

CONSULT PROCESSES AND PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides policy for consult scheduling processes and procedures.

2. SUMMARY OF MAJOR CHANGES:

a. Amendment dated April 5, 2021 updates all website links in the directive to the most up-to-date versions and removes General Business Rules Uses of the Consultation Package regarding Community Care Consults to instead reference the Office of Community Care Field Guidebook for additional information (see Appendix B).

b. Amendment dated June 28, 2019, adds and/or clarifies:

(1) Updates the policy statement, changing consults PENDING status no more than 7 calendar days to 2 business days to align with the Deputy Under Secretary for Health for Operations and Management Memo dated June 5, 2017;

(2) Responsibilities for Facility Chief of Staff, paragraph 5.h.; and

(3) Responsibilities for Consult Receiving Services, paragraph 5.i.

(4) The addition of Appendix C, Minimal Scheduling Efforts for Outpatient Appointments.

c. This revised VHA directive provides updates to policies, responsibilities, and definitions for consult processes and procedures. Consult business rules were developed to outline consult set up and usage. Consult processes have been standardized and oversight responsibilities defined. Policy is provided regarding disposition of consults, entry of clinically indicated date, and changes to permitted urgency statuses. All non-mental health consults may be discontinued without provider review after one no show or cancellation, or failure to respond to minimal scheduling efforts in all services as specified in this directive. Low risk consults may be discontinued without rescheduling attempts.

RELATED ISSUES: H.R. 3230 – Veterans Access, Choice and Accountability Act of 2014; VHA Directive 1231, Outpatient Clinic Practice Management, dated November 15, 2016; VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016; and VHA Directive 2007-033, Telephone Service for Clinical Care, dated October 11, 2007.

3. RESPONSIBLE OFFICE: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this directive. Questions

may be referred to the Executive Director, Access and Clinic Administration Program Office via email at 605-720-7174 or VHA10NC10Action@va.gov.

4. RESCISSIONS: VHA Directive 2008-056, dated September 16, 2008, is rescinded.

5. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of August 2021. This directive will continue to serve as national VHA policy until it is recertified or rescinded.

/s/ David J. Shulkin,
M.D. Under Secretary
for Health

NOTE: Amendments to this directive and all active Deputy Under Secretary for Health Operations and Management (10N) memoranda are considered policy and will remain in effect until this directive is recertified. Applicable 10N/USH memoranda are located on the Office of Veterans Access to Care (OVAC) SharePoint site at the following link: <https://dvagov.sharepoint.com/sites/vhaovac/SitePages/Policy.aspx>. **NOTE:** This is an internal Web site that is not available to the public.

NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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CONSULT PROCESSES AND PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for consult management. All national or local policies are superseded to the extent that they conflict with this directive, and will not be followed. VHA's use of the electronic consultation package includes traditional clinical consultation, administrative communication, Community Care coordination (including purchased non-VA care and Department of Defense care), clinical procedures (diagnostic equipment vendor reports), prosthetics and future care. **AUTHORITY:** 38 U.S.C. 7301(b).

2. BACKGROUND

The Computerized Patient Record System (CPRS) electronic consultation software was not uniformly implemented in the past. This led to inconsistent implementation and management of consults. In order to improve the management of clinical consultation processes, VHA is standardizing certain aspects of electronic consultation. These standards aim to improve transparency and timeliness of consult completion while preserving the freedom to use the consult package for administrative uses, prosthetics, and other purposes.

3. DEFINITIONS

a. **Administrative Consult.** An administrative consult is a consult document in CPRS used as one-way communication on behalf of a patient to make a clinical request to transfer care or communicate an order or series of orders. Administrative consult orders include requests to schedule where clinical review is not required.

b. **Care Coordination Agreements.** A care coordination agreement is an agreement or understanding between two or more services within or between facilities, one of which sends work to the other(s), defining the work flow rules. This is a written document that is developed based on discussion and consensus between the involved services and facilities. The care coordination agreement is signed by service chiefs from the involved services. **NOTE:** See appendix A for recommended content for care coordination agreements. This definition does not refer to facility integration across systems or between VA and non-VA providers.

c. **Clinical Consult.** A clinical consult is a consult document in CPRS used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver). The CPRS consult package must be used for all clinical consultations.

d. **Clinically Indicated Date.** The clinically indicated date (CID), previously referred to as the earliest appropriate date, is the date care is deemed clinically

appropriate by the VA sending provider. CID is entered into Consult Request in the field labelled clinically indicated date. The CID determination is made based upon the needs of the patient and should be at the soonest appropriate date.

e. **Clinical Procedures Package with Vendor Interface.** A request for a clinical service when the response includes a computer-generated report that flows from diagnostic equipment (vendor) to the CPRS consult package. VA medical facilities may consider these clinical or administrative depending on whether the consult includes one way or two-way communication. The CPRS consult package may be used for clinical procedures with a vendor interface.

f. **Community Care.** Community Care includes NVCC Consults, Choice, and DoD Care.

g. **Consult.** A consult is a request for clinical services on behalf of a patient. In VHA, consult requests are made through an electronic document in CPRS communicating service requests and/or results.

h. **Consult Status Definitions.** The receiving service must update the status of pending as soon as possible and no later than 2 business days of the request receipt. Merely adding a comment without changing the status from pending is not acceptable.

(1) **Active (a).** This status occurs when a consult is “received” and efforts are underway to fulfill a consult. A consult may also revert to “active” in other scenarios such as when an appointment is canceled or no-showed.

(2) **Pending (p).** This status designates requests that have been sent, but not yet acted on by the receiving service.

(3) **Scheduled (s).** This indicates that an appointment has been made and linked to the consult request. Scheduled status automatically sends an alert to the sending provider. The consult status should not be manually changed to “scheduled” in the consult package, but should be linked to appointments so that the consult status changes when the appointment status is changed.

(4) **Partial Result (pr).** This status designates partial but not complete resolution of the consult request.

(5) **Complete (c).** This status designates completion of the requested service.

(6) **Administrative Complete.** This function may be used by administrative or clinical staff to complete a consult without a consult titled progress note. This function must be used with extreme care in order to avoid compromising care. This status triggers an alert to the sending provider.

(7) **Forward.** This status is selected by the receiving service when the decision is made to forward the consult to another service. This is not used to forward to a

specific provider. Forwarding consults to NON-VA Care Coordination (NVCC) is not allowed. An alert is sent to the sending provider.

(8) **Add Comments.** This function is used to enable and document communication including instructions to the scheduling clerk. Adding comments may trigger an alert to the sending provider depending on consult notification setup.

(9) **Significant Findings.** This function allows a sender or a receiver to flag a consult as containing vital or specific information for special attention. This triggers an alert to the sending or receiving provider.

(10) **Discontinue (dc).** This status is used by the sending or receiving provider to discontinue a consult no longer wanted or needed. If the sender discontinues a consult an alert may be sent to the receiving service. If a receiving provider discontinues a consult an alert must be sent to the sending service. The Consult Resolution notification pathway must be set to mandatory so that a notification will be sent. **NOTE:** See paragraphs 5.I.(6)-(7) for current discontinuation procedures.

(11) **Cancel/Deny (x).** This status is selected by the receiving service to return a consult request to the sender. Cancel/Deny is used if the ordering provider did not ask an appropriate consult question or provide sufficient information. This status may also be used to correct an obvious error in the consult order (e.g., Future Care Consult with CID of Today). Selection of this status sends an alert to the sending provider. Canceled consults are never to be resubmitted if they are more than 90-calendar days old.

