HEDIS/Star and COMPACT Care Toolkits

Premier Health Plan

Premier Health Group

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Important Contact Information

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Medical Management	To obtain prior authorizations, or assistance with patient admissions/discharges	**(855) 869-7140**
Provider OnLine	For technical issues related to the Provider Portal or to obtain login	**(855) 222-1043**

Member Services Phone Numbers

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Premier Health Employee Plan	For Premier Health employees and their families	**(855) 869-7139**
Premier Health Advantage (HMO)	For Medicare beneficiaries	**(855) 572-2161**
Premier Health Advantage VIP (HMO SNP)	For Dual Eligibles, enrolled in Medicare and Medicaid	**(855) 572-2161**
Premier HealthOne (HMO)	For individuals and families	**(855) 572-2159**
Premier Health Business Value (PPO and HMO)	For employer plans	**(855) 572-2160**

Healthcare Effectiveness Data and Information Set (HEDIS)

Improving Quality and Care through Performance Measures

Premier Health Plan is making new strides in quality performance and patient care through their participation in the Healthcare Effectiveness Data and Information Set (HEDIS). Premier Health Group will contribute to the health plans' annual quality and performance assessments as part of our ongoing effort to build healthier communities, one patient at a time.

What is HEDIS?

HEDIS is a quality and performance assessment tool, required by the Centers for Medicare and Medicaid Services (CMS), which employs standardized measures set by the National Committee for Quality Assurance (NCQA). The review is conducted each January to May 15, and takes a retroactive look at care and services through claims, medical record reviews, and member surveys. The results guide the organization in developing quality initiatives, assessing performance, and building educational programs.

What are the benefits to providers?

Premier Health Group is committed to supporting the essential role physician practices play in promoting the health of our members. HEDIS measures help us identify ways to bolster quality of care and performance that not only improves patient outcomes, but maximizes a practice's productivity and compensation. Premier Health Group offers you the tools you need to effectively manage your patient population and our provider incentive programs reward your efforts in this regard.

What are the benefits to patients?

Our patients thrive when we work toward and achieve excellence. The HEDIS initiative puts patients in reach of preventive care and self-management, enhancing physician-patient relationships and resulting in quality outcomes.

Why is HEDIS important to Premier Health Group?

Care and performance assessment allows Premier Health Group to continue its commitment to lead the region in high-quality, high-value care. Our focus on quality standards helps us remain a competitive choice for employers and a growing population of consumers, as well as meet requirements for our health plans. Our focus on quality and performance is part of what makes us a trusted provider of comprehensive care in our communities.

HEDIS Quick Reference Guide

Annual Monitoring for Patients on Persistent Medication

Line of Business	Medicare, Commercial
Age	18–74
Timeframe	Measurement year or year prior
Documentation	If ACE or ARB Rx need CLAIM for: • Lab panel results OR • Serum potassium and serum creatinine results If Digoxin Rx need CLAIM for: • Lab panel and serum digoxin results or • Serum potassium and serum creatinine and serum digoxin results If Diuretics Rx need CLAIM for: • Lab panel results OR • Serum potassium and serum creatinine results **EXCLUSIONS** by December 31st of the measurement year need claim for either: • Acute Inpatient encounter OR • Non-acute inpatient encounter
Description	Patients who have received at least 180 days of ambulatory medication therapy in the measurement year and at least one therapeutic monitoring during the measurement year for selected agents: • ACE/ARB: lab panel OR serum potassium and serum creatinine. • Digoxin: lab panel and serum digoxin OR serum potassium and serum creatinine and serum digoxin. • Diuretics: lab panel OR serum potassium and serum creatinine

BMI

Line of Business	Medicare, Commercial
Age	18–74
Timeframe	Measurement year or year prior
Documentation	• BMI Date & Value (age 20 and older) • BMI Date & Percentile (age 18 & 19) • Weight and date • Height and Date **EXCLUSIONS** by December 31st of the measurement year: • Documented pregnancy in MR OR • Claims/encounter data for pregnancy
Description	Patients age 18–74 with BMI, height & weight documented in outpatient record during the measurement year or the prior year. BMI percentile for age 18 & 19 needs either: • Value (e.g. 85th percentile) OR • Plot on age-growth chart

Breast Cancer Screening

Line of Business	Medicare, Commercial
Age	50–74
Timeframe	Oct 1st, two years prior to the measurement year to Dec 31st, of the measurement year
Documentation	Claim for Mammogram between Oct 1st, two years prior to the measurement year and Dec 31st of the measurement year. **EXCLUSIONS** by December 31st of the measurement year: • Claim/encounter data for bilateral mastectomy • Claim/encounter data for unilateral mastectomy x 2 • Encounter data for 'history of bilateral mastectomy'
Description	Women age 50–74 with at least one mammogram in the past 27 months (on or between Oct 1st two years prior to measurement year and Dec 31st of the measurement year).

