From M. Carol Greenlee, MD speaker for PCR 4.0 July 2014
High Value Care Coordination tool kit:

Care Coordination - High Value Care Coordination (HVCC) Toolkit

The High Value Care Coordination (HVCC) Toolkit provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors.

The toolkit was the work of the HVCC Project, collaboration between the American College of Physicians' (ACP) Council of Subspecialty Societies (CSS) and patient advocacy groups. Its recommendations are informed by ACP's 2010 policy paper, The Patient-Centered Medical Home Neighbor:
The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.

Pertinent Data Sets

Pertinent data sets (PDS) consist of patient information not typically included in a generic referral request to help ensure an effective and high value clinical engagement by the referred to out-patient specialist/subspecialist. These PDS were developed by participating societies belonging to ACP's Council of Subspecialty Societies (CSS), were reviewed by ACP representatives specializing in primary care, and are generally linked to a specific common clinical condition.
Access Pertinent Data Sets

Model Specialty Out-Patient Referral Request and Response Checklists

These checklists were developed as part of the American College of Physicians' Patient Centered Medical Home Workgroup and updated as part of the High Value Care Coordination project. Both efforts were authorized through the College's Council of Subspecialty Societies. The elements recommended in these checklists were established through a consensus process following a review of the literature and recommendations from participating medical societies. The goal of these recommendations is to facilitate high value and effective referral engagements.

- Generic Physician Referral Checklist
- Generic Referral Response Checklist

Facilitating a Patient- and Family-centered Discussion with a Patient

The American College of Physicians with input from a workgroup composed of primary care and specialty physicians, and patient/family advisors, has developed this set of recommendations to help referring physicians and other healthcare professionals engage in an effective "patient- and family-centered" referral process.

- Recommendation for Physicians to Facilitate a Patient-centered Discussion with a Patient

Care Coordination Agreements

A care coordination agreement defines expectations and responsibilities for the practices involved in a referral relationship. These agreements are implemented to promote increased care coordination and integration. They can address such issues as clinical care arrangements, clinical accountability, preferred clinical content and methods of communication, and expected patient engagement activities.

The American College of Physicians' policy paper The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices provides a fuller description of these agreements and the issues that can be addressed within them. These agreements can be developed through direct discussions between practices, or determined by the leadership of a larger system (e.g. IPA or healthcare system). In some cases, they are provided as a requirements for any practice that "wants to do business" with the determining practice. The modal forms provided, developed as part of the ACP High Value Care Coordination project, serve only as an example -- it is the expectation that modifications will be based on the needs, preferences and the local community practice standards of the practices (systems) involved.

- Agreement Between Primary Care Practice and Hospital Care Team
- Agreement Between Primary Care Physician and Subspecialist