



**AAVBC**

AMERICAN ACADEMY OF VALUE BASED CARE

# **Value-Based Care Specialist Management Quick Reference Guide**

**2026**

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## VALUE-BASED CARE SPECIALIST MANAGEMENT

This QRG provides a practical framework for PCPs, care coordinators, medical groups, ACOs, and Medicare Advantage teams to **manage specialty involvement across the full referral episode**. Its purpose is to align specialist engagement with **better outcomes, lower total cost, reliable two-way communication**, and **coordinated care that returns to the PCP** once the referral question is answered. Management begins after a referral is initiated and continues through episode completion, loop closure, and any ongoing co-management agreement.



### AAVBC PERSPECTIVE

*AAVBC advocates for effective specialist management in which the PCP curates high-performing referral networks, establishes shared clinical pathways, and enforces reliable two-way data exchange. The goal is to **reduce avoidable downstream costs, duplicate testing, conflicting treatment**, and specialist visits **that no longer add value** while preserving timely specialty access when expertise, procedure, or high-acuity management is needed.<sup>1,2</sup>*

*The PCP remains the central leader of the longitudinal care plan.<sup>3</sup> Specialty involvement is a defined episode or partnership, **not an automatic transfer of accountability**.<sup>2,4</sup> Once the question that triggered referral is answered and the patient is stabilized, routine monitoring and management **should return to the PCP** unless an explicit co-management or principal-care agreement remains necessary.<sup>2,4</sup>*

### Core Objectives

| OBJECTIVE                   | MANAGEMENT APPROACH <sup>5-7</sup>                                                                                                      | VALUE PROTECTED <sup>5,6,8</sup>                                                                                       |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Improve quality</b>      | <b>Use:</b> shared pathways, timely specialty expertise, evidence-based treatment, and specialty-specific outcome measures              | <b>Better chronic disease control</b> , safer procedures, <b>fewer complications</b> , and <b>goal-concordant care</b> |
| <b>Lower total cost</b>     | <b>Reduce:</b> redundant tests, low-value repeat visits, preventable emergency care, avoidable readmissions, and out-of-network leakage | Lower episode and per-member-per-month spending <b>without suppressing necessary care</b>                              |
| <b>Enhance coordination</b> | <b>Define roles before the visit;</b> transmit complete information; reconcile recommendations; <b>track return of care</b>             | One medication list, one care plan, and <b>fewer contradictory instructions</b>                                        |

## Specialist Management in Value-Based Care

Specialists are evaluated by clinical quality, care coordination, access, total episode cost, complications, and patient outcomes **rather than procedure volume alone**.<sup>9,10</sup> **PCP practices actively select partners**, define service expectations, monitor referral and episode performance, and address recurrent variance **through feedback and corrective action**.<sup>11,12</sup>



### CLINICAL PEARL: REFERRAL VALUE LIES IN THE FOLLOW-THROUGH, NOT THE VISIT

**A specialist visit is not the endpoint.**<sup>13</sup> In value-based care, "value" means **better patient outcomes per dollar spent across the whole episode**: the combination of improved clinical quality, coordinated and goal-concordant care, and lower total cost, **not the completion of a visit or the volume of services delivered**.<sup>14,15</sup> By that definition, a referral generates value only when **three conditions are met**: the consultation actually **changes a shared care plan** (quality), the patient can **realistically execute that plan** (outcomes and experience), and **ownership of the next decision is explicit** so nothing is duplicated, dropped, or left uncoordinated (cost and coordination).<sup>2,9</sup> A completed visit that produces a note but no change in management, no feasible plan, or no clear owner has **consumed resources without protecting any of these values**.<sup>16,17</sup>

## PCP AND SPECIALIST RESPONSIBILITIES

| RESPONSIBILITY      | PCP ROLE <sup>2,4,18</sup>                                                                                                            | SPECIALIST ROLE <sup>4,19</sup>                                                                                                 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| Initial guidance    | <b>Define</b> the <b>clinical question, urgency, desired care track, and expected return plan</b>                                     | Prioritize access according to urgency and address the requested question                                                       |
| Data sharing        | <b>Send</b> relevant <b>baselines, trends, medication list, allergies, imaging access, prior treatment, and barriers</b>              | Use available information; <b>avoid unnecessary duplication; return findings, studies, medication changes, and a clear plan</b> |
| Medication safety   | Maintain the longitudinal medication list and <b>reconcile all specialist changes</b>                                                 | <b>Recommend target treatment while:</b> identifying interactions, monitoring, duration, and cross-specialty conflicts          |
| Routine maintenance | <b>Own:</b> daily chronic-disease management, preventive care, lifestyle support, and routine monitoring between specialty milestones | Provide advanced diagnostic, procedural, or interventional oversight and <b>defined periodic reassessment</b>                   |

| RESPONSIBILITY     | PCP ROLE <sup>2,4,18</sup>                                                                                                                     | SPECIALIST ROLE <sup>4,19</sup>                                                                       |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>Transitions</b> | <b>Track:</b> high-risk emergency, inpatient, surgical, and post-specialist transitions; <b>contact the patient and integrate the new plan</b> | <b>Send discharge or procedure information promptly</b> and state follow-up needs and return criteria |
| <b>Missed care</b> | <b>Resolve:</b> transportation, cost, scheduling, cognition, caregiver, language, or other access barriers                                     | <b>Notify the PCP promptly</b> after a no-show or cancellation without rescheduling                   |

**ABBREVIATIONS:** PCP = primary care physician

## Specialist Value Expectations

- **Timely information return:** send the signed **consultation note**, relevant **studies**, and **medication changes within 24 to 48 hours** when feasible; urgent findings are communicated verbally the same day<sup>4,20</sup>
- **Data reuse:** accept clinically current PCP-obtained laboratory, EKGs and imaging results when they answer the question and can be accessed<sup>21,22</sup>
- **Site and product stewardship:** use an **ambulatory site of care, generic, biosimilar**, or lower-cost clinically equivalent option when appropriate and not medically contraindicated<sup>23</sup>
- **Least burdensome effective approach:** consider **conservative or noninvasive management** before procedural escalation when clinically reasonable<sup>22,24</sup>
- **Return to primary care:** explicitly transition routine management back after the acute or specialized threshold is met<sup>25</sup>

## THE THREE CARE MANAGEMENT TRACKS

Every referral should be assigned to **one of three care tracks**.<sup>4</sup> The track **may change as severity changes**, but the change should be **documented** and **communicated** rather than assumed.

| CARE TRACK               | SPECIALIST RESPONSIBILITY <sup>4,26</sup>                                                       | PCP RESPONSIBILITY <sup>4,26</sup>                               | TRANSITION TRIGGER <sup>2,19,26</sup>              |
|--------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------|
| <b>Consultation only</b> | <b>Answer a discrete diagnostic or treatment question</b> and provide an <b>actionable plan</b> | Implement and monitor the plan; <b>retain overall management</b> | <b>Specialist response received and reconciled</b> |

| CARE TRACK     | SPECIALIST RESPONSIBILITY <sup>4,26</sup>                                          | PCP RESPONSIBILITY <sup>4,26</sup>                                                                   | TRANSITION TRIGGER <sup>2,19,26</sup>                                                |
|----------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Co-management  | Manage the defined organ system, high-risk therapy, or specialty milestone         | Manage overall health, unrelated conditions, preventive care, and <b>agreed baseline monitoring</b>  | Condition stabilizes, specialty intensity falls, or compact-defined criteria are met |
| Principal care | Assume most care during a critical, high-acuity period such as active chemotherapy | Maintain visibility, manage unrelated needs when appropriate, and <b>prepare for transition back</b> | Acute episode or protocol ends and <b>specialist documents the return plan</b>       |

**ABBREVIATIONS:** PCP = primary care physician

### Minimum Ownership Questions

- Who writes and renews the **specialty medication**, and who monitors **adverse effects**?<sup>4</sup>
- **Who orders** routine laboratory tests, imaging, or surveillance and **who acts on results**?<sup>4</sup>
- **Who** handles after-hours questions, urgent deterioration, or treatment complications?<sup>4</sup>
- Which problems remain with primary care and **which require direct specialty contact**?<sup>2</sup>
- What stabilization, completion, or time threshold **returns management to the PCP**?<sup>19,25</sup>



### MAKING CONNECTIONS

Consult the [AAVBC When to Refer to a Specialist QRG](#) for route selection, emergency red flags, e-consult suitability, the SOS referral format, and specialty-specific referral guidance. Once the need and route are established, consult the [AAVBC Referral Management: Cost-Efficient/Clinically Effective Specialist Selection QRG](#) to identify an appropriate specialist using clinical performance, total cost, access, network status, and patient-fit criteria. This QRG guides management of the specialist relationship after referral and specialist selection.



### QUALITY OUTCOME:

The **care track** should appear **in the referral order**, specialist note, shared care plan, and referral registry.<sup>4,27</sup> If no track is named, the default risk is **duplicated work** and **indefinite specialty follow-up**.<sup>4</sup>

## STANDARDIZED CLOSED-LOOP WORKFLOW

**Closing the referral loop**, ensuring every referral is completed, the consultation note returned, reviewed, acted upon, and communicated to the patient, is a **core safety and value function of primary care**, not an administrative formality.<sup>2,13</sup> When loops stay open, patients experience **delayed diagnoses, missed abnormal results, duplicated testing, and preventable emergency visits and readmissions**; reliable closure conversely **shortens time to definitive care, prevents diagnostic error, curbs redundant imaging and labs, and keeps management coordinated** across the medical neighborhood.<sup>28-30</sup> The standardized cycle below operationalizes this by assigning explicit actions, completion evidence, and a named owner **at each step**, from framing the clinical question through transition and governance, so **accountability remains visible** and **no referral is lost** between the signed order and an acted-upon, patient-communicated result.

### Five-Step Referral Management Cycle

| STEP                            | REQUIRED ACTION <sup>19,31,32</sup>                                                                                                      | COMPLETION EVIDENCE <sup>31-33</sup>                                                      |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>1 Generate</b>               | <b>PCP documents:</b> a narrow clinical question, urgency, desired care track, and latest clinically acceptable response date            | Referral order contains <b>purpose, track, urgency, and monitoring plan while waiting</b> |
| <b>2 Package</b>                | <b>Coordinator sends:</b> relevant history, trends, medications, allergies, studies, image access, prior treatment, and patient barriers | Receiving practice <b>confirms a complete and usable package</b>                          |
| <b>3 Track access</b>           | <b>Registry records:</b> acceptance, scheduled date, attendance, cancellation, no-show, and outreach                                     | Appointment or e-consult <b>completed within the locally defined clinical window</b>      |
| <b>4 Receive and synthesize</b> | <b>Specialist returns the note; PCP reviews:</b> recommendations, reconciles medication and testing, and updates the care plan           | <b>Signed</b> PCP review, patient communication, and <b>next action recorded</b>          |
| <b>5 Transition and govern</b>  | <b>Team documents:</b> consultation closure, ongoing co-management, or principal-care status and evaluates specialist performance        | Named owner, next review date, and return-to-PCP criteria <b>remain visible</b>           |

**ABBREVIATIONS:** PCP = primary care physician

### Workflow Implementation Strategies

- **Care coordinator ownership:** designate an RN, medical assistant, referral clerk, or centralized team to **own open-loop tracking** and **missing reports**<sup>13,34</sup>

- **EHR triggers:** create **alerts** for unscheduled referrals, approaching due dates, no-shows, delayed notes, and unreviewed results<sup>35</sup>
- **Daily huddles:** surface recent external specialist notes and upcoming post-specialist visits that require integration<sup>4</sup>
- **Standing orders:** allow staff to retrieve outside notes, hospital summaries, and imaging access before the PCP visit<sup>36</sup>
- **Post-consult audit:** require clinician review of incoming recommendations before a loop can be marked closed<sup>13</sup>



### CLINICAL PEARL: CLOSING THE LOOP REQUIRES ACTION AND OWNERSHIP, NOT JUST RECEIPT

Closing the loop requires **action** and **ownership, not just receipt**. A loop is closed only after the specialist note is **received, reviewed, acted upon, communicated to the patient, and assigned to a named owner**.<sup>13,32</sup> In a large health-system analysis, only 34.8% of scheduling attempts ended in a **documented completed visit**, and a "closed loop" required **results being available to the referring PCP**.<sup>32</sup> Information return is inconsistent (98% of PCPs send information but only 67% get it back), and true endpoints are **adherence** and **patient communication**.<sup>3,37</sup>

#### EHR strategies that operationalize action and ownership:

- **Dedicated referral-tracking module with status visibility.** An enhanced referral manager made status tracking significantly easier (+1.43 on a 5-point scale,  $P < .0001$ ) and improved completed visits, acknowledged notes, and documented patient communication<sup>32</sup>
- Route notes to a named owner's actionable inbox, not a passive chart file, with a specific person or team accountable for follow-through<sup>13,32</sup>
- **Automated overdue alerts** with escalation to a population-health team when consults pass a defined turnaround maximum<sup>38</sup>
- Require a **documented clinician-review/acknowledgment step** before a loop can be marked closed, tracking acknowledged notes as a distinct metric<sup>13,32</sup>
- Capture bidirectional PCP–specialist dialogue **in the EHR** (eConsult/eReferral) to **make recommendations traceable and actionable**<sup>39</sup>
- Document **patient communication of the plan** as a discrete, trackable field<sup>32,37</sup>

## PRE-CONSULT AND POST-CONSULT CONTROLS

### Before the Referral Leaves Primary Care

- Confirm the **reason for specialty involvement** and assign consultation, co-management, or principal care<sup>4,40</sup>
- Use a **specific clinical question** instead of a broad request to evaluate and treat<sup>40</sup>
- **Complete** clinically appropriate, pathway-based **PCP treatment and diagnostic workup** without creating a universal testing barrier<sup>24</sup>
- **Transmit** recent **trends, medication reconciliation, allergies, prior treatment response**, and actual **image** access when relevant<sup>40</sup>
- Share social and access context, including transportation, finances, caregiver availability, communication needs, and patient preference<sup>41</sup>
- Brief the patient on **why the referral is needed**, what the specialist is being asked to decide, what to bring, and what to do while waiting<sup>42</sup>



#### MAKING CONNECTIONS

Use the [AAVBC When to Refer to a Specialist QRG](#) for the SOS referral structure - Status, Optimization, Specific Question - and for specialty-specific pre-referral information. Avoid repeating studies that remain current and answer the clinical question.

### After the Specialist Responds

| CONTROL                          | PCP ACTION <sup>4,29,43</sup>                                                                          | FAILURE PREVENTED <sup>4,29,43</sup>                       |
|----------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| <b>Note review</b>               | Review the consultation note <b>within approximately 48 hours or sooner</b> for urgent findings        | Unacted recommendations and <b>delayed treatment</b>       |
| <b>Medication reconciliation</b> | Update the master list and <b>resolve duplicate, interacting, unaffordable, or conflicting therapy</b> | Adverse drug events and <b>contradictory prescribing</b>   |
| <b>Test ownership</b>            | <b>Identify who:</b> orders, receives, communicates, and acts on pending tests                         | Orphaned results and <b>repeat testing</b>                 |
| <b>Patient touchpoint</b>        | Use a visit, telephone call, portal message, or telehealth check to <b>reinforce one plan</b>          | Confusion, nonadherence, and <b>unnecessary acute care</b> |

| CONTROL                     | PCP ACTION <sup>4,29,43</sup>                                                                                            | FAILURE PREVENTED <sup>4,29,43</sup>                   |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| <b>Transition statement</b> | Document whether the episode is <b>complete</b> , <b>shared care continues</b> , or <b>principal care remains active</b> | <b>Indefinite specialist follow-up</b> without purpose |

**ABBREVIATIONS:** PCP = primary care physician



### DOCUMENTATION REMINDER — PATIENT TEACH BACK

**Ask:** What did the specialist **change**? Which clinician should you call about this condition? what tests or visits are **next**? and what symptoms require **urgent help**?

## COLLABORATIVE CARE AGREEMENTS (CCA)

### CCA Purpose and Tracks

Use a **Collaborative Care Agreement (CCA)**, care compact, or memorandum of understanding to **define**: communication standards, clinical responsibilities, access expectations, and transition rules.<sup>2,4</sup> For high-volume referral partners, consider formalizing these expectations in a **written agreement** and reviewing them **at least annually**.<sup>2,4</sup>

### Example Referral Template Agreement

| FIELD                        | ENTRY                                                                                                                             |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <b>Parties</b>               | [Primary Care Practice Name] and [Specialty Group/Provider Name]                                                                  |
| <b>Effective date</b>        | [Date]                                                                                                                            |
| <b>Review date</b>           | [Date, commonly one year after effective date]                                                                                    |
| <b>Purpose</b>               | Seamless, high-quality, cost-effective care; reduced diagnostic duplication; reliable information return; explicit care ownership |
| <b>Communication channel</b> | [Shared EHR/direct messaging/secure fax/designated portal]                                                                        |

**ABBREVIATIONS:** EHR = electronic health record

## Care Management Tracks in the Agreement

| TRACK                    | AGREEMENT LANGUAGE                                                                                                                                                                                                      |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Consultation only</b> | The specialist <b>answers the stated question</b> and <b>returns management to the PCP</b> after the consultation report and recommendations are delivered                                                              |
| <b>Co-management</b>     | The <b>PCP retains overall baseline and unrelated chronic care</b> ; the specialist manages the <b>named condition or organ system</b> ; prescribing, testing, monitoring, and urgent-contact roles are <b>itemized</b> |
| <b>Principal care</b>    | The specialist assumes most care <b>during a defined high-acuity period</b> ; the PCP <b>retains visibility</b> and receives transition information; the <b>return trigger is documented</b>                            |

**ABBREVIATIONS:** PCP = primary care physician

## Core Service-Level Expectations

- **Same-day verbal communication** for emergency or critical findings<sup>40</sup>
- Written consultation report generally **within 24 to 48 hours**, with a locally agreed maximum turnaround **no later than 72 hours**<sup>44</sup>
- No-show or cancellation-without-rescheduling notification **within approximately 24 hours**<sup>45</sup>
- **Urgency-based access windows defined locally**, using same-day emergent, 5 to 7 business day urgent, and approximately 30-day routine examples from the brief<sup>44</sup>
- Explicit **return-to-PCP statement** when acute intervention or specialty protocol is complete<sup>46</sup>

## CCA Responsibilities

| PRIMARY CARE PRACTICE COMMITMENTS                                                                                                                                                                                 | SPECIALTY PRACTICE COMMITMENTS                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| Provide the <b>clinical question</b> , requested <b>care track, urgency, relevant history</b> , current <b>medication list, allergies</b> , recent <b>trends, studies</b> , and <b>image</b> access <sup>31</sup> | Schedule according to agreed urgency categories and communicate inability to meet the target promptly <sup>47</sup> |
| Explain the <b>referral purpose</b> and <b>urgency</b> to the patient and <b>address predictable access barriers</b> <sup>31,40</sup>                                                                             | <b>Review provided data</b> before ordering new studies and avoid unnecessary repetition <sup>4,27</sup>            |

| PRIMARY CARE PRACTICE COMMITMENTS                                                                                                       | SPECIALTY PRACTICE COMMITMENTS                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Track acceptance, scheduling, attendance, report receipt, PCP review, patient communication, and return status <sup>3,27</sup>          | Send a <b>concise report containing findings, studies, medication changes, monitoring, pending results, escalation instructions, and care-track recommendation</b> <sup>2,40</sup> |
| <b>Reconcile specialist recommendations</b> into the longitudinal care plan and clarify medication or testing conflicts <sup>3,27</sup> | Notify primary care of missed appointments and urgent findings through the agreed channel <sup>40</sup>                                                                            |
| <b>Manage routine maintenance and unrelated conditions</b> unless the compact assigns a different responsibility <sup>4</sup>           | <b>Consult the PCP before nonurgent external subspecialty referrals</b> when required by the compact; emergency action is not delayed <sup>2,4</sup>                               |
|                                                                                                                                         | <b>Use high-value medications, sites, and procedures</b> when clinically equivalent and appropriate <sup>48</sup>                                                                  |
|                                                                                                                                         | <b>Return appropriate management to primary care</b> when the specialized episode is complete <sup>4,25</sup>                                                                      |

## Secondary Referral and Testing Terms

| TOPIC                                              | COMPACT LANGUAGE                                                                                                                                                                                                          |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional testing</b>                          | Use current prior results when clinically adequate; document <b>why repeat or advanced testing is needed</b>                                                                                                              |
| <b>Subspecialty referral</b>                       | Coordinate <b>nonurgent external handoffs with the PCP</b> to preserve network, information, and medication continuity                                                                                                    |
| <b>Ancillary services</b>                          | Use high-value <b>in-network</b> laboratory, imaging, therapy, facility, and ambulatory options <b>when available and appropriate. Avoid outpatient hospital as site of care unless medically or clinically indicated</b> |
| <b>Clinical autonomy</b>                           | <b>Nothing</b> in the compact delays emergency care or replaces clinician judgment, patient preference, or medical necessity                                                                                              |
| <b>ABBREVIATIONS:</b> PCP = primary care physician |                                                                                                                                                                                                                           |



## QUALITY OUTCOME: IMPLEMENTATION

A **collaborative care agreement** is an operational agreement that delineates referral, communication, and comanagement responsibilities between primary care and specialty practices.<sup>4</sup> It **sets shared expectations** for who prescribes, who follows up on results, and who responds to patient concerns, but it does not confer clinical privileges or licensure.<sup>4</sup>

Credentialing, privileging, and peer review remain governed by medical staff bylaws, state statute, Joint Commission standards, and CMS conditions of participation.<sup>49</sup> Reimbursement and financial-risk terms are established through payer contracts, **not the agreement**.

**Before adoption, route the agreement through:** organizational legal, compliance, and contracting review; **align it** with existing bylaws and payer agreements; and **revisit it** as regulatory or contractual conditions change.<sup>49</sup>

## CCA Contacts and Signatures

### Primary Contacts

| ORGANIZATION          | ROLE                                          | NAME AND CONTACT                                          |
|-----------------------|-----------------------------------------------|-----------------------------------------------------------|
| Primary care practice | Referral or care coordinator                  | [Name]   [Phone]   [Direct address/secure channel]        |
| Primary care practice | Clinical lead                                 | [Name, credentials]   [Phone]   [Escalation availability] |
| Specialty practice    | Referral or clinic coordinator                | [Name]   [Phone]   [Direct address/secure channel]        |
| Specialty practice    | Clinical lead                                 | [Name, credentials]   [Phone]   [Escalation availability] |
| Network or payer      | Specialist management contact when applicable | [Name]   [Phone]   [Portal/escalation route]              |

### Escalation Ladder

| LEVEL       | EXAMPLE                                                                                      | EXPECTED ACTION                                                              |
|-------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| Operational | Missing demographics, authorization, image access, scheduling, or note transmission          | <b>Coordinator-to-coordinator resolution</b> within the local service window |
| Clinical    | <b>Urgency disagreement, conflicting treatment</b> , concerning result, or unclear ownership | <b>Direct clinician-to-clinician communication</b>                           |

| LEVEL             | EXAMPLE                                                                                                            | EXPECTED ACTION                                                                         |
|-------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <b>Governance</b> | Repeated delayed access, missing notes, duplicate testing, excessive leakage, or <b>persistent metric variance</b> | <b>Collaborative agreement review</b> , scorecard feedback, or <b>corrective action</b> |

## Signature Block

By signing, both practices agree to the **communication** and **clinical workflows** in this Collaborative Care Agreement and to **periodic review of**: performance, access, patient experience, and return-to-PCP expectations.

| AUTHORIZED SIGNATORY | ORGANIZATION                 | SIGNATURE AND DATE   |
|----------------------|------------------------------|----------------------|
| [Name and title]     | [Primary Care Practice Name] | _____<br>Date: _____ |
| [Name and title]     | [Specialty Group Name]       | _____<br>Date: _____ |

## Review Questions

- Are access windows **realistic** and **stratified by clinical urgency**?
- Are note and no-show notifications **reliably transmitted** through the named channel?
- Do both parties agree on **medication**, **testing**, **after-hours**, and **transition ownership**?
- Are specialty performance data **accurate**, **risk-adjusted**, and **actionable**?
- Has the compact **reduced duplicate work** and **indefinite specialty follow-up**?

## SPECIALIST REFERRAL TRACKING LOG

Under the status quo, a referral is often considered complete once the order is signed, with no reliable system to confirm the patient was seen, the consult note returned, the plan reconciled, and the patient informed, so referrals **routinely fall into an unmonitored gap** between primary and specialty care.<sup>50,51</sup> **A value-based approach** treats the referral as an **open obligation until the loop is explicitly closed**: every order is tracked through scheduling, attendance, information return, PCP reconciliation, and patient communication, with a **named owner** and **next action** at each open stage. The registry fields and open-loop view below operationalize that shift, making the status of every referral visible and assigning the next action required to close it.

## Recommended Registry Fields

| FIELD GROUP                                        | SUGGESTED ELEMENTS                                                                                        |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>Patient and order</b>                           | Patient name or ID; date of birth; referral ID; date ordered; referring clinician                         |
| <b>Receiving service</b>                           | Specialty; named specialist or group; network status; authorization status                                |
| <b>Care design</b>                                 | Consultation, co-management, or principal care; urgency level; target appointment date                    |
| <b>Pre-consult</b>                                 | <b>Clinical question; data package sent;</b> image access confirmed; patient barriers and accommodations  |
| <b>Access</b>                                      | Scheduled date; actual date; status as scheduled, attended, cancelled, no-show, redirected, or declined   |
| <b>Information return</b>                          | <b>Consult note date;</b> pending results; <b>PCP review date; patient communication date</b>             |
| <b>Closure</b>                                     | <b>Loop closed;</b> care track after consult; next owner; next milestone; outreach status when incomplete |
| <b>ABBREVIATIONS:</b> PCP = primary care physician |                                                                                                           |

## Illustrative Open-Loop View

| REFERRAL STATUS                          | WHAT IT MEANS                                                       | REQUIRED NEXT ACTION                                                                                       |
|------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <b>Unscheduled</b>                       | Referral accepted but <b>no appointment or e-consult response</b>   | <b>Contact receiving office and patient;</b> resolve authorization, transport, cost, or scheduling barrier |
| <b>Scheduled</b>                         | Date exists but attendance and readiness are <b>not confirmed</b>   | <b>Confirm:</b> patient understanding, preparation, caregiver, language, and transportation                |
| <b>No-show</b>                           | Visit missed or cancelled <b>without rescheduling</b>               | <b>Specialty notifies PCP;</b> coordinator performs barrier-focused outreach and creates a new plan        |
| <b>Seen; note pending</b>                | Encounter occurred but plan is <b>not available to primary care</b> | Request report through the <b>compact escalation route</b>                                                 |
| <b>Note received; PCP action pending</b> | Information is present but <b>not reconciled</b>                    | <b>Route to accountable clinician;</b> reconcile medication, testing, and follow-up                        |

| REFERRAL STATUS | WHAT IT MEANS                                                                   | REQUIRED NEXT ACTION                                      |
|-----------------|---------------------------------------------------------------------------------|-----------------------------------------------------------|
| Closed          | Note reviewed, plan acted on, patient informed, and <b>ownership documented</b> | <b>Maintain or transition</b> according to the care track |

**ABBREVIATIONS:** PCP = primary care physician



### QUALITY OUTCOME: REGISTRY RULE

**Mark Loop Closed as “Yes” only after:** the specialist note is **received**, the PCP **reviews and acts on it**, the **patient is informed** when action is needed, and **ownership** of the next step is **documented**.



### MAKING CONNECTIONS

The [AAVBC When to Refer to a Specialist QRG](#) contains an EHR-ready referral checklist and closed-loop milestone model that can supply the clinical fields feeding this management registry.

## HIGH-VALUE SPECIALIST NETWORK MANAGEMENT

Under the status quo, specialist networks are assembled largely by contract participation, reputation, and historical referral patterns, and are **rarely revisited once established**, so quality, access, coordination, and total cost are **seldom evaluated as ongoing conditions of continued partnership**. A value-based approach treats the network as an **actively managed asset**: partners are selected and retained against **explicit, measurable domains**, monitored over time, and given transparent feedback and a defined chance to improve before any sanction. The domains and operational expectations below operationalize that shift, defining **what to evaluate in each area** and the corresponding PCP or network action to sustain a high-value network.

### Selection and Stewardship Domains

| DOMAIN                  | WHAT TO EVALUATE <sup>19,52</sup>                                                                                                           | PCP OR NETWORK ACTION <sup>19,52</sup>                                                       |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <b>Clinical quality</b> | Evidence-based care, complications, outcomes, <b>specialty-specific measures</b> , procedural success, and <b>patient-reported recovery</b> | Prefer partners with <b>sustained risk-adjusted quality and transparent improvement work</b> |
| <b>Access</b>           | Time to appointment, urgent capacity, post-discharge access, no-show process, and <b>geographic or virtual availability</b>                 | Match urgency and patient needs; <b>maintain a backup path when access fails</b>             |

| DOMAIN                    | WHAT TO EVALUATE <sup>19,52</sup>                                                                                                    | PCP OR NETWORK ACTION <sup>19,52</sup>                                                              |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| <b>Coordination</b>       | Note turnaround, direct messaging, care-track clarity, medication reconciliation, and <b>transition back</b>                         | Use <b>care compacts</b> and quarterly feedback to correct recurring gaps                           |
| <b>Total cost of care</b> | Episode cost, imaging and facility patterns, <b>ambulatory site use, generic or biosimilar use</b> , and <b>avoidable acute care</b> | Evaluate the <b>whole episode</b> rather than a single procedure price                              |
| <b>Patient value</b>      | Experience, travel, copay, accessibility, caregiver burden, and goal concordance                                                     | <b>Honor informed preference and document exceptions</b> when the preferred network is not workable |
| <b>Network integrity</b>  | Out-of-network leakage, secondary referrals, data continuity, and <b>adherence to pathways</b>                                       | <b>Address preventable leakage</b> while preserving medical necessity and patient choice            |

**ABBREVIATIONS:** PCP = primary care physician

## High-Value Operational Expectations

- Use **interoperable data exchange** and **shared care plans** whenever available<sup>1,27</sup>
- Align high-volume conditions to agreed **evidence-based pathways** and pre-consult packages<sup>39,53</sup>
- Reserve urgent appointment capacity and support **rapid post-discharge contact**<sup>54</sup>
- Use **ambulatory settings** and clinically equivalent **lower-cost therapies** when appropriate<sup>48,55</sup>
- Engage smaller independent specialty practices with administrative, analytic, and technical support **rather than excluding them solely for infrastructure limitations**<sup>56</sup>
- Provide transparent data, peer comparisons, education, and a defined opportunity to improve **before network sanctions**<sup>12</sup>

## SPECIALIST MANAGEMENT METRICS

Specialist management is only as good as **what gets measured**, a value-based program needs a **defined metric set that spans the full referral episode** rather than tracking volume or single-visit completion alone. The four domains below (referral and coordination, communication and transition, utilization and optimization, and patient experience) pair each set of core measures with the management question it answers, and are followed by practice success markers, specialty-specific cross-walks, and cross-specialty financial measures.

## Four Core Measurement Domains

| DOMAIN                              | CORE MEASURES <sup>4,57</sup>                                                                                                                                       | MANAGEMENT QUESTION <sup>27,57</sup>                                       |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Referral and coordination</b>    | <b>Loop closure</b> ; note timeliness; referral acceptance; appointment completion; <b>pre-referral data package completion</b>                                     | Did the patient reach the right service and did usable information return? |
| <b>Communication and transition</b> | Care compact adherence; medication-list synchronization; shared care-plan use; explicit <b>return-to-PCP rate</b>                                                   | Are both teams operating from one plan with clear ownership?               |
| <b>Utilization and optimization</b> | <b>Ambulatory care-sensitive specialty visits</b> ; specialty-driven <b>ED or inpatient use</b> ; imaging; readmission; episode cost; <b>out-of-network leakage</b> | Did specialty involvement reduce avoidable utilization and total cost?     |
| <b>Patient experience</b>           | <b>Coordination satisfaction</b> ; <b>access burden</b> ; functional recovery; PROMs; complaints and unresolved barriers                                            | Did the patient experience one coordinated team and a workable plan?       |

**ABBREVIATIONS:** PCP = primary care physician; ED = emergency department; PROMs = patient-reported outcome measures

## Practice Success Markers

- Lower overall spending through **fewer duplicate services** and **avoidable acute-care episodes**<sup>4</sup>
- Faster clinically appropriate **access** and fewer delayed handoffs<sup>2,4</sup>
- Higher completion of chronic and preventive-care goals across the shared population<sup>58</sup>
- **Improved blood pressure, glycemic, lipid, heart failure**, or specialty-specific control where relevant<sup>59</sup>
- Higher patient confidence that the PCP and specialist communicate and **work as one team**

## Specialty-Specific Quality Metrics

Quality measurement in referral relationships works best when **measures are matched to the level of care each party actually controls**, so that specialists are held to specialty-relevant clinical and utilization measures while shared domains (access, medication reconciliation, note return, and transitions) are treated as jointly owned. The specialty-specific measures below pair **validated clinical and utilization indicators** with an operational overlay reflecting the coordination work at the primary-to-specialty handoff, and are cross-walked to publicly reportable **HEDIS** and **MIPS measures** (MY2026) so that internal profiling aligns with **externally accountable performance data** where it exists. These sets are a starting framework; applicability depends on adequate case volume, statistical reliability, and appropriate risk adjustment for each specialty and population.

| SPECIALTY               | SUGGESTED CLINICAL AND UTILIZATION MEASURES                                                                                          | OPERATIONAL OVERLAY                                                                      | HEDIS AND MIPS MEASURES (MY2026)                                                                                                                       |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cardiology</b>       | Heart failure guideline-directed medical therapy; <b>blood pressure control</b> ; heart failure readmission; avoidable ED use        | Post-discharge access; medication reconciliation; note return; episode cost              | <b>HEDIS:</b> BPD/BPD-E (diabetes), BPC-E, CBP, CRE, PBH, SPC-E<br><b>MIPS:</b> #005, #007, #008, #167, #168, #236, #243, #317, #326, #332, #392, #393 |
| <b>Orthopedics</b>      | <b>Postoperative infection</b> ; complication rate; pre- and postoperative patient-reported outcome improvement; functional recovery | Site of care; implant and episode cost; post-acute utilization; transition back          | <b>HEDIS:</b> HFO<br><b>MIPS:</b> #024, #355, #357, #358, #376, #459, #461, #471, #470, #477, #480, #503                                               |
| <b>Endocrinology</b>    | <b>Diabetes control</b> appropriate to population; annual kidney screening; severe hypoglycemia; medication safety                   | E-consult use; specialist-to-PCP repatriation; affordability and formulary alignment     | <b>HEDIS:</b> BPD/BPD-E,<br><b>MIPS:</b> #001, #118, #236, #438, #488                                                                                  |
| <b>Gastroenterology</b> | <b>Adenoma detection</b> ; surveillance-interval adherence; completion after abnormal screening; procedure complications             | Duplicate testing; ambulatory site; bowel-preparation access; report timeliness          | <b>HEDIS:</b> HFC, GSD, KED, MAC, MAD, MAH, SPC-E, SPD-E, SUPD<br><b>MIPS:</b> #113, #320                                                              |
| <b>Oncology</b>         | <b>Documented goals or advanced-care planning</b> ; symptom control; avoidable acute care; late-life treatment intensity             | Navigation; treatment-plan exchange; caregiver support; transition and survivorship plan | <b>HEDIS:</b> BCS-E, CCS-E, DBM-E, PSA<br><b>MIPS:</b> #451                                                                                            |

**ABBREVIATIONS:** HEDIS = Healthcare Effectiveness Data and Information Set; MIPS = Merit-based Incentive Payment System; MY = measurement year; ED = emergency department; PCP = primary care physician

## Cross-Specialty Financial and Operational Measures

| MEASURE                       | DEFINITION                                                                                                |
|-------------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>Total cost of care</b>     | <b>Risk-adjusted cost per episode</b> and <b>per-member-per-month</b> trend across attributed populations |
| <b>Thirty-day readmission</b> | Planned and unplanned <b>readmissions after the specialty episode</b> , with cause review and exclusions  |

| MEASURE                                | DEFINITION                                                                                                              |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <b>Avoidable emergency utilization</b> | <b>ED visits related to the co-managed condition</b> within a defined post-intervention window                          |
| <b>Referral loop closure</b>           | Completed consultations with <b>returned documentation</b> and documented PCP action                                    |
| <b>Out-of-network leakage</b>          | Referred services <b>outside the preferred VBC network</b> , interpreted with patient choice and access exceptions      |
| <b>Patient-reported outcome</b>        | Function, symptom burden, or recovery <b>reported by the patient</b> using a <b>validated instrument when available</b> |

**ABBREVIATIONS:** ED = emergency department; PCP = primary care physician; VBC = value-based care

### Cross-Specialty Financial and Operational Measures

Provide specialists with the patient's **full clinical complexity** and **relevant social context**.<sup>4</sup> Validate attribution, exclusions, coding, case mix, and data latency **before comparing partners**.<sup>60</sup> HCC documentation should reflect **supported conditions** and **continuity needs**; it should **not replace clinical outcomes** or become the sole explanation for poor performance.<sup>61</sup>

## EXAMPLE PERFORMANCE DASHBOARD TEMPLATE

This dashboard template gives the PCP or medical group a **single, scannable view of specialist and referral performance** across financial, coordination, quality, utilization, and experience domains, pairing each metric with a goal, current value, trend, and a concrete next action so that **variance can be triaged and owned** rather than merely observed. **The example values below are illustrative**; each practice should set targets to its own contracts, population, and baseline, and use the review questions that follow to test whether a flagged metric reflects a true, actionable performance gap.

