

Collaborative Care Agreement

The primary care practice of (Name Removed) and (Name Removed) has developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

Collaborative Guidelines

I. Purpose

- To provide optimal health care for our patients.
- To provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers

II. Principles

- Safe, effective and timely patient care is our central goal.
- Effective communication between primary care and behavioral health care is key to providing optimal patient care and to eliminate the waste and excess costs of health care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- A high functioning medical system of care provides patients with access to the 'right care at the right time in the right place'.

III. Definitions

- Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients.
- Specialist (Psychiatrist) – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.
- Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.
- Care Manager – An APN who uses evidence based guidelines and assessment tools to identify high risk patients in the primary care practice. The CM then facilitates patient care through the complex health system according to PCMH principals including but not limited to:
 - i. Whole person orientation
 - ii. Coordinated and/or integrated care
 - iii. Quality and safety
 - iv. Enhanced access
- Behavioral Health Navigator – a social worker who works as a team member with a Nurse Navigator and the patients primary care provider to assist the patient in negotiating the complex health care system
- Nurse Navigator – an RN who works as a team member with the Behavioral Health Navigator and the patients primary care provider to assist the patient in negotiating the complex health care system
- Patient-Centered Medical Home – a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with a accessible, coordinated, comprehensive and continuous health care across all stages of life.
- Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment options, and expectations taking into consideration the patient's psychosocial and personal needs.
- Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

IV. Types of Transitions of Care

- Pre-consultation exchange – communication between the PCP and Health Options Social Worker to
 - i. Answer a clinical question and/or determine the necessity of a formal consultation.
 - ii. Facilitate timely access and determine the urgency of referral to specialty care.
 - iii. Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.
- Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.
- Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient's health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources as outlined by the "Joint Principles" and meeting the requirements of NCQA PPC-PCMH recognition.
- Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.
 - i. Co-management with shared management for the disease – the specialist shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the PCMH and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.
 - ii. Co-management with Principal Care for the Disease (Referral) – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The PCMH continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.
 - iii. Co-management with Principal Care for the Patient (Consuming illness) – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The PCMH remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.
 - iv. Emergency Care – medical or surgical care obtain on an urgent or emergent basis.

Primary Care – Behavioral Health Compact

V. Mutual Agreement for Care Management

- Review tables and determine which services you can provide.
- The *Mutual Agreement* section of the tables reflects the core element of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The *Expectations* section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or Behavioral Health.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to Behavioral Health, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCMH, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.
- Each provider should agree to open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

Primary Care – Behavioral Health Compact

Transition of Care	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Maintain accurate and up-to-date clinical record. • When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record (CCR) or Continuity of Care Document (CCD). • Ensure safe and timely transfer of care of a prepared patient. 	
<i>Expectations</i>	
Primary Care	Behavioral Health
<ul style="list-style-type: none"> <input type="checkbox"/> PCP maintains complete & up-to-date record including demographics <input type="checkbox"/> Transfers information as outlined in Patient Transition Record <input type="checkbox"/> Orders appropriate studies that would facilitate the Behavioral Health visit <input type="checkbox"/> Provides patient with Behavioral Health contact information & expected time frame for appointment <input type="checkbox"/> PCP Care Manager facilitates the Transition of Care by communicating directly with the Behavioral Health Social Worker to plan a strategy for the transition. <input type="checkbox"/> Patient/family are in agreement with the referral, type of referral & selections of specialist 	<ul style="list-style-type: none"> <input type="checkbox"/> Determines &/or confirms insurance eligibility <input type="checkbox"/> Identifies a specific referral contact person to communicate with in the PCP office <input type="checkbox"/> Assist PCP prior to the appointment regarding appropriate pre-referral work-up <input type="checkbox"/> Informs patient of need, purpose, expectations & goals of transfer

Addendum
<i>Additional Agreement/Edits</i>

Primary Care – Behavioral Health Compact

Access	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Be readily available for urgent help to both the physician and patient • Provide adequate visit availability • Be prepared to respond to urgencies • Offer reasonably convenient office facilities and hours of operation • Provide alternate back-up when unavailable for urgent matters • When available and clinically practical, provide a secure email option for communication with established patients and/or providers 	
<i>Expectations</i>	
Primary Care	Behavioral Health
<ul style="list-style-type: none"> <input type="checkbox"/> Communicate with patients who miss appointments to Behavioral Health <input type="checkbox"/> Determines reasonable time frame for specialist appointment 	<ul style="list-style-type: none"> <input type="checkbox"/> Notifies PCP of missed appointments or other actions that place patient jeopardy <input type="checkbox"/> Schedule patient's first appointment with requested provider <input type="checkbox"/> Provide PCP with a list of practice physicians who agree to agreement principles

Addendum
<i>Additional Agreement/Edits</i>

Primary Care – Behavioral Health Compact

Patient Communication	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Consider patient/family choices in care management, diagnostic testing & treatment plan • Provide to & obtain consent from patient according to community standards • Explore patient issues on quality of life in regards to their specific medical condition & shares this information with the care team 	
<i>Expectations</i>	
Primary Care	Behavioral Health
<ul style="list-style-type: none"> <input type="checkbox"/> Explains, clarifies, & secures mutual agreement with patient on recommended care plan <input type="checkbox"/> Assists patient in identifying their treatment goals <input type="checkbox"/> Engages patient in the PCMH concept and identifies whom the patient wishes to be included in their care team 	<ul style="list-style-type: none"> <input type="checkbox"/> Informs patient of diagnosis, prognosis & follow-up recommendations <input type="checkbox"/> Provides educational material & resources to patient when appropriate <input type="checkbox"/> Recommends appropriate follow-up with PCP <input type="checkbox"/> Be available to the patient to discuss questions or concerns regarding the consultation of their care management <input type="checkbox"/> Participates with patient care team

Addendum
<i>Additional Agreement/Edits</i>

Primary Care – Behavioral Health Compact

Collaborative Care Management	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> • Define responsibilities between PCP, Behavioral Health, and patient • Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up) • Maintain competency and skills within scope of work & standard of care • Give & accept respectful feedback when expectations, guidelines or standards of care are not met • Agree on type of care that best fits the patient’s needs 	
<i>Expectations</i>	
Primary Care	Behavioral Health
<ul style="list-style-type: none"> <input type="checkbox"/> Follows principles of PCMH <input type="checkbox"/> Manages Behavioral Health problem to the extent of the PCP’s scope of practice, abilities & skills <input type="checkbox"/> Follows standard practice guidelines related to evidence-based guidelines <input type="checkbox"/> Resumes care of the patient as outlined by Behavioral Health & incorporates care plan recommendations into overall care of the patient <input type="checkbox"/> Shares data with Behavioral Health in a timely manner including data from other providers 	<ul style="list-style-type: none"> <input type="checkbox"/> Review information sent by PCP; address provider & patient concerns <input type="checkbox"/> Confer with PCP & establish protocol before ordering additional services outside of practice guidelines <input type="checkbox"/> Confers with PCP before referring to other specialists; uses preferred provider list <input type="checkbox"/> Sends timely reports to PCP; shares data with care team <input type="checkbox"/> Notifies PCP of major interventions, emergency care, & hospitalizations

Addendum
<i>Additional Agreement/Edits</i>