Care for Older Adults (Medicare Special Needs Plans Only)

Line of Business	Medicare
Age	66+
Timeframe	Measurement year
Documentation	Advance care planning Includes a discussion about preferences for resuscitation, life sustaining treatment and end of life care. Examples include: • Advance Directives • Actionable Medical Orders • Living Will Medication review Includes at least one medication review with the presence of a medication list or includes notation that the member is not taking any medication Functional status assessment Includes evidence of at least one functional status assessment and the date it was performed as documented by: • Instrumental Activity of Daily Living (IADL) – or at least four of the following were assessed: shopping for groceries, driving, using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances OR • Activities of Daily Living (ADL) – or that at least five of the following activities were assessed: bathing, dressing, eating, transferring, using toilet, walking OR • Results of a standardized functional status assessment tool OR • Notation that at least 3 of the 4 following were assessed: notation of functional independence, sensory ability, cognitive status, and ambulatory status Pain assessment • Includes evidence of a pain assessment and the date it was performed
Description	Measure evaluates four components: • Evidence of advance care planning discussion or the presence of a plan • At least annually a review of the patient's medications by a prescribing practitioner. Includes the presence of a medication list and review of the medications. Transitional Care Management (TCM) services also meet criteria. • At least one functional status assessment per year. Can be a standard assessment tool or notation of either of the following: ADLs, IADLs, or notation of cognitive status, ambulation status, hearing, vision and speech, and/or other functional independence. • Pain assessment, either through a standardized pain assessment tool or documentation that pain was assessed.

Cervical Cancer Screening

Line of Business	Commercial
Age	21–64
Timeframe	See description
Documentation	• Date and result of cervical cancer screening test OR • Date and result of cervical cancer screening test and date of HPV test on the same date of service OR **EXCLUSIONS** by December 31st of the measurement year: • Evidence of hysterectomy with no residual cervix
Description	Female members 24–64 during the measurement timeframe (measurement year and two years prior) who had cervical cancer screening OR Female members ages 30–64 who had cervical cancer screening and HPV test (measurement year and four years prior)

Childhood Immunization Status

Line of Business	Commercial
Age	Under 2
Timeframe	Measurement Year
Documentation	• 4 DTAP • 3 IPV • 3 HIB • 3 HEP B • 1 MMR • 4 PCV • 1 HEP A (the series is 2 injections, usually given at 12 and 18–23 months) • 2 or 3 Rotavirus • 1 VZV • 2 Influenza
Description	Percentage of children who had all of the required immunizations prior to turning two.

Colorectal Cancer Screening

Line of Business	Medicare, Commercial
Age	50–75
Timeframe	2007–2016
Documentation	Documentation (date and result) of one or more of these screenings: • Colonoscopy during measurement year or 9 years prior; • FOBT during measurement year; • Flexible Sigmoidoscopy during measurement year or 4 years prior or **EXCLUSIONS** by December 31st of the measurement year: • Patients who have a history of colon cancer or • Patients who have had a total colectomy are exempt from this measure.
Description	Measure evaluates the percentage of members ages 50–75 who had at least one appropriate screening for Colorectal Cancer in the past year. Appropriate screening is annual FOBT, sigmoidoscopy in the last 5 years or colonoscopy in last 10 years.