| METRIC                                | DOMAIN       | EXAMPLE GOAL | EXAMPLE CURRENT | TREND | ACTION                                                |
|---------------------------------------|--------------|--------------|-----------------|-------|-------------------------------------------------------|
| <b>Total cost of care per episode</b> | Financial    | <\$18,000    | \$19,250        | Up    | <b>Audit episode components and high-cost drivers</b> |
| <b>Out-of-network leakage</b>         | Financial    | <5%          | 3.20%           | Down  | <b>Maintain; review exceptions and access</b>         |
| <b>PCP referral loop closure</b>      | Coordination | >90%         | 84%             | Flat  | <b>Check EHR feed and missing-note workflow</b>       |

| METRIC                  | DOMAIN               | EXAMPLE GOAL | EXAMPLE CURRENT | TREND | ACTION                                         |
|-------------------------|----------------------|--------------|-----------------|-------|------------------------------------------------|
| Thirty-day readmission  | Quality/ utilization | <4%          | 5.10%           | Up    | Review discharge transition and causes         |
| Avoidable ED visits     | Utilization          | <2%          | 1.80%           | Down  | Maintain and monitor                           |
| Clinical outcome marker | Quality              | >75%         | 78%             | Up    | Maintain; verify specialty-specific definition |
| Patient satisfaction    | Experience           | >85%         | 82%             | Flat  | Review wait times and coordination feedback    |

**ABBREVIATIONS:** PCP = primary care physician; EHR = electronic health record; ED = emergency department

### Illustrative Dashboard Review Questions

- Is the measure **clinically meaningful** and **attributed to the specialist fairly**?
- Are the numerator, denominator, exclusions, time window, and risk-adjustment method **defined**?
- Does the metric reflect a **clinically meaningful, sustained performance pattern** rather than short-term variation?
- Which patient-level cases **explain the variance** and **what operational process failed**?
- Could improvement on this target worsen access, equity, patient choice, or another outcome?
- **Who owns the intervention**, when will process data be reviewed, and **what marks resolution**?

## ACTION TRIGGERS AND GOVERNANCE

This section translates dashboard signals into **graded, pre-agreed responses**. It defines performance bands and their triggers, a governance sequence that **validates data before assigning consequences**, and common corrective interventions **matched to recurring problem patterns**, so that action on an underperforming specialist is **consistent, transparent, and proportionate** rather than reactive or ad hoc.

| PERFORMANCE BAND               | ILLUSTRATIVE TRIGGER                                                  | MANAGEMENT RESPONSE                                                                                                 |
|--------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <b>Green - on target</b>       | Goal met with stable or improving trend                               | <b>Maintain preferred status</b> and standard VBC/ shared-savings eligibility; continue monthly or quarterly review |
| <b>Yellow - mild variance</b>  | Approximately <b>1% to 5%</b> off target                              | <b>Send an alert</b> ; share peer benchmark data; agree on focused self-correction and an early reassessment date   |
| <b>Red - critical variance</b> | <b>More than 5%</b> off target or two consecutive quarters of decline | Joint clinical and operational review; initiate a <b>90-day corrective action plan</b> when the signal is validated |

**ABBREVIATIONS:** VBC = value-based care

## Governance Sequence

1. **Validate data:** confirm attribution, case mix, coding, exclusions, and material data lag **before** labeling a performance failure
2. **Review cases:** examine patient-level events to identify clinical anomalies, operational failures, access gaps, or network barriers
3. **Meet peer to peer:** include a clinical leader and operational owner from both organizations<sup>62</sup>
4. **Co-design the response:** focus on **operational fixes** and **evidence-based pathways** rather than dictating individual medical decisions
5. **Track process before outcome:** confirm the intervention is being executed **before** judging final results
6. **Apply consequences proportionately:** use incentive holds, tier demotion, or contract action only when authorized, communicated, and supported by persistent validated failure<sup>63</sup>

## Common Corrective Interventions

| PROBLEM PATTERN                            | POTENTIAL INTERVENTION <sup>32,54,64</sup>                                                                        |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>Delayed consultation notes</b>          | <b>Automated direct messaging at note sign-off</b> ; named work queue; 24- to 48-hour report monitoring           |
| <b>Post-discharge readmissions</b>         | <b>48-hour patient contact</b> ; medication reconciliation; rapid-access clinic slots; red-flag escalation script |
| <b>Excess imaging or duplicate testing</b> | <b>Shared pathway</b> ; prior-image access; ordering feedback; compact-defined approval or coordination process   |

| PROBLEM PATTERN        | POTENTIAL INTERVENTION <sup>32,54,64</sup>                                                                 |
|------------------------|------------------------------------------------------------------------------------------------------------|
| Out-of-network leakage | Accurate preferred directory; patient choice documentation; access remediation; ancillary-service steering |
| Low referral closure   | Registry alerts; coordinator ownership; no-show notification; overdue-note escalation                      |



### CLINICAL PEARL: KNOW WHEN TO SEEK A SECOND OPINION OR CHANGE SPECIALISTS

A second opinion is warranted for the individual patient, not a network judgment, when **the diagnosis is uncertain**, the **recommendation is a high-risk, elective, or irreversible intervention**, the proposed plan **diverges from guideline-based standards**, or the **patient lacks confidence in the plan**; in these settings second opinions change the diagnosis, treatment, or prognosis in roughly **10% to 60% of cases**, with the highest discordance in elective orthopedic and spine surgery.<sup>65-67</sup> Because a second opinion is most valuable precisely where **diagnostic variability is high** or an **intervention carries substantial risk**, obtaining one is a marker of high-value care, not distrust, and should be offered proactively for major elective procedures.<sup>66,68</sup>

Distinct from the single-patient decision, redirecting future referrals to a different high-performing specialist should be **triggered only by a validated performance signal**; for example, a **red-band variance** (more than 5% off target, or two consecutive quarters of decline) that survives confirmation of attribution, case mix, coding, exclusions, and data lag, and **only after a failed corrective-action cycle**, applied through the transparent, pre-agreed governance process rather than on a single case or on cost alone.<sup>11,69</sup> Selection of the replacement specialist should rest on **objective quality, outcome, and coordination metrics** rather than reputation or referral habit, and the rationale should be **transparent to both physician and patient**.<sup>11,69</sup>



### CLINICAL PEARL: IN CANCER CARE, A SECOND OPINION IS STANDARD PRACTICE, NOT A CHALLENGE TO THE TREATING ONCOLOGIST

In **oncology**, a second opinion is common, expected, and often encouraged, and should be **offered proactively** rather than treated as distrust.<sup>50,70</sup> A rigorous review **addresses two questions**: whether the **pathologic diagnosis** (histotype, grade, subtype, stage) is correct, and whether the **treatment plan is optimal**, since a change in diagnosis can shift the entire treatment trajectory.<sup>50,71</sup>

Patient-initiated second opinions alter the diagnosis, treatment, or prognosis in a widely variable range **up to roughly 69%** of cases.<sup>71,72</sup> **Expert pathology re-review** is a major driver, with management-changing discordances commonly **near 14%** and highest in thyroid, gynecologic, neuropathology, and bone/soft tissue specimens.<sup>51,73,74</sup> **The value often lies in doing less**: at a high-volume cancer center, subspecialists changed the plan in about one-third of cases, **frequently de-escalating to observation** or less extensive therapy while maintaining prognosis, with mean savings **near \$15,015 per patient**.<sup>75,76</sup>

The highest-yield triggers are a **rare or unusual tumor**, a **highly aggressive proposed plan** (major surgery, intensive chemotherapy, or radiation), and the **absence of a single clear standard of care**.<sup>50,70,72</sup> So framed, a second opinion is a marker of high-value care that **guards against both over- and undertreatment**, with the main tradeoff being **potential delay**, which should be minimized for time-sensitive disease.<sup>77</sup>

