Lehigh Valley Health Network

Breast Care Management
Cooperative Care Agreement Between:

PCMH: LEHIGH VALLEY PHYSICIAN PRACTICE (LVPP)
&
PCMH-N: HEMATOLOGY ONCOLOGY ASSOCIATES (HOA)
&
PCMH-N: BREAST HEALTH SERVICES (BHS)
&
LEHIGH VALLEY SURGICAL ONCOLOGY (LVSO)

PURPOSE:

The Cooperative Care Agreement for care of the High Risk and Invasive Breast Cancer Patients will define for all parties named above the types of referral, consultation, and co-management arrangements available. This agreement will specify who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements. This agreement will define expectations regarding the information content requirements, as well as the frequency and timeliness of information flow within the referral process. This is a bidirectional process reflecting the needs and preferences of both the referring and consulting physician and other health care professionals. This agreement will specify how secondary referrals are to be handled and situations of self referral. This agreement will also maintain a patient-centered approach including consideration of patient/family choices, ensuring explanation/clarification of reasons for referral, and subsequent diagnostic or treatment plan and responsibilities of each party, including the patient/family. This agreement will include regular review of the terms of the care coordination agreement by all parties. In addition there will be a mechanism for all parties to periodically evaluate each other's cooperation with the terms of the care coordination agreement, and the overall quality of care being provided through their joint efforts.

Source: Lehigh Valley Health Network, Allentown, PA; featured in Achieving Care Continuity from Advisory Board's Nursing Executive Center.

Lehigh Valley Health Network's Breast Care Management Cross-Continuum Care Agreement

AGREEMENT:
ALL PARTIES INCLUDING HEMATOLOGY ONCOLOGY ASSOCIATES (HOA), LEHIGH VALLEY PHYSCIAN PRACTICE (LVPP), BREAST HEALTH SERVICES (BHS) & LEHIGH VALLEY SURGICAL ONCOLOGY (LVSO) representing the Surgical Oncology Clinic AGREE TO THE FOLLOWING COOPERATIVE CARE PRINCIPLES AS LISTED BELOW:

> "All parties agree to provide patient & family centered care, anticipate any special needs of the patient and families and arrange for appropriate interventions/accommodations if necessary, notify patient and family of plan of care and secondary referrals when appropriate. All parties agree to pre-treatment consultation if requested and to notify all related parties of patients with a no show status."
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> Please refer to Figure 1 which illustrates the flow of patients getting mammograms from BHS, the return of the patient with a normal mammogram to the PCP for continuing primary care, the navigation of abnormal mammograms and biopsies, referral to the High Risk Breast clinic, and referral to the Breast MDC (Multi-disciplinary Clinic) of patients with invasive breast cancer.

1. LVPP will be responsible for ordering routine screening mammography at recommended intervals as per LVHN standard for screening mammography.

LVPP, in the clinical judgment of the PCP, will be responsible for ordering diagnostic mammography or ultrasound for patients presenting with breast symptoms or abnormal findings on breast examination.

LVPP will be responsible for initial scheduling of patient for screening (or diagnostic) mammogram at Breast Health Services and be responsible for referring uninsured patients to Healthy Women Program or the Breast Cancer Coalition Program through the Allentown Health Bureau at [phone number]. Assistance with completing the appropriate paperwork will be provided through [individual] at [phone number].

2. BHS will perform routine mammograms as per BHS policy, report normal mammograms to LVPP within 72 hours and refer patient back to LVPP for routine care and follow up for normal mammograms.

A breast diagnostic navigator is assigned to every patient with an abnormal mammogram until resolution of the findings, including navigating the patient to biopsy. When the biopsy results are positive for Atypia, LCIS, DCIS, or invasive breast cancer, a treatment navigator facilitates subsequent referrals to surgery or the Breast MDC.

BHS will perform additional views when indicated and perform biopsy at Breast Health Services for all patients with a BIRADS 4 or 5.