(12) **Edit/Resubmit.** This status is used by the sending provider to resubmit a canceled (denied) consult after appropriate modification. An alert is sent to the receiving service.

i. **Earliest Appropriate Date.** The earliest appropriate date (EAD) is the former name of the clinically indicated date (CID) field in the consult template.

j. **E-Consult.** The e-consult clinical consultation is provided by a clinician who provides diagnostic and medical management of a specific patient in response to a request seeking opinion, advice, or expertise. Utilizing information provided in the consult request and/or review of the patient's electronic medical record, the consultant provides a documented response that addresses the request without a face-to-face visit. Sending services may request e-consult; however, receiving consults may choose whether to order a face to face appointment. The receiving service may also decide to complete a face to face consult as an e-consult, if appropriate. E-consults should be promoted to the extent possible because they often allow the consult question to be answered more quickly. E-consults should also be used in the case where the ordering provider did not complete necessary prerequisite tests or treatments. For further details on e-consults, refer to the E-Consults Guidebook at the following link:

<https://dvagov.sharepoint.com/sites/vhaovac/cpm/Shared%20Documents/Forms/AllIt>

ems.aspx?id=%2Fsites%2Fvhaovac%2Fcpm%2FShared%20Documents%2FGuidebooks%2FE%2DConsult%20Guide%20Book%20V%203%2E0%2Epdf&parent=%2Fsites%2Fvhaovac%2Fcpm%2FShared%20Documents%2FGuidebooks. **NOTE:** This is an internal Web site that is not available to the public.

k. **Future Care Consults.** Requests for care where the earliest appropriate date/clinically indicated date is more than 90 days from consult initiation. Future care consults should not be used to address issues of access or availability. Future care appointments may be managed within the consult package using consult titles with the words “future care” or “FC” and with the earliest appropriate date/clinically indicated date field completed by the sending provider. Future care consults may remain in a pending or active status and be scheduled closer to when the appointment is needed. For further details on future care consults, see appendix B, paragraph 6.

l. **Low Risk Clinics.** For the purposes of consult processes, VHA has defined low risk clinics nationally to include: physical therapy, occupational therapy, kinesiotherapy, acupuncture, smoking clinic, MOVE clinic, massage therapy, chiropractic care and erectile dysfunction clinic. A full list of low risk clinics can be found in the VHA Consult SOP at the following link:
<https://dvagov.sharepoint.com/:b:/r/sites/vhaconsults/Consult%20SOPs%20and%20Directives/VHA%20Consult%20SOP%202-24-17.pdf?csf=1&web=1&e=fbajW6>. Facilities may cease efforts to reschedule appointments and discontinue the consult without provider review after one no show or one patient cancellation in these clinics. **NOTE:** This is an internal VA Web site not available to the public.

m. **Community Care Consult.** The Community Care consult must be set up in CPRS and performed as outlined in the Office of Community Care (OCC) Field Guidebook:
<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. **NOTE:** This is an internal Web site that is not available to the public.

n. **Urgency Status.** The urgency status is used by the sending provider to communicate a timeframe when the consult should be addressed. The only two acceptable urgencies are Routine and Stat:

(1) **Routine.** A Routine consult indicates the patient should be seen in accordance with the clinically indicated date.

(2) **Stat.** Stat consults will be defined as an “immediate” need. The sender of a stat consult is required to:

(a) Contact the intended receiver of the consult request to discuss the patients’ situation.

(b) Enter “Today” in the clinically indicated date/earliest appropriate date field of the consult.

(c) Enter “Stat” in the urgency field of the consult.

(d) Before the patient leaves the clinic either schedules an appointment or documents when the patient will be seen.

(e) A stat consult must be completed within 24 hours.

o. Veterans Health Information Systems and Technology Architecture Group Update. Veterans Health Information Systems and Technology Architecture (VistA) menu option that allows the status of multiple consults be updated simultaneously. This process should generally be avoided because of the risk to closing the consult before the needed care. Any use of group closure should be used with strict oversight.

