Research under Contract No. HHS2902009000191 TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011. Available from:

<http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf>