The Royal Australian College of General Practitioners

Collaborative Care Agreements

A Guide for Collaborative Care Agreements in General Practice

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RACGP Collaborative Care Agreement – A guide for Collaborative Care Agreements in general practice

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1. Background

On 1 November 2010, the Commonwealth Government extended access to the Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) to nurse practitioners (NPs) who hold an endorsement as an NP with the Nursing and Midwifery Board of Australia, and have a Collaborative Care Agreement with an eligible medical practitioner.

Since this time, The Royal Australian College of General Practitioners (RACGP) has been working with key stakeholders nationally to ascertain the impact of these changes on Australian general practice, and to develop resources and a guide for general practices working with NPs in primary and ambulatory care.

The guide has been developed to answer questions health practitioners may have regarding collaborative arrangements, and how they may be structured, as well as to identify key issues that general practitioners (GPs) and NPs should take into account when entering into, or being part of, a Collaborative Care Agreement.

The following guide and the attached Collaborative Care Agreement template for a written collaborative arrangement have been developed with three key aims:

- to offer Australian patients access to the safest, highest quality primary care
- to clearly identify roles and responsibilities, mutually agreeable processes for consultation, referral and transfer of a patient's care, and to provide clarity between both parties before the commencement of a Collaborative Care Agreement
- to facilitate a continuum of care, and to minimise the potential litigation risk to medical practitioners, NPs and their staff.

2. *Development of the Collaborative Care Arrangement – Important areas for consideration*

The RACGP suggests that, when entering into a Collaborative Care Arrangement, the GP and NP meet, in the first instance, to discuss and clarify the following:

- the clinical setting/s in which care will be provided
- responsibilities
- agreed scope of practice
- patient coverage
- communication methods and requirements
- pathology and diagnostic imaging including communication and results management
- agreements for sharing relevant information from patient records
- prescribing formulary, and determining agreements for prescribing medications in the PBS 'shared care' or 'continuing' categories
- agreements for consultation, referral, and/or transfer to a medical practitioner
- agreements for after hours care
- ongoing review of collaborative arrangements
- agreements for terminating the Collaborative Care Agreement
- remuneration for non-MBS related support
- indemnity insurance cover
- legal implications of the Collaborative Care Agreement
- patient consent arrangements.

It may take several meetings to reach mutual understanding and agreement. The following guide and accompanying Collaborative Care Agreement template provide a summary of key points to be considered.

2.1 Clinical setting/s in which care will be provided

The clinical setting, or settings, in which patient care will be provided, should be clearly identified. For instance, the Collaborative Care Agreement may specify that care will be provided only in your practice, or it might include home visits, continence clinics in state funded facilities, and/or other settings. Regardless of where patient care will be provided, it should be clearly identified in the agreement.

2.2 Responsibilities and agreed scope of practice

When entering into a collaborative care agreement, it is suggested that the GP ask the NP whether they have entered, or intend to enter, into a Collaborative Care Agreement with any other GP (or GPs) – on similar or different terms to the proposed agreement with you. There is the potential for confusion if NPs are operating under agreements on different terms, and you may wish to consider the level of review that is appropriate in all the circumstances.

It is essential that both the GP and the NP are each mutually agreeable to, and clearly understand, the roles and responsibilities of the other. Depending on the professional relationship between the two parties, an agreement may require a number of detailed meetings.

Although there is some variation in mandated process between jurisdictions, NPs are required to have an approved document detailing their scope of practice, based on the skills and experience of the relevant NP. The approved scope of practice document may be used as a reference for the Collaborative Care Agreement. Scope of practice can be developed in consideration of service gaps and/or the organisation or practice requirements, as well as the previous experience, skills and educational preparation of the NP, which will vary between individual NPs. Discussions may also include members of the extended healthcare team, such as local pathology and imaging services, local pharmacist and other allied health professionals who may receive referrals from the NP.

It is important to define precisely the scope of practice for sharing care, including for example:

- general community primary care triage
- diabetes management
- mental health
- lifestyle management (including motivational counselling)
- wound care
- continence
- chronic pain management
- residential care.

A mutual understanding around the scope of practice will help ensure the Collaborative Care Agreement realistically takes into consideration the NP's expertise and whether it is practicable for both parties.