4. POLICY

a. It is VHA policy to ensure timely and clinically appropriate care to all Veterans by standardizing and managing consultation processes. The sending provider determines the CID, which is the date care is deemed clinically appropriate. The CID determination is made based upon the needs of the patient and should be at the soonest appropriate date care is needed. The CID should not be used to indicate the latest appropriate date. The CID may not be changed by the receiving service due to lack of availability of appointments. The date may only be changed if it was entered in error, (e.g. a future care consult with a CID of today). The date must either be manually entered into the consult order or generated through an order menu that includes the CID. The CID should be entered into the scheduling package when the appointment is made.

b. Consults should remain in PENDING status no more than 2 business days from the consult creation date. Prosthetics consults and future care consults are exceptions and may remain PENDING for longer than 2 business days.

c. All non-mental health consults can be discontinued without provider review after a single no show or patient cancellation. Low risk consults do not require rescheduling attempts prior to discontinuation after one no show or one patient cancellation.

5. RESPONSIBILITIES

a. Under Secretary for Health. The Under Secretary for Health has the overall responsibility for consults in VHA.

b. Deputy Under Secretary for Health for Operations and Management. The Deputy Under Secretary for Health for Operations and Management has responsibility for oversight of consults in VHA.

c. Assistant Deputy Undersecretary for Health (ADUSH) for Access to Care. The Assistant Deputy Undersecretary for Health for Access to Care oversees the

Office of Veterans Access to Care (OVAC) and is responsible for consult policy and process education, improvement, and oversight. In addition, OVAC is responsible for establishing the national approved list of low risk clinics and publishing it in the VHA Consult SOP.

d. **Executive Director, Office of Compliance and Business Integrity.** The Executive Director, Office of Compliance and Business Integrity (CBI) is responsible for:

(1) Providing guidance and training to CBI Officers related to auditing and monitoring facility procedures for consult management.

(2) Evaluating field based audits to determine systemic causes and circumstances related to delays in consult management activities and accuracy of consult documentation, identifying systemic trends, educational opportunities, and recommending process improvements as necessary.

(3) Providing periodic consult management reports to the Principal Deputy Under Secretary for Health through the Business Integrity Committee or its successor enterprise-wide compliance committee.

e. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for VISN oversight of policy implementation and performance management within the VISN including:

(1) Overall responsibility to regularly review and apply corrective measures to address VISN data on consult quality outcomes.

(2) Implementation of standardized processes for consult management and reporting across the VISN.

(3) Assigning a VISN level point of contact to be responsible for coordination within the VISN and to serve as a liaison at the national level.

(4) Supporting the role of the VISN CBI Officer.

f. **VISN CBI Officer.** The VISN CBI Officer is responsible for

(1) Ensuring consistency in consult management auditing and monitoring practices at each facility within the VISN; evaluate the accuracy of quarterly consult management audit data submitted by facilities to the VHA Office of Compliance and Business Integrity.

(2) Evaluating facility-based audits to determine VISN-wide causations and trends relating to delays in consult management activities and accuracy of consult documentation and providing quarterly reports to VISN leadership.

(3) Sharing facility-based audit results with the VISN Chief Medical Officer and relevant CBI Committee, making recommendations, as necessary.

(4) Ensuring VISN CBI Committees follow up on the status of consult management audit recommendations on a monthly basis until complete.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Oversight of the facility consult policy, processes, and outcomes.

(2) Regular monitoring and improvement of facility consult performance and results. This review shall occur at least monthly and more frequently if outcomes are not being met.

(3) Allocating sufficient resources to enable management of consultations and timely delivery of care.

(4) Ensuring all new Licensed Independent Practitioners complete consult training in TMS.

(5) Ensuring new residents complete consult management training. Recommend the use of abbreviated resident consult training materials posted at the following link:

<https://dvagov.sharepoint.com/sites/vhagroup-practice-manager-pilot/SitePages/AL-CL-Training.aspx>. **NOTE:** This is an internal VA Web site not available to the public.

