## COLLABORATIVE AGREEMENT

This document outlines the referral agreement between _____and _____ for pre-consultation exchange, formal consultation, and co-management of chronic disease or illness. The purpose of this agreement is to provide a framework for better communication, coordination of care, and the transition of care between primary care (PCP) and specialty care (SCP) providers to eliminate waste and excess cost of health care, as well as optimizing patient health.

_____(PCP) and _____ (SCP) agree to collaborate in the care and treatment of patients as set forth below.

_____[Allotted days per week], an SCP will come to the PCP office to be available to see patients onsite.

The PCP office will provide office space and a laptop with secure access to create and incorporate patient notes at the time of service. The SCP will be responsible for billing for his/her own services.

The PCP agrees that referrals to the SCP shall include a reason for the referral; any thought process related to that reason; clinical information including diagnosis, problem list, pertinent diagnostic tests, medication list, and allergy list; and the timeframe within which the referral is requested.

The SCP agrees to send all new clinical information back to the PCP with care recommendations.

The PCP and SCP agree to the following types of care management/referral transitions. (Check all that apply)

☐ **Pre-consultation exchange** – communication between PCP and SCP to:

- ☐ Answer a clinical question and/or determine the necessity of a formal consultation with the SCP.
- ☐ Facilitate timely access and determine the urgency of referral to the SCP.
- ☐ Facilitate diagnostic evaluation of the patient prior to the SCP's assessment.

☐ **Formal consultation**—referral for advice:

- ☐ Request for referral and/or advice on a discrete question regarding a patient's diagnosis, diagnostic test results, procedure, treatment, or prognosis, with the intention that patient care will be transferred back to the PCP after one or a few visits.
- ☐ The SCP will provide a detailed report on the diagnosis and recommended care and NOT manage the care; this report may include an opinion on the appropriateness of co-management.
- ☐ The SCP is responsible for communicating with the patient on any diagnostic test results until the SCP transitions the patient back to the PCP.

(Continued)

* Adapted from Keuka Primary Care Associates

☐ **Co-management for chronic disease/illness:**

- ☐ Both the PCP and SCP actively contribute to patient care for a medical condition and are responsible for defining their individual responsibilities for communication with the patient, drug therapy, referral management, diagnostic testing, and patient follow-up.
- ☐ The PCP continues to receive consultation reports and provides input on secondary referrals and quality of life and treatment decision issues.
- ☐ The PCP continues care for all other aspects of patient care and new or other related health problems and remains the patient's first contact.

This agreement outlines expectations between the PCP and SCP. It does not, in any way, limit the patient's freedom to select his/her physician of choice or make a self-referral to a provider of the patient's choice. Both parties agree to review agreed-upon objectives and expectations throughout the collaboration, including data for mutual use for the purpose of quality improvement.

Patient confidentiality will be maintained as per HIPAA. SCP access to PCP records is limited to information pertinent and germane to patient issues being treated by the SCP.

## APPROVAL SIGNATURES

### Primary Care Provider

Authorized name _____

Title _____

Signature _____

Date _____

### Specialist Care Provider

Authorized name _____

Title _____

Signature _____

Date _____