In addition to this, it is as equally and critically important to identify and source the relevant clinical guidelines to be used in care so that both parties are aligned in approaches to management. In general practice, the list is long and reflects the importance of being clear on the specific scope of practice to be covered. Clinical guidelines for current general practice care are many and include the RACGP guidelines, which are available at: www.racgp.org.au/guidelines.

2.3 Patient coverage

It is unlikely in general practice that the Collaborative Care Agreement will cover one single patient only. Therefore, if the Agreement is to cover a number of patients being treated across a range of conditions, the conditions must be clearly specified, including:

- the range of conditions and/or services that will be treated
- the range and scope of responsibilities.

2.4 Communication protocols

The clarification and agreement in relation to expectations around communication is pivotal to the Collaborative Care Agreement. Communication represents the greatest area of risk in terms of quality and safety, and consequently may lead to issues of indemnity. Arrangements around two-way communication and the handover of clinical details between the NP and the GP are critical to help ensure high quality patient outcomes and the minimisation of disputes.

It is important to clearly identify the expectations and requirements of both the GP and NP, including:

- communication relating to the occurrence and outcome of patient consultation, including recording of information and data
- information sharing and patient consent
- investigation, ordering, and results
- management of abnormal results (especially those requiring urgent action)
- follow up and/or consultation on issues the NP does not feel confident managing, and/or outside scope of practice.

2.5 Arrangements for initiating (and GP receipt) of pathology and diagnostic imaging tests

Arrangements for initiating, and receiving, pathology and diagnostic imaging tests are important areas in their own right, and can be a significant cause of uncertainty for GPs.

Receipt of unsolicited pathology and radiology results may trigger a 'duty of care' requirement for GPs receiving them.

One option to avoid this is to arrange for the results and NP consultation summary to be forwarded to the practice as one care package, with a clear management summary and follow up identified. To achieve this, arrangements will need to be made with the local pathology/radiology practices to ensure that the patient's usual GP is not automatically copied in on all test results.

The desired approach regarding test ordering and/or review of patient test results should be closely examined with the NP, and should include input and consent from local pathology/radiology providers to ensure consistency.

2.6 Arrangements for sharing relevant information from the patient's medical record

Patients need to be aware that their patient health information is being disclosed to a third party. Where personal health information is to be disclosed to a third party, the GP must consider what information is relevant for the proposed purpose, and ensure that no personal health information is disclosed unnecessarily.

A GP may not be justified, for example, in forwarding a copy of a patient's complete medical record to another medical practitioner where the record contains personal health information that has no bearing upon the condition to which the referral relates.

The RACGP makes reference to sharing of relevant information from the patient's medical record in the current edition of the Standards for general practices (4th edition, 2010), available at www.racgp.org.au/standards, as well as in the Handbook for the management of health information in private medical practice (2002), available at www.racgp.org.au/privacy/handbook.

2.7 Prescribing arrangements and protocols

The RACGP has developed a Position Statement on independent non-medical practitioner prescribing, available at www.racgp.org.au/policy/non_medical_prescribing.pdf. The RACGP believes the quality use of medicines requires the close cooperation of all prescribers before the addition of any new medication. Poly-pharmacy (the concurrent use of 5 of more prescription medications), over-the-counter or complementary medicines, constitute a particular risk. Collaborative Care Agreements should clearly state the extent to which any drugs may be autonomously prescribed by the NP as well as make clear the importance of involving the usual care GP in avoiding drug-drug or disease-drug interactions, especially in the elderly or those with comorbidity. Medication misadventure is a common cause of adverse patient events, avoidable hospitalisation in the elderly and indemnity risk.

2.8 Collaborative care protocols for consultation, referral, and/or transfer to a medical practitioner

It is important that collaborative care protocols for consultation with, or referral or transfer to a medical practitioner, are discussed in detail, and clearly identified in the Agreement, including:

- which patients need to be reviewed
- when this should occur
- the preferred method of contact (phone and/or face-to-face appointment)
- when the GP expects to be contacted
- when the NP expects GP support and anticipated turn-around times.