Resident Training can be found at the link below:

<https://dvagov.sharepoint.com/sites/vhaconsults/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhaconsults%2FShared%20Documents%2FTraining%2FHPT%2DResident%2DConsultTraining%2Epdf&parent=%2Fsites%2Fvhaconsults%2FShared%20Documents%2FTraining>. **NOTE:** This is an internal VA Web site not available to the public.

(6) Ensuring that consults are discontinued appropriately.

(7) Defining in local policy a process for managing the urgency of consults. The only two acceptable urgencies are Routine and Stat (see definition for urgency statuses).

(8) Ensuring specific consult set up rules, stop code alignment, and naming conventions are followed.

(9) Ensuring schedulers link a consult request to the appointment.

(10) Adherence to national timeliness, completion, and clean-up standards.

(11) Ensuring Community Care is utilized in accordance with regulatory authority and guidance from the Office of Community Care.

(12) Following Non-VA Medical Care Coordination (NVCC) procedures

including utilizing standardized NVCC consult templates, as appropriate.

(13) Supporting the role of the facility CBI Officer.

h. **Facility Chief of Staff.** The Facility Chief of Staff is responsible for:

(1) Regularly reviewing and improving facility consult performance and outcomes.

(2) Ensuring the CPRS consult package is used for all clinical consultations.

(3) Ensuring that the facility complies with the designation of low risk clinics approved by the ADUSH for Access. **NOTE:** *Facilities may not designate individual clinics as low risk.*

(4) Ensuring appropriate no show follow-up. See Appendix C.

(a) Consults in low risk clinics may be discontinued without provider review after a single no-show or patient cancellation without rescheduling attempts. See Appendix C. The VHA Consult SOP may be found at the following link:

<https://dvagov.sharepoint.com/sites/vhaconsults/Consult%20SOPs%20and%20Directives/Forms/AllItems.aspx?id=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives%2FVHA%20Consult%20SOP%202%2D24%2D17%2Epdf&parent=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives>.

NOTE: *This is an internal VA Web site not available to the public.*

(b) The following process is recommended: consults identified as lower risk state that the consult will be discontinued after a single no show; the appointment letter contains instructions if the patient cannot keep an appointment and that the appointment will be discontinued after a single no-show; the no-show letter informs the patient that the consult was discontinued and instructs them to contact their provider if they want the consult to be reinstated; notifications must be set to mandatory. See Appendix C. Additional detail may be found in the VHA Consult SOP at the following link:

<https://dvagov.sharepoint.com/sites/vhaconsults/Consult%20SOPs%20and%20Directives/Forms/AllItems.aspx?id=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives%2FVHA%20Consult%20SOP%202%2D24%2D17%2Epdf&parent=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives>.

NOTE: *This is an internal VA Web site not available to the public.*

(5) Timely review and application of corrective measures as needed to address consult quality outcomes.

(6) Oversight and facilitation of effective relationships between services using Care Coordination Agreements.

i. **Service and Department Clinical Leaders.** Each Service and Department Clinical Leader is responsible for ensuring:

- (1) Adherence to any consult related national program office guidance.
- (2) Regular review and improvement of Service or Departmental performance gaps.

(3) Managing patients effectively through the use of Care Coordination Agreements. Care Coordination Agreements must be established and utilized with a goal of optimizing referral relationships, establishing clear processes, and reducing the need for inspection and rework. Consult templates in CPRS are used to assist in the operationalization of Care Coordination Agreements and enhance the effectiveness of referrals.

(4) Identifying, requesting, and managing resources needed to comply with consult performance measures.

(5) Creating, managing, and improving access through local Care Coordination Agreements.

j. **Facility Consult Management Steering Committee.** Each facility must perform the following functions. These functions are assigned to individuals in this Directive. The following list identifies suggested functions of a facility Consult Management Steering Committee or an equivalent local functional committee.

