

Primary Care-Hospital Care Team --- Model Care Coordination Agreement*

Primary Care Practice (PCP)¹

The PCP agrees to:

- **If admission³ directly initiated by PCP:**
 - Discuss the case with HCT member on duty in preparation for admission
 - Provide demographics
 - Patient name, DOB, and contact information
 - Contact person if not patient e.g. healthcare proxy or guardian
 - Any special considerations required such as vision/hearing impairment, cognitive deficits, language/cultural preferences
 - PCP designation, referring provider, contact information
 - Provide reason for hospitalization
 - Primary complaint /medical issue/assessment and diagnosis
 - Relevant notes, key physical findings and/or test results as well as summary of recent changes in status
 - Any co-morbid conditions that will need attention during hospitalization
 - Prepare patient/family/caregiver
 - Ensure there is understanding of reason and agreement with planned hospitalization
 - Ensure safe transfer to the appropriate facility in manner that takes into account patient preferences
 - Provide hospital contact information and expected time frame for hospital length of stay.
- **For any hospitalization of a patient under a PCP's care:**
 - Upon notification of the patient's hospitalization, provide appropriate and adequate information to the HCT in a timely manner. When available, this information should include:
 - Problem list
 - Reconciled medication list
 - Allergy/contraindications list
 - Relevant medical and surgical history
 - Advanced directives
 - List of other relevant healthcare professional involved
 - Any additional information specifically requested by a member of the hospital care team.
 - Address communication issues
 - Establish a standard communication protocol with HCT that ensures secure, timely, and reliable transfer of information. This protocol should address the following situations:
 - Transfer of required patient clinical and other information at admission, during hospitalization and at discharge
 - Means of contact during routine and urgent situations.
 - Receives and responds to all incoming calls or other communications from HCT in timely manner in order to provide input on clinical and other issues
 - Engages with HCT around significant clinical issues arising in the hospital that will extend beyond the hospital stay

Hospital Care Team (HCT)²

The HCT agrees to:

- **At the beginning of the hospitalization:**
 - Review patient Information available
 - Inform patient/family/caregiver of need/purpose, expectations and goals of hospitalization
 - Ensure patient's/healthcare proxy's understanding and agreement with hospitalization
- **Establish communication with PCP**
 - Establish a standard communication protocol with PCP that ensures secure, timely, and reliable transfer of information. This protocol should address the following situations:
 - Transfer of required patient clinical and other information at admission, during hospitalization and at discharge
 - Means of contact during routine and urgent situations
 - Identify and make contact with the PCP within 24 hours of admission with mode of communication based on clinical needs and acuity.
 - If not admitted directly by the PCP, ensures that PCP is aware of admission and reason for admission with appropriate patient permission
 - Provides PCP with information on how best to communicate with the HCT, including means for urgent contact
 - Obtains contact information from PCP as well as preferred method for urgent contact
 - Obtains and reviews pertinent medical information from PCP, and requests any additional pertinent information as needed)
- **Engage in collaborative care management during hospital stay**
 - Keep PCP abreast of major clinical developments
 - Involve the PCP when needed in significant patient care decisions that significantly impact care beyond the hospitalization, e.g. regarding longitudinal medical issues, advanced care planning/goals of care determinations, and care transitions issues

Primary Care Practice (PCP)

- **Engage in collaborative care management regarding discharge**
 - Engage with HCT around transitional care planning
 - Ensure receipt of discharge notification (i.e. has systems in place to receive such information, such as EMR, fax, etc.)
 - Resume care of patient
 - Review patient Information upon discharge from hospital setting
 - Agree to make contact with the patient within two business days of discharge
 - Arrange clinically appropriate patient-centered appointment time
 - Incorporates care plan recommendations into overall care of the patient and provides revised care plan to other physicians and healthcare professionals involved with patient, as appropriate.
 - Assume responsibility for follow up of pending results and/or scheduling recommended testing for diagnosis and/or medication monitoring
 - Reach out to HCT if issues arise post-discharge that require input from that team

Hospital Care Team (HCT)

- **Prepare patient for discharge**
 - Inform patient/family/caregiver of diagnosis, prognosis and follow-up recommendations
 - Assess understanding of these issues by patient/family/caregivers
 - Ensure patient/family/caregiver is in agreement with discharge plans
 - Provide educational material and resources to patient when appropriate
 - Provide patient/family/caregiver with written care plan including patient-centered reconciled medication list and any scheduled appointments and planned therapies
 - Advise patient/family/caregiver of any outstanding laboratory and/or other testing that will require follow up by the PCP
 - Provide patient/family/caregiver with a plan for the transition period including how to manage symptoms/signs and how to identify those requiring immediate medical attention and related contact information for appropriate provider
- **Provide appropriate and adequate information at discharge**
 - Transmit a discharge notification to PCP within 24 hours of discharge. This should include the following:
 - Reason for inpatient admission
 - Major procedures and tests performed during inpatient stay and summary of results
 - Principal diagnosis at discharge
 - Current medication list
 - Studies pending at discharge (e.g., laboratory, radiological), AND
 - Patient instructions
 - Make follow up appointment for patient with PCP if clinically appropriate and necessary
 - Send a concise discharge summary to PCP within 48-72 hours of discharge
 - Reaffirm direct contact information to be used by PCP to contact HCT
 - Receive calls from PCP as needed for additional information or clarification

¹The term “Primary Care Practice” reflects those settings dedicated to providing first contact, whole person, and longitudinal care to their patient panel.

²The term “Hospital Care Team” reflects the broad set of physicians and other health professionals involved with the care of the patient within the hospital setting. Professionals involved will vary by location but can include emergency room staff, admission staff, inpatient physicians, nurses, case managers, social workers, and members of various other hospital departments.

³The term “admission” in this sample agreement reflects entrance into any of a broad set of hospital care situations including emergency room care, observational status care, and formal hospital admission.

*This model care coordination agreement was developed by a Task Force consisting of primary care representatives of the American College of Physicians and representatives of the Society of Hospital Medicine.