Comprehensive Diabetes Care

Line of Business	Medicare, Commercial
Age	18–75
Timeframe	Measurement year or year prior
Documentation	• Most recent HbA1c testing and result in the measurement year • Most recent Blood Pressure date and result in the measurement year • Nephropathy: Medical attention to nephropathy (micro/macro urine, ACE/ARB medication therapy) in measurement year • Retinal Eye Exam during the measurement year or a negative retinal eye exam during the year prior **EXCLUSIONS** by December 31st of the measurement year: • Patients who do not have a diagnosis of diabetes, and who had a diagnosis of gestational diabetes or steroid induced diabetes.
Description	Measure demonstrates the percentage of members with diabetes (types 1 & 2) who were compliant in the following submeasures: An HbA1c test is completed at least once per measurement year (includes rapid A1c). Use the CPT II codes to reflect the result of the HbA1c test. Eye Exam – a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) is completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior.

Controlling High Blood Pressure (CBP)

Line of Business	Medicare, Commercial
Age	18–85
Timeframe	Measurement year or year prior
Documentation	• Last BP reading (date & result) in the measurement year • If BP is elevated during a visit, best practice suggests retaking the BP later in the visit and documenting all BP readings. **EXCLUSIONS** by December 31st of the measurement year: • Exclude patients with end-stage renal disease or a kidney transplant. • Exclude patients who have a diagnosis of pregnancy during the measurement year.
Description	Measure evaluates the following: • Members 18–59 years old with diagnosis of diabetes and whose BP was <140/90 • Members 60–85 years old with diagnosis of diabetes and whose BP was <140/90 • Members 60–85 years old without a diagnosis of diabetes and whose BP was <150/90

Medication Reconciliation Post-Discharge

Line of Business	Medicare
Age	18+
Timeframe	Measurement year
Documentation	• Medication reconciliation completed by the prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. • Need documentation that it was completed and the date that it was done.
Description	Measure evaluates the percentage of discharges for members age 18 and older for whom medications at discharge were reconciled

Osteoporosis Management in Women Who Had a Fracture

Line of Business	Medicare
Age	67–85
Timeframe	July 1st of the year prior to the measurement year through June 30th of the measurement year
Documentation	• Perform bone mineral density testing within six months of a fracture on members 67 years old and older (fractures of finger, toe, face and skull are not included in this measure.) AND/OR • Prescribe a medication to treat osteoporosis
Description	Measure evaluates the percentage of women who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 6 months after the fracture.

Persistence of Beta-Blocker Treatment After a Heart Attack

Line of Business	Medicare, Commercial
Age	18+
Timeframe	July 1st of the year prior to the measurement year through June 30th of the measurement year
Documentation	• Diagnosis of AMI • Prescription for beta-blocker medication **EXCLUSIONS** by December 31st of the measurement year: • Documentation of intolerance or allergy to beta-blocker therapy. • Documentation of Asthma, COPD, Chronic respiratory conditions due to fumes or vapors, hypotension, heart block > 1 degree, sinus bradycardia • A medication dispensing event indicative of a history of asthma
Description	Measure evaluates the percentage of members age 18 and older who were hospitalized and discharged with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Pharmacotherapy Management of COPD Exacerbation

Line of Business	Medicare, Commercial
Age	40+
Timeframe	Measurement year
Documentation	Prescriptions for systemic corticosteroid and a bronchodilator Two rates are reported: • Systemic Corticosteroid–Dispensed prescription for systemic corticosteroid within 14 days after the date of service • Bronchodilator–Dispensed prescription for a bronchodilator within 30 days after the date of service.
Description	Measure evaluates the percentage of COPD exacerbations for members who had an acute inpatient discharge or an ED visit and who were dispensed appropriate medications. Intent is to measure compliance with recommended pharmacotherapy management for those with COPD exacerbations.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Line of Business	Medicare, Commercial
Age	40+
Timeframe	Measurement year
Documentation	Need claims/encounter data for spirometry testing.
Description	Measure evaluates the percentage of members age 40 and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. Spirometry testing should be completed within 6 months of the new diagnosis or exacerbation.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Line of Business	Commercial
Age	3–17
Timeframe	Measurement year
Documentation	• Health and developmental history (physical and mental) • Physical exam • Health education/anticipatory guidance related to nutrition and physical activity **EXCLUSIONS** by December 31st of the measurement year: • Diagnosis of pregnancy
Description	Measure evaluates the percentage of patients who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile assessed, counseling for nutrition, and counseling for physical activity.

Medicare Advantage Star Rating Measures Fact Sheet

What are CMS Star Ratings?

