Collaborative Care Agreement

Nebraska Western Iowa

Veterans Health Care System

March 2011, Version 14.0

Service Agreement and Consult Process:

Patient services at the VA Nebraska-Western Iowa Healthcare System occur through an organized and systematic process designed to ensure the delivery of safe, effective and timely treatment focused on the veteran through the patient aligned care teams (PACT).

Patient care encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and research. The medical staff, nurses, and allied healthcare professionals function collaboratively as a part of an interdisciplinary team to achieve positive patient outcomes.

Purpose:

The purpose of the service agreement is to define relationships between primary care (referring provider) and specialty care/surgical care service lines (henceforth referred to collectively as specialty care). The agreement defines the work flow rules in order to improve the referral process, reduce the demand for specialists, and decrease any delay in care. The goal of the service agreement is to have the referring provider "send the right work, packaged the right way" to the specialty provider. In turn, the specialty provider s are expected to be "accessible for the right work, right away."

Process:

The General Service Agreement below details a common process for all specialty agreements with primary care and is based on requirements outlined in **VHA Directive 2008-056 and VHA Directive 2010-027**. This General Agreement outlines work flow rules for both the referring provider and the specialty care provider. The goal of the agreement is to provide the best clinical care possible in a coordinated fashion with minimal delays. The consult process assumes equitable ownership of the patient with regards to the problem for which the consultant is giving an opinion and thereby equitable ownership of the work load in caring for that patient with regards to the problem for which the consultant is giving an opinion. The work flow process for consults will be implemented though the CPRS Consult Package and will reinforce the service agreements between the referring provider and specialty care. The CPRS Consult Package will be one tool used to monitor the compliance of the agreement below.

Each specialty will list the particular services that they provide specialty care for at NWI identified below in the Specialty Care Service Agreement. The Specialty Care Service Agreement will provide detail for those elements in the General Service Agreement where required (*).

General Service Agreement:

1. **Statement of specific services to be covered by specialty care (*)**
    a. Referring provider:
        i. Review indications guidelines from specialty upon when to refer care to specialty
        ii. Referring provider is responsible for making sure that the patient has clear understanding about and buy-in for the referral to specialty care. See Appendix B
        iii. Contact specialty care provider when in doubt regarding referral either via phone or question only consult.
        iv. Reason for referral must be specific and clearly stated in referral.
    b. Specialty care:
        i. Will provide list of specialty care services at NWI.
        ii. Services that are not routinely provided at NWI but are usually sent to Fee Basis should be listed if known.
        iii. For each service provided, each specialty will provide the following information as applicable (see example: www.mamc.amedd.army.mil/Referral/guidelines/index_rgli.htm) :
            1. Diagnosis/Definition
            2. Initial Diagnosis and Management
            3. Ongoing Management and Objectives
            4. Indications for Specialty Care referral.
                a. EBM Indications for referral
                b. Referral/Procedure Not helpful for…
                c. Referral/Procedure Contraindicated for…
                d. Referral/Procedure Gray Area…
            5. Criteria for return back to Primary Care
        iv. Specific question on the referral will be addressed by specialty service
2. **Prerequisites (*):**
    a. Referring provider:
        i. Accepts dual ownership of the patient with specialty care in getting prerequisites completed. See Appendix C

ii. Provides sufficient history in consult to allow consultant to make informed decision
iii. Orders Pre-requisite imaging/procedures

b. Specialty care:
   i. Accepts dual ownership of patient with referring provider. See Appendix C
   ii. Provides evidenced based pre-requisites
   iii. Does not discontinue consults with incomplete pre-requisites. They can be *denied* such that the sending provider can resubmit the consult request upon completion of the pre-requisite studies. However, if the consult is denied the specialty case manager will ensure notification to the PCP's designated patient care coordinator for appropriate handoff of patient care. Prior to resubmitting the consult the PCP will ensure pre-requisites are achieved and results are available for the specialist accordingly.
   iv. Follow up on test results ordered by specialty service. The ordering provider is responsible for initiating appropriate clinical action and following up on the results of any orders which they have placed (VA Policy, COS-061).
      1. Thus, abnormalities unrelated to the consult question which are noted on tests/studies for specialty care which are ordered by the specialist service and are not ordered by the referring provider need to be addressed initially by the specialty care provider who ordered the test/study.
      2. If follow up is needed in primary care for treatment of problem unrelated to the initial consult, it is the responsibility of the specialist to contact the primary care provider of these abnormal results so that follow up can be arranged.
         a. If emergent or urgent follow up is indicated, a page/phone call to the primary provider listed on the top of CPRS is indicated.
         b. Non urgent follow ups can be done electronically.

      3. The patient should be notified of the abnormal finding by the provider who ordered the test. Thus, specialist providers are responsible for notifying patients of the complete test results which are ordered by specialty service, including results unrelated to the initial consult.
         a. If handoff to the primary care provider is needed for follow up of the problem, the ordering specialist provider should state this to the patient. This way the patient is notified immediately and can help facilitate follow up if there is a problem with the handoff.

3. Co-management of Patients in primary and specialty care

a. Referring provider:

i. Accepts dual ownership of patient with specialty provider.
ii. Informs consultant services and helps coordinate appropriate follow up when the status of problem changes for which the primary provider has consulted the specialist.
iii. Orders prerequisites as indicated in Specialty Care Service Agreement.

b. Specialty provider:

i. Accepts dual ownership of patient with referring provider for the clinical problem/question for which they are consulted.

ii. Orders recommendations for care (medication changes, further studies, etc) which are made by specialty services in outpatient setting needs to be ordered by specialty care. Recommendations by specialty care on inpatient service can be ordered by specialty care only if primary team is notified and is in agreement.

iii. Informs the patient of the results of studies ordered by specialty care will be the responsibility of the specialty service, not the primary care provider.

iv. Follows and manages the patient for the clinical problem until problem is resolved or patient meets criteria for discharge back to primary care as stated in service agreement. Informs primary provider of recommendations from follow up specialty clinic as needed.

4. Criteria for discharge from specialty care (*):

a. Referring provider:
i. Accepts management of patient into primary care when subspecialty care discharge criteria have been met
b. Specialty Care:
i. Define specific criteria for when patients can be referred back to primary care
ii. Actively discharges patients from specialty care services when criteria for discharge to primary care have been met. This will open up more clinic appointments for new and more urgent specialty care visits.
iii. Notifies referring provider that patient is discharged from clinic for this specific problem.

5. Timeframe for response from consultant.

a. Referring provider:

1. Desired date of appointment is recorded. The desired appointment date is the date on which the patient or the provider wants the patient to be seen.
2. Initial consult results are tied to CPRS consult Tracking Package in CPRS and referring provider is responsible to read these results.

b. Specialty care provider:
   i. Inpatient within 24 hours
   ii. Outpatient

      1. Emergent Referral is completed within 24 hours

      2. Urgent Referral consult is completed within 7 days

      3. Routine Referral consult is completed within the timeframe benchmark for access as set by VA/VISN.

      4. Routine referral requires electronic consult request completion. Desired date needs to be accommodated. The desired appointment date is the date on which the patient or the provider wants the patient to be seen.

   iii. Initial consult results are tied to CPRS consult Tracking Package in CPRs and specialty provider is responsible to attach initial consult note to the consult request.

   iv. Subsequent follow up appointments (not initial appointment) in specialty care clinics at the discretion of specialty care.

6. Communication regarding results between referring provider and specialty care:

a. Outpatient referring provider.

   i. Primary care will establish a nurse (RN or LPN) to coordinate communication between primary care and specialty services. There will be single contact phone number made available to specialty services for urgent referral to primary care providers. This phone service will be coordinated by a primary care nurse who will relay (hand off) information to appropriate provider. This will minimize the handoff difficulties for specialty services.

   ii. Referring provider will be available by pager for specialty care to contact if provider to provider communication is necessary. This pager contact information for both attending and the assigned resident is listed at the top of CPRS by clicking on middle box where primary care assignment is listed.

1. If the referring resident provider is unable to be reached, the primary care nurse coordinator or the attending of record for primary care (listed at the top of CPRS) needs to be notified.

iii. Urgent Referral to primary care includes a phone call to nurse patient care coordinator (see above) and/or provider as indicated.

iv. Routine referral requires return to clinic appointment order for primary care.

v. Initial consult results are tied to CPRS consult Tracking Package in CPRS and referring provider is responsible to read these results.

vi. Emergent referral to specialty services requires phone call to specialty service on call and an electronic consult request completion. The call schedule is listed in CPRS Tools section under Clinician tools.

vii. Urgent Referral to specialty care includes phone call and electronic consult request completion. The call schedule is listed in CPRS Tools section under Clinician tools.

viii. Routine referral to specialty care requires electronic consult request completion

b. Outpatient Specialty provider

i. Specialty care will be available by pager within 1 hour for emergencies. The call schedule is listed in CPRS Tools section under Clinician tools.

