September 16, 2008

VHA CONSULT POLICY

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines policy for management of the clinical consultation process and describes processes of care related to those consults associated with clinical consultation. *NOTE:* This Directive is not relevant for other uses of the consult functionality, such as requesting prosthetic items.

2. BACKGROUND

a. A clear and solid consultation process is vital to patient care. The consultation process works best when there is a relationship between the sending and receiving services (in addition to those between sending and receiving facilities), where defined work flow rules exist. Effective use of service agreements improves the relationship, establishes clear processes, and reduces the need for inspection and rework. Creation of consult templates in the Computerized Patient Record System (CPRS) can operationalize service agreements, enhancing the effectiveness of referrals. CPRS has a consultation functionality that is widely used for communication of patient issues beyond strict clinical consultation.

b. **Definitions**

- (1) **Consult Tracking.** Consult tracking is a CPRS functionality that facilitates documented communication of patient specific activities, which can be either clinical or administrative in nature.
- (2) **Consult.** A consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests and subsequent activities.
- (3) **Clinical Consultation.** A clinical consultation is provided by a physician or other health care provider in response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem (e.g., consult to Dermatology for rash). A clinical consultation request is initiated by a physician or appropriate source with the clear expectation that a reply will be provided in a timely fashion.
- (4) **Non-consultative Service Request**. A non-consultative service request is sent using the CPRS consult functionality for a purpose other than a clinical consultation, i.e., a request to Dermatology for a non-formulary approval or request to reschedule a no-show.
- (5) **Service Agreement.** A service agreement is an agreement or understanding between any two or more services, one of which sends work to the other(s), defining the work flow rules. The agreements may exist within one facility or between two or more facilities. Typically this is a written document that is developed based on discussion and consensus between the involved

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services and facilities. The document is signed by service chiefs from the involved services. *NOTE:* See Attachment A for recommended content for service agreements.

- **3. POLICY:** It is VHA policy that all requests for clinical consultation be clinically completed with results consistent with VHA timeliness standards and resolved efficiently taking into account individual health care needs.
- **4. ACTIONS:** In order to provide timely and clinically appropriate care to all veterans, all requests for clinical consultative services must be resolved efficiently taking into account individual health care needs.
- a. <u>Director of VHA Systems Redesign.</u> The Director, VHA Systems Redesign (10NSR), is responsible for overall oversight of implementation of requirements of this Directive, to include measurement and monitoring of ongoing performance.
- b. <u>Veterans Integrated Service Network (VISN) Director.</u> Each VISN Director, or designee, is responsible for the oversight of the consultation process.
 - c. **Facility Director.** Each facility Director, or designee, is responsible for ensuring:
- (1) The CPRS consult functionality is the mechanism used to initiate, manage, and communicate clinical consultations.
- (a) Clinical consultations that can be resolved without a face-to-face encounter need to be answered electronically and the consult completed without scheduling an appointment. All other clinical consultations must be acted on by scheduling an appointment within VA's established timeframe or documenting the reason why an appointment is not scheduled within the timeframe. Facility staff must ensure outpatient appointments created in response to CPRS intra-facility and inter-facility consult requests are effectively linked in VistA to the specific CPRS consult request.
- (b) Facility staff must understand the recommendation that urgent or emergent requests for a clinical consultation are verbally communicated in addition to sending an electronic clinical consultation.
- (2) The preferred strategy for scheduling is used, i.e., having the referring providers' teams schedule as many clinical consultation appointments as possible on the day the consult is ordered before the patient leaves the referring provider team area.
- (3) Effective use of service agreements, well-designed communication processes, and effective electronic templates are in place in order to obviate the need for review of consults before scheduling. The ideal process is direct scheduling of consult appointments without clinical review by the receiving service. If review is necessary, however, it needs to be performed on a regular, timely basis to ensure adherence with timeliness standards.