The Centers for Medicare and Medicaid Services (CMS) uses a 5-star rating system to measure quality and assess Medicare beneficiaries' experience with their health plan and health care system. The ratings are publicly available on the CMS website (www.medicare.gov), and provide beneficiaries with additional information about Medicare Advantage (MA) plans offered in their markets to guide consumer choice. Plans are awarded between 1 (poor performance) and 5 (excellent performance) stars, evaluated based on a series of individual measures spanning 5 broad categories:

- Outcomes
- Intermediate Outcomes
- Patient Experience
- Access
- Process

Since 2012, CMS has used Star Ratings to reward high scoring plans with financial bonuses, and monitor plans with consistently lower scores, with the goal to move MA services towards higher quality, patient-centered care.

What are benefits to patients?

Star rating measures fall into patient-centric domains that focus on ensuring patients receive the necessary preventive care and appropriate management of long-term conditions. They provide a base for improving the patient-doctor relationship and empowering patients towards self-management. Together, health plans and physicians work to provide patients with better care and outcomes.

What are benefits to physicians and how can you help?

Premier Health Plan is committed to partnering with physician practices to improve quality through evidence-based medicine and population health management. We have enhanced analytics and reporting to identify care gaps and get the needed information to maintain or improve patient health status. Elevated quality not only means better care and outcomes for patients, but also increased productivity and maximized incentive payments for your practice. To better support your efforts, the following grid highlights the most important Star measures and how you can impact them.

Key Measures and Relevant Requirements for 2016 Star Ratings

All are HEDIS metrics, endorsed by the National Quality Forum, and represent national standards used for provider accountability and consumer comparison.

Quality Measure	Measure Specifics	No Need for Additional Action If:
Medication Adherence for Diabetes Medications	Any patient 18 years and older with a prescription for diabetes medication should adhere to and fill their prescription often enough to cover 80% or more of the time he/she is supposed to be taking the medication. This includes drug therapy across classes of diabetes medications: biguanides, sulfonylureas, thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, incretin mimetics, and meglitinides.	N/A
Medication Adherence for Hypertension Medications	Any patient 18 years and older with a prescription for RAS antagonist medication should adhere to and fill their prescription often enough to cover 80% or more of the time he/she is supposed to be taking the medication. This includes ACE, ARB, or a direct renin inhibitor drug.	N/A

Quality Measure	Measure Specifics	No Need for Additional Action If:
Medication Adherence for Cholesterol Medications	Any patient 18 years and older with a prescription for cholesterol medication (a statin drug) should adhere to and fill their prescription often enough to cover 80% or more of the time he/she is supposed to be taking the medication.	N/A
Diabetes: Eye Exam	Any patient 18–75 years old with diabetes (type 1 and type 2) should have a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) at least every 12 months	Patient had a negative retinal eye exam in the prior year
Diabetes: Nephropathy	Any interventions below will independently close this gap • A urine micro/macroalbumin test within a 12 month period • If the patient has been dispensed an ACE Inhibitor or ARB • If the patient has had a nephrologist office visit within 12 months	Patient has evidence of Stage 4 CKD, ESRD, or kidney transplant
Diabetes: HbA1c Controlled	Any patient 18–75 years old with diabetes should have a HbA1c test at least every 12 months, and most recent HbA1c level <9.0%	N/A

Quality Measure	Measure Specifics	No Need for Additional Action If:
Hypertension: Blood Pressure Controlled	Any patient 18–85 years old with a diagnosis of hypertension should have adequately controlled blood pressure (BP), as defined by the below criteria • 18–59 years old should have a BP <140/90 mm Hg. • 60–85 years old with a diagnosis of diabetes should have a BP <140/90 mm Hg • 60–85 years old without a diagnosis of diabetes should have a BP <150/90 mm Hg	Patient has evidence of ESRD, kidney transplant, dialysis, or is pregnant
Rheumatoid Arthritis (RA) Management	Any patient 18 years and older with a diagnosis of RA should be dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).	Patient has evidence of HIV or is pregnant
Readmission after Inpatient Discharge	Any patient 18 years and older with an acute inpatient discharge should be managed and provided follow-up care to prevent an unplanned acute readmission for any diagnosis within 30 days • Planned hospital stays such as chemotherapy, rehab, and organ transplants are not considered readmissions	Patient is discharged for pregnancy, a perinatal condition, or death