ii. Emergent Referral requires that patient be seen within 24 hours

iii. Urgent Referral requires that patient is seen within 7 days

1. Routine referral requires that the patient is seen within timeframe benchmark for access as set by VA/VISN.

iv. Initial consult results are tied to CPRS consult Tracking Package in CPRS and referring provider is responsible to read these results. The referring provider is not added on the initial consult as an additional signer because the CPRS Consult Tracking Package sends the initial consult results to the ordering provider.

v. Subsequent follow up visits need to be documented in CPRS electronic progress notes by specialty care provider. If the specialty services feel that the referring

provider needs to be aware of the subsequent visit outcome, then the referring provider needs to be added to note as additional signer.

c. Inpatient Referring Provider:

    i. All requests for consults on inpatient service will be called to inpatient specialty service and electronic consult for inpatient will be completed as well.

d. Inpatient Specialty Provider:

    i. All requests for consults will be seen and staffed within 24 hours of consult being placed.

    ii. Staffed inpatient notes need to be signed by specialty attending within 24 hours of consult being placed.

    iii. Results of recommendations from consult service will be called to inpatient team when completed. If the inpatient referring team/resident physician is not available, the specialty service is to call the attending provider for the patient on the inpatient team listed on the top of CPRS.

7. Scheduling Consults:

a. Referring provider:

    i. Prerequisites must be met if the patient is to be directly scheduled into specialty care without review by specialty services

    ii. If a patient does not need to be seen by specialty care but a question still needs to be answered, a question only consult can be submitted.

    iii. The initial consult to specialty care is considered active for one calendar year for the same diagnosis unless the specialty care service deems continued follow up appointments in specialty care are necessary.

        1. This applies to those patients who were seen on the inpatient service and need outpatient follow up. A new consult is not needed.

    iv. If a new problem arises, a new consult will need to be placed. However, exacerbation of an already established diagnosis to specialty clinics will not

require a new consult, unless it has been at least two years from initial specialty visit for that problem and the patient has not been seen in over 2 years.

v. Return to clinic (RTC) appointment order set for return to specialty care will be available in CPRS menu for inpatient and outpatient order sets.

1. The referring provider should use this order set for returning those patients to specialty care that are already established in that clinic for the same reason that the patient was initially seen by specialty care. Thus, only those patients who are actively enrolled in specialty care clinic and are established patients can use the RTC appointment order set.

2. The referring provide should NOT submit a new consult for those patients who are actively followed by specialty care service but instead use the RTC appointment to do so.

3. If the indication has changed, the specialty clinic can require a new consult be placed.

8. The initial appointment must be made by contacting the patient in person or by telephone to ensure desired date is achieved and to minimize no-shows.
9. If the veteran no shows for the appointment, the veteran needs to be contacted by phone to reschedule the appointment (VA Policy AMB-005).
    1. If the veteran is unable to be reached by telephone a letter (see **Appendix D**) will be sent informing them of their failure to report and information on how to rescheduled their appointment by contacting the clinic.

    2. The consult can be cancelled if no contact can be made. The consult should not be discontinued.

b. Specialty care providers (*)

i. Review/Deny:

1. If prerequisites are met by referring provider, referring provider's clerks can directly schedule patient into specialty care clinic without review by specialty services (VHA Directive 2010-027, pg 6; VHA Directive 2008-056, pg2)

2. If review of consult is felt to be necessary

    a. The reviewer must be at the level of a physician or staff mid-level provider (APRN or PAC) with expertise in the specialty care and as agreed upon within the scope of practice agreement with the midlevel provider and the physician.

    b. Triggers for review need to be established by specialty service

    c. Review of consults need to be completed within 72 hours to ensure adherence with timeliness standards.

3. If a consult is to be denied based on clinical reasoning, then the specialty attending will need to be informed and documented that they concur. Reasons for the denial need to be made in the progress notes section of CPRS.

4. It is the responsibility of the specialty service to notify the patient in the event that the consult is denied. This needs to be documented in the medical record that the patient was notified.

ii. Discontinue:

1. Consults can be discontinued by ordering provider only

2. Reasons for discontinue include:

    a. Patient is dead

    b. Patient does not want consult

    c. Patient seeks care for his/her medical problem at an outside medical institution.

    d. Patient is ineligible for VA service

iii. Cancellation of Consults

1. Reasons for cancelling consult:

    a. Patient is dead

    b. Patient does not want consult

    c. Patient seeks care for his/her medical problem at an outside medical institution.

d. No-show x2

e. Patient is ineligible for VA service

2. Cancelled consults for above reasons need to be documented in the medical record in the progress notes.

iv. Follow up of Established Patients in Specialty Care

1. Return to clinic (RTC) appointment order set for return to specialty care for established patients needs to be available in CPRS menu for use by referring providers inpatient and outpatient order sets.

2. The initial consult is considered active for one calendar year for the same diagnosis unless the specialty care service deems continued follow up appointments in specialty care necessary. If a new problem or exacerbation of the old problem arises after one calendar year from the date of the initial consult and the patient has had no ongoing follow up with the specialty care clinic, a new consult will need to be placed.

v. Specialty care will remind patient of specialty care appointment either through reminder material or call before appointment

10. Question Only consults

a. Referring provider:

i. A specific question for the specialty service which does not meet criteria for referral but would like input from specialty service would best be addressed by question only consult.

ii. Referring providers are not to assume that the patient will be scheduled in specialty clinic when question only consult is completed. This is not a short cut to an appointment in specialty care.

b. Specialty Care (includes specialty, surgical, radiology, etc…):

i. All specialty care services will have a question only consult option. **(VHA Directive 2008-056)**

ii. The patient does not need to be seen to complete the question only consult

iii. All question only consults will be completed as would a regular consult with a consult note.

iv. If specialty care feels that additional information is needed, they can ask the referring provider to complete any prerequisites and then submit a full consult request.

v. If specialty care feels that the patient needs to be seen in order to answer the question asked, then they can make the consult into a full consult and book the patient into an appointment if this is appropriate.

vi. Answering a question only consult does not obligate the specialty service to see that patient or to follow up on any data. There is no formal doctor patient relationship established with the question only consult and the specialty provider is not obligated to follow up on the patient outside of answering the expert opinion.

vii. All question only consults will be completed by physician, or physician assistants or APRN with expertise in that specialty care.

11. CPRS Consult Package Process:

    a. Specialty service completes consult using a note that is tied to the consult request. All consults must be completed with a progress note.

    b. No recommendations/results of the consult can be added as a comment to the consult. The consult must be completed in all cases with a progress note.

    c. The titles for the specialty service notes in CPRS will be consolidated as much as possible. These titles will be added to the specialist's title menu for progress notes by CAC.

    d. Consults are to remain in effect for a specified problem for 364 days beyond the initial consult request. If the same service is seeing the patient for a different problem within that 364 days time frame, a new consult will be needed.

    e. Consult services will have an order menu available for patients to be returned to specialty clinic for follow up of the original problem within the 364 days. If a patient needs to return to specialty care for the same problem, the order for return to specialty clinic will be used in lieu of a new consult request.

12. Review and Auditing of Service Agreements

    a. Service agreements will be audited for compliance by Service Agreement Steering Committee at least annually and on an as needed basis. Both referring provider and specialty care services will be audited.

b. Metrics for Audit include:

    i. Appropriate referral as outlined in Service Agreement

    ii. Required information provided by referring provider present

    iii. Compliance with agreed upon time frame for consult by specialty service

    iv. Appropriate follow up of patient until problem is resolved or patient meets criteria for discharge from specialty service

    v. Percentage of Consults completed with a note

    vi. Patient satisfaction

    vii. Referring provider satisfaction

    viii. Specialty provider satisfaction

c. Problems discovered in routine audits will be mediated by Service Agreement Steering Committee and problems with process will be addressed in a timely fashion.

d. Each service will have annual review of Specialty Service Agreement

Appendix A:

Definitions:

Referring provider:	The provider who initiates the consult process. Typically this is primary provider either in primary care clinic or on inpatient internal medicine ward service; however, this can be a subspecialty service requesting another subspecialty service or requesting primary care service/internal medicine service.
Specialty Care:	The provider who is providing content expert for service that is requested.
Desired Date:	The desired appointment date is the date on which the patient or provider wants the patient to be seen. The provider specified time frame for the appointment needs to be the date of the provider request, unless otherwise specified by the provider. Thus, the clock starts at the time of the referring provider request, unless another date is specified by the referring provider. Per VHA directive 2010-027 pg7, once the desired date has been defined, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.
Discontinued consult:	Specific reasons for discontinuing the consult must be met as listed above. The clock stops when a consult is discontinued and the consult must be rewritten/reentered into CPRS if the consult is to be requested again. Discontinued consults cannot be resubmitted. The consult can be discontinued only by the referring provider.
Denial of Consult:	Consultant is refusing to have the patient seen by the specialty care service at the time the consult is submitted. The ability to use this CPRS function is limited to reasons listed above and the mechanism for how this is done is detailed above. The referring provider can resubmit the consult when the consult is denied. The clock does not stop when a consult is denied and thus we are able

to track the time it takes for specialty service to provide the requested consultation.