- (4) Procedures are established to track and process clinical consultation requests that are without action within 7 days of the request.
- (5) Needs of patients who fail to keep an appointment are addressed. When a patient fails to keep a scheduled consultative appointment, the receiving service must reassess the need for service and either reschedule the appointment or cancel the consult request, as appropriate.
- (6) When the receiving service or provider cancels a scheduled consultative appointment, the receiving service or provider reassesses the patient's clinical need and reschedules the appointment as expeditiously as possible.
- (7) Reports of consult requests are attached to the consult request in the CPRS consult package. This enables the requestor to be alerted to the report's availability and ensures that the results are available and easily identifiable.
- (8) Non-VA care is utilized in accordance with regulatory authority when service is not available in a timely manner within VHA due to capability, capacity, or accessibility.
- (a) Availability of non-VA care and access to VA care must be taken into account before non-VA care is authorized. Analysis of costs of care needs to be undertaken at appropriate intervals to determine if services could be more efficiently provided within VA facilities.
 - (b) Use of Purchased Care is to be considered <u>only</u> when:
- <u>1</u>. The patient can be treated sooner with purchased care than at VA and the service is clinically appropriate and of high quality.
- <u>2</u>. The request for consultative care can be resolved efficiently including having results available to the referring provider in a timely manner.
- (9) That when VHA obtains care outside VA, the results are made available to the referring provider within CPRS in a timely manner.
- (10) Appropriate checks and balances are in place <u>before</u> the consult request for non-VA care is closed out, to ensure the clinical documentation from the non-VA provider is obtained and scanned into CPRS and attached in the consult package in the patient's medical record. This information is not required before payment is made.
- **5. REFERENCES:** None.
- **6. FOLLOW-UP RESPONSIBILITY:** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to the Director, Systems Redesign Program at (605) 720-7174.

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7. RESCISSIONS: None. This VHA Directive expires on September 30, 2013.

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ATTACHMENT A

RECOMMENDED CONTENT FOR SERVICE AGREEMENTS

- 1. The service agreement is a written agreement made between any two or more parties, where one party sends work to the other, outlining the work flow rules. The agreements may exist within or between facilities. They are developed by consensus; signed by service chiefs from involved services; reviewed or updated as changes are needed, at a minimum annually; and audited.
- 2. The service agreement is available for reference by posting on the facility or Veterans Integrated Service Network (VISN) website, as appropriate.
- 3. The service agreement must contain, at a minimum, the following elements:
- a. The services covered by the agreement are listed and defined in order to clarify which topics are selected to be covered by the service agreement.
 - b. The timeframe expected for response from the consultant is established.
- c. Judicious and appropriate history, physical, and diagnostic information from the sending provider are provided in order to put the consultant in a position to be able to make a patient care decision on the initial visit.
- d. Criteria for discharge from specialty care. It is the expectation that patients are discharged from the specialty clinic once consultation and any needed procedure and follow-up is completed. If ongoing care is co-managed by both the sender and consultant, responsibilities must be clarified.
- e. The method for communicating recommendations and treatment plan back to the referring clinician is delineated in order to simplify, standardize, and clarify communication.
- f. The agreement has a review and renewal date. *NOTE:* An annual timeframe is recommended.
- 4. Additional valuable elements may include:
- a. Concurrence signatures of the written agreement by the involved service chiefs, as well as the Chief of Staff (or the Chiefs of Staff and VISN Chief Medical Office in the event the request is for an Inter-facility Consult (IFC)).
- b. Definition of a method for accessing consultants outside of the formal consultation process, so questions may be asked or advice given, potentially avoiding the need for formal consultation.

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- c. Definition of a method for immediate access to the consulting service for clinical issues that need urgent or emergent attention.
- d. A description of how primary care and specialty care evaluate and monitor the service agreement, including identification of data sources.
- (1) Adherence to agreements is monitored by measuring the sender responsibilities of sending the right work (right requests) (see Att. A, subpar. 3a) packaged the right way (correct pre-work is included) (see Att. A, subpar. 3c).
- (2) The receiver responsibilities are measured by auditing adherence to agreed upon timeliness response standards (see Att. A, subpar. 3b).
 - e. CPRS Consultation referral templates.