The BHS navigator/RN will communicate abnormal mammogram results and/or biopsy results and recommendations to the PCP within 24 hours. The navigator will also be empowered, on behalf of the patient's PCP to make patient referrals to either High Risk Breast Clinic if pathology is atypical hyperplasia (ADH, ALH) or lobular neoplasia (Lobular Carcinoma In-situ,

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LCIS), to surgery if DCIS (ductal carcinoma in situ), or to Breast Multidisciplinary Clinic for all invasive breast cancers and will assist the patient with scheduling appointments.

A treatment navigator is assigned to all patients with a diagnosis of breast cancer and will follow them from the time of final pathology until completion of their treatments.

3. When requested by BHS, and per agreement, Surgical Oncology Specialty Clinic agrees to see all patients with a BIRADS 4a or 4b at the next scheduled Surgical Oncology Clinic to evaluate for biopsy. Patients with 4c or 5 mammograms will be recommended to undergo biopsy at the earliest opportunity—either in BHS or in surgical clinic.

In addition the breast clinic agrees to notify the PCP of self-referrals to the clinic by their patients. The clinic agrees to schedule diagnostic breast imaging in BHS when necessary, collaborate with the breast navigator to assist biopsy patients with scheduling of appointments for OR scheduling, High Risk Breast Clinic or Breast MDC within 1 week of receiving biopsy results when appropriate.

Surgical Oncology Specialty Clinic as part of LVPP and LVSO agree to permit recommendation by the BHS navigator for referral to the High Risk Breast Clinic for all patients with a final pathology of ADH, ALH, and LCIS. The navigator will recognize that some patients may wish to discuss the referral with either or both their surgeon and PCP before accepting an appointment.

The physicians of LVSO who oversee the Surgical Oncology Specialty Clinic agree that for the patients seen at this clinic they will forward a dictated note to LVPP including recommendations, patient and family discussions, patient and family decisions and plan for follow up.

4. HOA agrees to schedule High Risk Breast Cancer patients within 6-12 weeks of receiving a request from the BHS navigator, Surgical Oncology Clinic, LVSO or LVPP. HOA agrees to notify all parties of acceptance of referral, date of scheduled appointments for high risk patients and of any self referrals.

HOA agrees to provide a comprehensive cancer risk assessment, individualized for each patient and family needs, and provide a patient centered recommendation of care for cancer surveillance. When appropriate, HOA will recommend consideration of chemoprevention with tamoxifen, raloxifene or exemestane if patient is qualified. If patient accepts chemoprevention, HOA (Cancer Risk clinic) will recommend patient visits at 6 month intervals during the 5 year course of treatment to monitor side effects or toxicities from the chemoprevention agent.

HOA agrees to notify LVPP and the Surgical Oncology Clinic through a dictated note of patient's plan of care including any recommendations made, patient and family discussions, patient and family decisions and plan for follow up. HOA agrees to help obtain insurance authorization for obtaining Breast MRI's or specialty testing if recommended for patients by either HOA or the Surgical Oncology Clinic.

For any High Risk Breast patient identified by Surgical Oncology Clinic, BHS or HOA that has no primary care physician all parties will agree to automatically refer the patient to the Community

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Cancer Center Nurse Practitioner at LVPP for a comprehensive medical evaluation and to establish primary care with LVPP.

5 Patients with invasive breast cancer will be recommended by the breast navigator to the Breast MDC within 1 week of the diagnosis of invasive disease. The patient's navigator will organize the initial MDC visit, prepare the patient for what will happen at the MDC, invite the PCP or PCMH care manager to the MDC, facilitate review of the patient's case at the Breast Tumor Board, communicate the recommended care plan to the patient in writing, facilitate next steps in the care plan, whether it be additional diagnostic imaging, or appointments, and communicate the recommended care plan to the PCMH care manager within 24 hours of the MDC.

PERIODIC REVIEW:
This agreement will be reviewed annually by all parties unless otherwise requested.

We mutually agree to the above Breast Cancer Management Cooperative Care Agreement:

[representative], MD (LVPP) **Date**

[representative], MD (HOA, Breast MDC) **Date**

[representative], MD (LVSO) **Date**

[representative], RN, BSN, MBA, OCN (BHS) **Date**

[representative], RN, MA, AOCN (Breast MDC) **Date**

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