Quality Measure	Measure Specifics	No Need for Additional Action If:
Flu Vaccination	Any patient should receive a flu vaccine every 12 months prior to flu season	N/A
Adult BMI Assessment	Any patient 18–74 years old should have a BMI assessment every 24 months; for patients <19 years old, documentation of BMI percentile is also acceptable	Patient is pregnant
Osteoporosis Management	Women 67–85 years old who have had a fracture should have at least one of the below tests or treatments • A bone mineral density (BMD) test within 6 months after the fracture • A BMD test during the inpatient stay if the fracture required hospitalization • Osteoporosis therapy within 6 months after the fracture • A dispensed prescription to treat osteoporosis within 6 months after the fracture	Patient has had the recommended tests or treatments during the 12 months prior to the fracture
Breast Cancer Screening	Women 50–74 years old should have a mammogram to screen for breast cancer at least every 2 years • This does NOT count biopsies, breast ultrasounds or MRIs, as they are not appropriate methods for primary breast cancer screening	Patient has evidence of bilateral mastectomy, or 2 unilateral mastectomies (either with a bilateral modifier, two different service dates at least 14 days apart, or separate right-side and left-side modifiers)

COMPACT Care

Improving Patient Care and Experience through Service Compacts

Premier Health Group is proud to introduce a coordinated care initiative for primary and specialty care practice systems, COMPACT Care. This adaptation of established service compacts creates standards to improve the quality and standardize the content of referrals generated by physicians participating in the compact. Our service compacts are designed to be patient-centric, ensuring that patients have what they need to receive a successful referral. COMPACT Care is another way for us to build on our commitment to lead the region in quality, comprehensive patient care.

What is COMPACT Care?

COMPACT care is an initiative to improve quality and standardize the content of referrals between primary care physicians and specialty care practices through the use of service compacts. Service compacts set guidelines for effective referrals to ensure that patient care is coordinated through collaborative efforts. In establishing these standards, we seek to make referrals patient-centric, and outline physician expectations for successful referrals as it pertains to quality, content and effective communication.

What are the benefits to providers?

COMPACT Care equips providers with communication and workflow standards that foster efficient and effective referrals. This improved quality and flow of information ensures that providers have what they need to deliver comprehensive, high-value patient care.

What are the benefits to patients?

When we commit to collaborative care, our patients reap the benefits. Coordination of care means that patients can focus on his or her health and wellness, secure in the knowledge that their care plan is well-managed and thorough. Complete, accurate, and timely exchange of information through referrals ensures that patients get the care they need when they need it.

Why is COMPACT Care important to Premier Health Group?

COMPACT Care facilitates a thorough and efficient referral process that standardizes the content contained in referrals, bolsters the quality of referrals and, in turn, improves care to the ultimate benefit of patients. As we strengthen our collaborative efforts, the positive results ripple across the system, promoting higher quality and greater efficiency in all the services we provide. COMPACT Care is another advantageous component of our system that enables us to lead the region in high-quality, high-value care, building healthier communities, one patient at a time.

Frequently Asked Questions About COMPACT Care

Q: What is COMPACT Care?

A: COMPACT Care is an initiative that seeks to improve the quality and standardize the content of referrals between participating primary care and specialty practices through service compacts. The effort establishes standards for timely, complete, patient-centric referrals that facilitate safe and smooth transitions for patients.

Service compacts were first developed 20 years ago and have since been used by integrated practice systems like Kaiser Permanente and Group Health Cooperative. It is the standard of practice for the National Committee of Quality Assurance's Primary Care Medical Home certification, and the Medicare Comprehensive Primary Care Initiative.

Q: What do service compacts do?

A: Service compacts help us achieve the following objectives: establish content and quality referral standards for Premier Health Group primary care and specialty practices; fit a patient-centric model so patients have what they need to have a successful referral; and, set a content standard and quality benchmark for what physicians should expect when receiving referrals from their colleagues.

Q: Are there things that service compacts cannot guarantee?

A: Service compacts cannot and do not guarantee referrals from or to participating physicians in the compact. The compact is not about changing the volume of referrals. Rather, the compact is about improving the quality and standardizing the content of referrals generated by physicians participating in the service compact. Even so, service compacts cannot guarantee that participating physicians will always follow the quality and content standards set forth in the compact. Service compacts aren't detailed enough to cover each individual contingency, and performance issues will still have to be addressed internally through Premier Health Group's (PHG) policies and procedures.

