Collaborative Care Agreements
Facilitating Effective Transitions of Care

What is a Collaborative Care Agreement?

A formal document outlining the mutually agreed upon roles and responsibilities of partners related to the care needs of patients transitioning within the Health Neighbourhood. This can include expectations of partners related to 2-way information sharing, packaging of information, appropriate access targets for services and warm hand-offs at transition points. Collaborative Care Agreements can be created between primary care, acute and community partners to facilitate transition processes such as those from Home to Hospital to Home (H2H2H) as well as between primary care and community specialists or programs.

Why are Collaborative Care Agreements Important?

These agreements can help to facilitate safe and effective transitions of care, reduce the chances of patients and information falling through the cracks, help to improve the overall efficiency of care process and improve integration within the health neighbourhood.

4 Key Elements of a Collaborative Care Agreement:

1. Defining the work
    - This is the crucial step where partners collaboratively identify the key components of the work involved in transition of care, identify the required information to support care processes, and agree who is responsible for each step.
    - An important component of defining the work includes identifying how information should be appropriately packaged by the "sender" to meet the "receiver's" needs.
2. Mapping the transitions process
    - Identifying the series of steps required to facilitate the transition process from sender to receiver is critical. Identifying the process steps will allow partners to clearly define the work and responsibilities, identify where delays may occur and identify how to measure these delays.
3. Identifying and minimizing delays
    - Effective transitions require that delays involved in the flow of information as well as physical flow of patients between Health Neighbourhood partners are identified and reduced or eliminated to best meet patients' needs. Access to services and information is critical for patients to experience effective, seamless and safe care coordination.
4. Auditing the process and continuous improvement
    - With a goal of minimizing delays and errors in transition processes, continuous measurement, auditing and improvement activities will ensure that transitions of care best serve the needs of patients and providers and that collaborative care agreements effectively drive positive behaviour improvements between senders and receivers in the Health Neighbourhood.

Example Considerations for a Collaborative Care Agreement for Home to Hospital to Home (H2H2H) transitions:

	Primary care physician and team agree to:	Acute care physician and team agree to:
At time of hospital admission	• Confirm the patient attachment and provide relevant information to hospital to assist with care processes	• Confirm the patient's primary care physician and notify them if the patient is admitted
During the patient's hospital stay	• Provide relevant information to acute care to assist with transition planning • Confirm receipt of transition care plan	• Coordinate with the family physician, patient and family to coordinate community supports post-discharge • Collaboratively create a transition care plan to facilitate effective transition out of hospital
After discharge from hospital	• Provide a timely post-discharge appointment for appropriate patients • Arrange necessary post-discharge tests/procedures • At follow-up visit review and follow transition care plan recommendations including medication reconciliation, ordering outstanding tests, etc. • Continually measure and improve the effectiveness of care coordination processes	• Coordinate with primary care physician to arrange a post-discharge follow-up appointment • Clarify any outstanding questions from transition care plan • Continually measure and improve the effectiveness of care coordination processes

References:

1. College of Family Physicians of Canada. Best Advice guide: Patient's Medical Neighbourhood. Mississauga, ON: College of Family Physicians of Canada; 2020. https://patientsmedicalhome.ca/files/uploads/PMN_BAG_ENG.pdf

2. Mark Murray & Associates. Service Agreements. 2012.