Additionally, the preferred means of patient follow up (for example face-to-face with patient or via phone), should also be agreed and appropriately documented.

2.9 Protocols for after hours care and emergency

Appropriate cover if the collaborating GP is unavailable, as well as urgent and emergency care, should be determined and agreed upon.

The effective follow up of abnormal and life threatening results relies on robust and reliable systems for contact and escalation of care. For after hours care, it is

recognised that seriously abnormal and life threatening results do not arise frequently, but when they do occur, prompt and adequate follow up is an important issue affecting patient safety.

There must be arrangements in place to allow seriously abnormal and life threatening results identified by a pathology provider to be conveyed to both the GP and the NP in a timely way, so that the GP and NP can make an informed and appropriate decision that is acted on promptly.

The Agreement will involve consideration to agreed systems and escalation protocols for:

- all abnormal results
- patients in severe pain
- emergencies, including unstable vital signs, bleeding, and changing conscious states.

The appropriate protocol in these situations should be linked with the GP and practice, and an emergency handover protocol should be in place.

2.10 Ongoing review of collaborative agreements

In order to determine how well the Collaborative Care Agreement is working in practice, a review procedure should be in place (eg. weekly, monthly, quarterly, yearly) as deemed appropriate by the GP and NP. A provision regarding how best to handle possible issues and disputes is equally important, and should therefore also be clearly outlined in the agreement. The review of the Collaborative Care Agreement should be a positive initiative to identify opportunities for the initial suggested review period, and could be triggered early by either party if concerns are raised.

2.11 Arrangements for terminating the Collaborative Care Agreement

The need for possible termination of the Collaborative Care Agreement should be agreed and clearly outlined, including both specific events (eg. changes in practice location or patient circumstances) and agreed timeframes.

2.12 Remuneration for non-MBS reimbursed support

Remuneration for non-MBS related issues should be discussed and agreed. GPs and NPs who have entered into a Collaborative Care Agreement will be able to charge MBS items, as per usual, for seeing patients.

However, there may be services provided by the GP that are not covered by MBS items, such as telephone advice and e-consulting with the NP. Appropriate remuneration for telephone discussion and e-consulting should be clarified and clearly identified in the agreement.

If the patient is fee paying, patient consent should be obtained. Therefore, a means for obtaining patient consent should also be discussed and clearly identified in the agreement.

2.13 Nurse practitioners' indemnity

GPs entering into a Collaborative Care Agreement with eligible NPs should be aware of the associated medical indemnity issues.

In order to be registered, medical practitioners must have appropriate medical indemnity insurance to cover their scope of practice. Currently, medical indemnity insurers offer a policy limit of $20 million for medical practitioners per claim, which includes unlimited cover for claims over insurance limits.

Similarly, in order to be registered, NPs must have appropriate professional indemnity insurance while they are practising nursing. Nurse practitioners have differing indemnity insurance depending on their scope of practice and the associated risk. Therefore, insurance for NPs varies, and cover limits can range from $5 million to $10 million per claim. However, insurance for NPs may not include unlimited cover for claims above the insurance limit, and this should be clarified before entering into a Collaborative Care Agreement with a NP.

GPs should seek advice from their medical defence organisation if they are unsure of the implications associated with NP indemnity insurance.

2.14 Legal implications of the Collaborative Care Agreement

A Collaborative Care Agreement, like any other contract, is a legally binding document and should not be entered into lightly. It is important that rights and obligations are clearly specified as the document will be the sole repository of the terms upon which the relationship (including shared patient care and legal responsibility) is based.

Medical practitioners should seek advice from their medical defence organisation if they are unsure of the legal implications and ramifications of Collaborative Care Agreements.

2.15 Patient consent arrangements

All patient consent arrangements, particularly regarding continuity of clinical information flow with the patient's usual GP, and non-MBS funded billing, should be identified, agreed and recorded as part of the agreement.

4. Collaborative Care Agreements – template

This guide should be used in conjunction with the Collaborative Care Agreement template for nurse practitioners, which reflects the issues covered in this document. The RACGP Collaborative Care Agreement – general practitioner/s and nurse practitioner/s can be downloaded at www.racgp.org.au/practicesupport/cca.

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