## CORRECTIVE ACTION PLAN WORKFLOW

| PHASE AND TIMING                                    | REQUIRED ACTIONS                                                                                                                                              | DECISION OUTPUT                                                                 |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <b>1. Identification and escalation Days 1 to 7</b> | Analytics <b>flags the variance</b> ; network notifies the specialty practice; <b>relevant incentive payments may be paused</b> when contractually authorized | Confirmed trigger, named owner, preserved baseline, and <b>notice delivered</b> |
| <b>2. Discovery and joint draft Days 8 to 21</b>    | <b>Review patient-level data</b> ; hold a clinical peer-to-peer meeting; identify operational and clinical-pathway causes; co-design interventions            | Root-cause statement and <b>draft corrective actions</b>                        |
| <b>3. Formal initiation</b>                         | <b>Both parties sign the plan</b> ; define targets, timelines, milestones, data sources, support, and consequences                                            | <b>Active CAP with shared accountability</b>                                    |
| <b>4. Monitoring and milestones Days 23 to 112</b>  | <b>Biweekly operational touchpoints</b> ; Day 45 interim data review; continue if improving; issue final warning if worsening                                 | <b>Documented execution and midpoint decision</b>                               |

| PHASE AND TIMING                                   | REQUIRED ACTIONS                                                                                                             | DECISION OUTPUT                              |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| <b>5. Resolution or exit<br/>Days 113 to 120</b>   | Compare the full performance period with baseline and targets; choose graduation, extension, tier change, or contract action | Final disposition and <b>monitoring plan</b> |
| <b>ABBREVIATIONS:</b> CAP = corrective action plan |                                                                                                                              |                                              |

## CAP Design Principles

1. Use a validated, material, and **actionable performance problem** rather than a single unexplained data point<sup>60</sup>
2. Specify **process measures that can change within the CAP window** and outcome measures that may require longer follow-up<sup>78,79</sup>
3. Provide data, education, technical assistance, and accountable contacts needed for improvement
4. **Preserve clinical autonomy** and **emergency access** while correcting operational waste or care fragmentation<sup>80</sup>
5. Document the exact consequence of missed milestones **before** the CAP begins<sup>63</sup>

## Corrective Action Plan Template

This illustrative template gives the PCP practice, medical group, or ACO a **structured, defensible instrument for documenting and executing a time-limited** (approximately 90-day) **corrective action plan** once a specialist's performance signal has been validated. It standardizes the metric at issue, required actions with named owners and process measures, interim milestones, and pre-agreed consequences, so remediation is **transparent, evidence-based, and consistently applied** rather than ad hoc.

### Plan Identification and Performance Metric at Issue

| FIELD                                 | ENTRY                                                                      |
|---------------------------------------|----------------------------------------------------------------------------|
| <b>Provider or practice</b>           | [Name]                                                                     |
| <b>NPI/Tax ID</b>                     | [Identifier]                                                               |
| <b>VBC specialist manager</b>         | [Name and contact]                                                         |
| <b>Initiation and target end date</b> | [Date]   [Date approximately 90 days later]                                |
| <b>Metric and baseline</b>            | [Validated metric, value, period, denominator, exclusions, and comparator] |

**ABBREVIATIONS:** NPI = National Provider Identifier; Tax ID = tax identification number; VBC = value-based care

## Deficiency Summary and Required Actions

| ELEMENT                              | TEMPLATE LANGUAGE                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------|
| <b>Identified issue</b>              | [Example: 30-day readmission is 6.8% versus a locally approved target below 4.0%]  |
| <b>Clinical and financial impact</b> | [Patient harm, utilization, experience, and episode-cost implications]             |
| <b>Action 1</b>                      | [Operational change, accountable owner, start date, and process measure]           |
| <b>Action 2</b>                      | [Clinical-pathway or communication change, owner, start date, and process measure] |
| <b>Action 3</b>                      | [Access, transition, or technology change, owner, start date, and process measure] |

## Milestones and Consequences

| CHECKPOINT                    | TARGET AND EVIDENCE                                                                                        |
|-------------------------------|------------------------------------------------------------------------------------------------------------|
| <b>Day 45</b>                 | [Example: post-discharge call completion exceeds 85%; process audit attached]                              |
| <b>Day 90</b>                 | [Example: readmission falls below the agreed interim target; risk-adjusted report attached]                |
| <b>If successful</b>          | Restore standard monitoring and applicable incentives; <b>document sustained-measurement period</b>        |
| <b>If marginally improved</b> | Extend 30 to 60 days <b>when good-faith execution and plausible improvement are present</b>                |
| <b>If unsuccessful</b>        | Apply the pre-agreed network tier, incentive, or contract consequence when governance requirements are met |

## Sign Off

| SIGNATORY                            | SIGNATURE AND DATE |
|--------------------------------------|--------------------|
| <b>Specialist or practice leader</b> | _____ Date: _____  |
| <b>VBC medical director</b>          | _____ Date: _____  |

## ROOT-CAUSE QUESTIONNAIRE

This questionnaire is used once a **specialist's underperformance signal has been validated**, to systematically diagnose **why the gap exists** before any corrective action or network consequence is applied. It walks the PCP practice and specialty partner through structured prompts across data and case mix, communication, pathways and access, and operational resources and incentives, then **maps the dominant problem area to a targeted first response** so remediation addresses the true root cause rather than a symptom.

### Data and Communication

#### Section 1 - Data Validation and Case Mix

1. Has the patient population changed in acuity or social complexity, including transportation, food insecurity, cognition, caregiver support, or other barriers?

**Response:** Yes - describe | No | Uncertain - request data

2. Are supported comorbidities documented accurately enough to reflect clinical complexity and HCC context?

**Response:** Yes | No | Training or audit needed

3. Are any cases misattributed, duplicated, miscoded, excluded incorrectly, or outside the measured period?

**Response:** Yes - list case IDs | No | Data validation needed

#### Section 2 - Care Coordination and Communication

4. Does the specialty clinic receive timely admission, discharge, and transfer alerts for attributed patients?

**Response:** Automated | Manual or delayed | No

5. What is the main barrier to returning consultation notes within the agreed target?

**Response:** EHR matching or interoperability | Staff burden | Notes complete but not transmitted | Other

6. Why are ancillary services or secondary referrals leaving the preferred network?

**Response:** Patient preference or geography | Directory visibility | Preferred access delay | Clinical need | Other

## Discovery Output

| FINDING        | EVIDENCE                                          | OWNER       | IMMEDIATE TEST OF CHANGE |
|----------------|---------------------------------------------------|-------------|--------------------------|
| [Root cause 1] | [Cases, workflow observation, or data validation] | [Name/role] | [Action and date]        |
| [Root cause 2] | [Cases, workflow observation, or data validation] | [Name/role] | [Action and date]        |

## Pathways and Resources

### Section 3 - Clinical Pathways and Access

7. How long does a recently discharged patient typically wait for a specialty follow-up?

**Response:** 1 to 3 days | 4 to 7 days | 8 or more days

8. Does the clinic reserve daily buffer capacity for same-day urgent visits that may prevent ED use?

**Response:** Yes - number per day | No

9. Are evidence-based pathways for high-volume conditions embedded and followed?

**Response:** Integrated in EHR | Available but inconsistently followed | No shared pathway

### Section 4 - Operation Resources and Incentives

10. Does the practice have a care coordinator, navigator, or clinical pharmacist for high-risk transitions?

**Response:** Dedicated | Shared | No

11. Are clinician incentives aligned to value-based quality and cost performance?

**Response:** VBC or quality aligned | Hybrid | Fee-for-service production only

12. Which technology would most immediately improve performance?

**Response:** Direct EHR messaging | Real-time patient cost estimates | Predictive analytics | Other

## Scoring and Action Key

| DOMINANT ISSUE                             | PRIMARY RESPONSE                                                                                        |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Section 1 - data or case mix</b>        | Risk-adjustment documentation support, attribution review, and <b>data validation audit</b>             |
| <b>Section 2 - communication</b>           | <b>EHR integration</b> , direct messaging, note-transmission workflow, and preferred-provider directory |
| <b>Section 3 - pathways or access</b>      | <b>Scheduling redesign</b> , buffer slots, post-discharge access, and shared clinical pathways          |
| <b>Section 4 - resources or incentives</b> | Embedded care-management support, technology assistance, education, and compensation alignment          |

**ABBREVIATIONS:** EHR = electronic health record

## PEER BENCHMARKING AND EDUCATIONAL FEEDBACK

This template supports **transparent, education-first performance feedback** to a specialist or practice before any formal corrective or contractual action. It pairs a risk-adjusted peer benchmark matrix with a narrative framework that explains the clinical and operational drivers behind the numbers, highlights workflows used by top performers, and offers **concrete improvement resources**, reinforcing that peer comparison is meant to **enable improvement** rather than to penalize.