Q: What are some characteristics of an effective service compact?

A: An effective service compact sets expectations for: appointment availability; standard content to be included in all referrals, follow-up plans, and post-referral communication; seamless, well-communicated patient transitions; referral testing; and, medication management.

Q: What are PHG's goals for service compacts?

A: PHG seeks to work toward decreased-variability referrals by implementing content and quality standards for referrals, through strategic plans and collaboration with physicians. Through the implementation of service compacts, our goal is to achieve: better patient experiences; coordination of care; closed-loop referrals; and, fostering development of high-performing practices through data and performance.

Q: Has a timeline been set for service compacts?

A: In 2015, initial compacts were introduced to select primary care groups and service lines with a focus on paper compacts. In 2016, paper compacts will be replaced with service compact concepts becoming the standard for consultative communication in PHG. The final step will be to develop standards for the content to be included in referrals, improve the quality of referrals, and establish metrics for service achievement.

Q: What is the status of the service compact initiative?

A: As of December 2015, service compacts were endorsed by Premier HealthNet, the Premier Health Group Specialty Council, and the Cardiology, Oncology, Women's Health and Orthopedic service lines.

Service Compact Premier Health Group

Select Premier Health Group primary care practices and the Premier Health Group specialty practices, are partnering together to improve the overall coordination of care for our patient population. These two groups have been part of the discussions about service compacts and have discussed how care could be best delivered for our patients collectively. The PHG Specialty Council will continue to meet to assess the collaboration and to continue to make improvements to the recommendations.

The primary care practices and the referring specialists agree upon basic elements of communication that fit within the medical home neighborhood and population health management strategies and includes the following (much of which may be carried over via the electronic medical record):

Guiding Principles:

1. Safe, effective and timely patient-centered care
2. Effective communication between practices and providers assuring safe and coordinated transitions of patient care
3. A working collaboration in order to foster and sustain a professional relationship between, and among, healthcare providers
4. A highly functional healthcare network providing patients with access to the right care, at the right time and in the right place

Responsibility of the PCP – Information Sent to Specialist:

- Brief history and reason for referral (what is the referral question) – examples:
  - One-time consultation (e.g. Diagnosis of atypical chest pain)
  - Specialty procedure need only (e.g. colonoscopy for screening)
  - Co-management/ongoing management (e.g. atrial fibrillation)
  - Definition of period of time after which the patient will be returned to the PCP as primary care provider
- Evaluation of conservative versus operative management with return of patient to PCP after treatment completed (e.g. knee injection, PT recommendation after post-op care completed, etc.)
- Suspected diagnosis/testing/treatment
- Medical history/review of systems
- Relevant social history
- Relevant exam findings
- Previously performed relevant testing and results
- PCP will contact specialist when care should or has been transitioned to palliative care
- PCP will perform or facilitate any medical clearances required for surgical or procedural intervention

Responsibility of the Specialists – Information Sent to the PCP:

- Appointment availability for non-emergent consultations within 4 weeks and sooner for more urgent and emergent patient needs (OR communication back to the PCP if unable to accommodate in this time frame)
- A phone call for a critical finding requiring immediate intervention
- Timely response (written or otherwise) for each encounter (within 72 hours) including:
  - Details of testing that is or will be ordered by the specialist
  - Details of testing that the specialist would like the PCP to order
  - Any patient needs that require referral to another specialist or other facility, except in situations requiring emergency management
  - Specialist will ensure that the patient is sent back to the PCP once the condition is managed
  - Specialist will contact PCP when care should be or has been transitioned to palliative care, providing explanatory documentation

Method of Communication:

- Electronic or if not available, written communication may be the routine process
- In certain situations a phone call may more quickly clarify the need and/or situation at hand

Our Practices Would Like to Show Our Commitment to this Process:

- Practices will work collaboratively with all members of the each other's practice team to ensure a highly coordinated and patient-centered consultation process
- The Specialty Council will revisit compact structure and feedback every 6 months as an oversight group

How We Will Measure Effectiveness of Compacts and Adherence:

Initially there is no formal measurement process nor are there formal penalties for not following the intention of the compact. Anecdotal information will be addressed with the appropriate practices and the Specialty Council. Going forward measurement metrics may be developed.

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