Cancelled Consult: The consult can be cancelled by the specialty provider for specific reasons listed above. The clock does not stop when a consult is cancelled and thus the consult can be resubmitted at a later date if desired.

Appendix B:

Examples of handouts for Primary Providers to give to patients for referrals. Each Specialty Service could develop a similar handout.

HEART DOCTOR=Cardiologist

Your primary care doctor is planning on sending you for a visit with the heart doctor. Your visit to see the heart doctor *does not necessarily mean* that you have a problem with your heart. It may be that the symptom that you are having can be seen with heart problems and your primary provider wants the expert opinion of the heart doctor to see if your symptom is (are) coming from the heart.

The clinic for the heart doctor is located in XXXX clinic at the Omaha VA. They will send you an appointment date in a letter.

You may need to get a test done before you see the heart doctor. These tests will be ordered by your primary doctor and need to be completed before you see the heart doctor. It is important that you get these tests done before your visit with the heart doctor as this will help the heart doctor make a decision about the condition of your heart.

If you do not want to be seen by the heart doctor or if you do not want to have any tests done on your heart, please notify your primary care nurse patient care coordinator:
_____at XXX-XXX-XXXX.

Appendix C:

Examples of Best Practice when there are issues with the consultation:

1. Imaging is ordered by PCP and orders are in CPRS. The test has not been scheduled (for whatever reason) when the consult is reviewed by Specialty Care Services. The Specialty care team becomes aware that this is not yet scheduled and denies the consult (consult IS NOT discontinued). The Specialty team should schedule the Imaging to facilitate patient care as they are aware that it has not yet been scheduled. Once the specialty care is aware of a problem in the process, they become part of the loop and also are expected to become part of the solution to the problem. Both Primary care and Specialty care nurse patient care coordinators should assume responsibility of coordinating this to ensure that patients are not lost in the process. Coordination between nurse care managers should help facilitate this process.

2. Imaging studies have been completed at outside hospital in appropriate time frame as acceptable to the consultant. This is noted in the consult request. Specialty service reviews the consult and notes that the records are not yet available in CPRS. The Specialty care team denies the consult. The specialty services should follow up on getting the test results that they need by contacting the patient to get those records brought in to the VA for placement into the CPRS chart. Both Primary care and Specialty care nurse patient care coordinators should assume responsibility of coordinating this to ensure that patients are not lost in the process. Coordination between nurse care managers should help facilitate this process.

3. Patient has diagnosis that the primary provider has a requested a specialist opinion to review. The consultant reviews the consult and determines that nothing needs to be done because the consultant usually does not do anything with that diagnosis. It would appear then that the primary provider is unaware of what is typically done for that particular diagnosis and a face to face consult for the patient with the specialty doctor would not be needed. Ideally, the referring provider would have treatment protocol for this diagnosis made available for review prior to submission of the consult. However, not all contingencies can have treatment protocol available. Thus, the best practice would then be for specialty provider reviewing consult to put a consult note into the computer (closing out the consult as if it were a question only consult) and notify the referring provider regarding this. If the diagnosis is one that is frequently referred to the consultant when not needed, then it would be beneficial for the consultant to provide treatment algorithm for this particular diagnosis with guidelines for when it is appropriate to refer to the specialty provider.

Appendix D

Dear Veteran

According to our records, you did not report for you appointment on:

Day of week, Month, day, year….at the……Clinic Name

This may have occurred due to improper notification on our part or an inability or unwillingness to attend on your part. In order to provide optimal medical care, it is necessary for you to attend clinic appointments. Missed appointments can potentially result in a delay in identifying and treating illness or lead to complicated hospitalizations.

Failure to keep appointments may also result in delayed care for other veterans waiting to be seen. In the future, if you no longer want an appointment or need to reschedule, please contact the relevant clinic. Doing so will allow us to schedule another veteran at that time.

YOUR APPOINTMENT HAS NOT BEEN RESCHEDULED. IF YOU WISH TO RESCHEDULE, PLEASE CALL: (Appropriate scheduling number).

Sincerely,

SIGNATURE

TITLE