### Report Header

| FIELD                                 | ENTRY                                                                                                                                                 |
|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>To</b>                             | [Provider or practice name]                                                                                                                           |
| <b>From</b>                           | [VBC network or payer performance analytics team]                                                                                                     |
| <b>Reporting period and specialty</b> | [Quarter/year]   [Specialty]                                                                                                                          |
| <b>Purpose</b>                        | Compare risk-adjusted performance <b>with regional peers</b> and high-performing cohorts; identify clinical and operational improvement opportunities |

**ABBREVIATIONS:** VBC = value-based care

### Illustrative Peer Benchmark Matrix

| CORE METRIC               | PRACTICE | REGIONAL PEER | TOP COHORT TARGET | STATUS          |
|---------------------------|----------|---------------|-------------------|-----------------|
| Thirty-day readmission    | 6.80%    | 4.20%         | <3.0%             | Action required |
| Total episode cost        | \$19,250 | \$17,400      | <\$16,500         | Mild variance   |
| PCP referral loop closure | 84%      | 89%           | >95%              | Mild variance   |
| Out-of-network leakage    | 3.20%    | 5.50%         | <5.0%             | Meeting target  |
| Avoidable ED visits       | 1.80%    | 2.10%         | <1.5%             | Near target     |

**ABBREVIATIONS:** PCP = primary care physician; ED = emergency department

### Feedback Narrative Template

- **‘The Why’ behind the data:** describe the patient-level pattern, timing, affected subgroup, and operational failure **rather than presenting a score alone**
- **Financial and clinical impact:** explain episode cost, shared-savings implications, patient harm, and experience **without overstating causality**
- **Peer practices:** identify **workflows used by top performers**, such as 48-hour outreach, rapid-access slots, and automated note return
- **Resources:** offer patient-level data, care coordination tools, coding or documentation support, technical assistance, and a named specialist manager
- **Next review:** state the owner, action, milestone, and date when progress will be assessed



#### QUALITY OUTCOME: FEEDBACK PRINCIPLE

Use peer benchmarking to support improvement, **not merely to rank clinicians**.<sup>81</sup> Pair every variance with **validated cases**, a **plausible intervention**, and access to the resources **needed to change the process**.<sup>82</sup>

## OLDER ADULT ACCESS AND IMPLEMENTATION ROADMAP

Older adults are the **highest-volume users of specialty care** and carry the **greatest exposure to the failure points** that derail a referral: reduced functional reserve, sensory and cognitive impairment, polypharmacy, fragmented care across multiple specialists, and Medicare-specific network and cost constraints. Because these vulnerabilities compound one another, **routing decisions that are adequate for a younger patient can break down entirely in this population**. The overlay below maps each major geriatric risk to a concrete management response, so the routing and coordination steps defined earlier can be adapted to functional status, caregiver support, and transition safety rather than diagnosis alone.

### Older Adult Management Overlay

| RISK                                  | MANAGEMENT RESPONSE <sup>54,83,84</sup>                                                                                           |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <b>Frailty and mobility</b>           | Match route and site to <b>functional reserve</b> ; arrange transport, mobility support, prehabilitation, and realistic follow-up |
| <b>Cognition, hearing, and vision</b> | Use caregiver inclusion, accessible instructions, interpreter or assistive communication, and <b>teach-back</b>                   |
| <b>Polypharmacy</b>                   | <b>Reconcile after every specialty change</b> ; clarify prescriber, duration, monitoring, and deprescribing responsibility        |
| <b>Multiple specialists</b>           | Maintain <b>one shared problem list and care plan</b> ; identify conflicting tests, medications, diets, or follow-up expectations |
| <b>Medicare network and cost</b>      | Verify network, authorization, site of care, copay, transportation, and affordable medication alternatives                        |
| <b>High-risk transitions</b>          | Use <b>rapid post-discharge contact</b> , medication review, urgent access, and direct PCP-specialist communication               |

**ABBREVIATIONS:** PCP = primary care physician



#### CLINICAL PEARL: A MISSED APPOINTMENT IS A DIAGNOSIS, NOT NONADHERENCE

A missed appointment in an older adult **may signal**: hearing loss, cognitive impairment, caregiver strain, transportation failure, or unaffordable cost.<sup>85</sup> Diagnose the access failure **before** labeling the patient nonadherent.<sup>86</sup>

## Implementation Roadmap

| PHASE                                              | PRIORITY ACTIONS                                                                                                                                           |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>First 30 days</b>                               | Name <b>referral coordinator ownership</b> ; <b>define three care tracks</b> ; standardize referral and note-review fields; identify top referral partners |
| <b>Days 31 to 60</b>                               | <b>Launch registry alerts</b> ; establish note and no-show service levels; begin <b>care compacts with highest-volume specialties</b>                      |
| <b>Days 61 to 90</b>                               | <b>Create first scorecard</b> ; validate data and risk adjustment; review access, leakage, readmission, and <b>loop-closure patterns</b>                   |
| <b>Quarterly</b>                                   | <b>Share peer feedback</b> ; update preferred network; initiate <b>targeted improvement work</b> ; review patient experience and equity balancing measures |
| <b>Annually</b>                                    | Renew compacts, access windows, measures, pathways, consequences, and <b>return-to-PCP expectations</b>                                                    |
| <b>ABBREVIATIONS:</b> PCP = primary care physician |                                                                                                                                                            |

## TEN KEY TAKEAWAYS

### 1 The PCP remains the longitudinal leader

Specialty expertise should **enter one accountable care plan** rather than create a parallel plan.

### 2 Name one of three care tracks

Consultation, co-management, or principal care should be **explicit** before orders begin.

### 3 Send a focused, clinically ready package

A narrow question and relevant existing data reduce duplicate work and wasted visits.

### 4 Track access as a clinical function

Acceptance, scheduling, attendance, no-show outreach, note return, and PCP action require named ownership.

### 5 Reconcile every specialist change

Medication, testing, monitoring, pending results, and urgent instructions should have one owner.

### 6 Return routine care to primary care

Specialty follow-up should continue only while it adds defined diagnostic, therapeutic, procedural, or co-management value.

### 7 Use care compacts with frequent partners

Shared service levels and transition criteria make communication and accountability measurable.

### 8 Curate networks by total value

Combine quality, access, coordination, patient experience, episode cost, and patient preference.

### 9 Use data for improvement

Validate case mix and attribution, explain patient-level causes, and pair every variance with practical support.

### 10 Escalate persistent validated failure

Use peer feedback, corrective action, tier changes, or contract consequences through transparent governance.

## AAVBC SUMMARY AND CONCLUSION

AAVBC supports a **PCP-led specialist management model** in which referral need, route, and urgency are followed by equally disciplined management of the specialty relationship. High-value care requires an **explicit care track, complete information exchange, timely specialist recommendations, active patient-access support**, medication and test **reconciliation**, and a **documented transition back to primary care** when specialized involvement no longer adds value.<sup>2,4,19</sup>

The strongest specialist networks are not defined by the **fewest referrals** or the **lowest isolated procedure price**.<sup>87</sup> They are defined by **timely access, high clinical quality, lower avoidable utilization, clear communication, appropriate site and product selection, patient-reported benefit**, and lower **total episode cost**.<sup>88</sup> Practices should use transparent scorecards, peer feedback, and corrective action to improve these relationships while preserving clinical judgment, patient choice, and emergency access.

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