(1) Ensuring the CPRS consult package is used for all clinical consultations.

(2) Assisting the VA medical facility Director and Chief of Staff in the oversight, management, implementation and improvement of the facility consult process to include all consult services.

(3) Facilitating coordination between VHA Directive 1230, Outpatient Scheduling Processes and Procedures, SOPs, and any other documents, policies, or agreements that impact consult management processes.

(4) Ensuring specific consult set up rules, stop code alignment, and naming conventions are followed.

(5) Defining in local policy a process for managing the urgency of consults. The only two acceptable urgencies are Routine and Stat (see definition for urgency status).

(6) Facilitating alignment of consults with Care Coordination Agreements. Care Coordination Agreements must be established and utilized with a goal of optimizing referral relationships, establishing clear processes, and reducing the need for inspection and rework. Consult templates in CPRS are used to assist in the operationalization of Care Coordination Agreements and enhance the effectiveness of referrals.

(7) Including Committee members that are in clinical, administrative, and technical roles.

(8) Meeting regularly.

(9) Working collaboratively with national level consult work groups and performance improvement efforts.

(10) Reporting its findings or concerns to the facility or VISN CBI Committee as appropriate.

k. **Consult Sending Service.** The consult sending service is responsible for:

(1) Adhering to Care Coordination Agreements including completion of appropriate and timely pre-work.

(2) Documenting contact with the receiving service for any Stat consults.

(3) Assuring that patients understand and are willing to keep any consult appointments that are scheduled.

(4) Completing the consult order, including manual entry of the CID for all consults to be completed by the Sending Provider.

(5) Ensuring Future Care Consults have a CID that is greater than 90-calendar days from the date the consult is entered.

(6) Reviewing the status of ordered consults to make sure that the patient receives timely care.

(7) Reviewing and acting on the results of completed consults for clinical services.

(8) Reviewing discontinued or canceled consults to determine if additional clinical measures are necessary.

(9) Ensuring the Forward status is selected by the receiving service only when the decision is made to forward the consult to another service. This is not used to forward to a specific provider. Forwarding consults to non-VA care is not allowed. An alert is sent to the sending provider.

l. **Consult Receiving Services.** The consult receiving service is responsible for ensuring:

(1) Adherence to the relevant Care Coordination Agreements.

(2) Timely review and response to consult requests.

(3) Consults are answered as e-Consults where appropriate and possible, including when prerequisite tests or treatments have not been provided.

(4) Initiation of e-consult responses or scheduling efforts as soon as possible, but no later than 2 business days.

(5) Implementation of the “minimum scheduling effort” for non-responding patients. See Appendix C.

(6) Implementation of the process of discontinuing a consult without provider review if the patient does not respond to the minimum scheduling effort or no shows or cancels one or more times. See Appendix C. Discontinued consults should always document the reason for discontinuation and can always be re-ordered or copied to a new order if appropriate. The Consult Resolution notification pathway must be set to mandatory so that a notification will be sent.

(7) Consults may be discontinued by administrative staff without provider review under the following conditions:

(a) Duplicate request;

(b) Care will be provided through a Non-VA Care Consult;

(c) Community Care appointment has been scheduled;

(d) Patient is deceased;

(e) Patient refuses care;

(f) Care already provided in the community; or

(g) Provider documented instructions to discontinue consult.

(h) Patient fails to respond to initial minimum scheduling attempts (See Appendix C)

(i) Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule in (See Appendix C). Rescheduling attempts are not required for low risk clinics

(8) Ensuring reasons for status changes including next steps needed for timely resolution of consult are documented.

(9) A review of patients who failed to present for the scheduled visit and timely initiation of efforts to reschedule or discontinue the consult according to the minimum scheduling effort described above. See Appendix C.

(10) The answer to the consult question is attached to the consult requests 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.

(11) Consult notes are linked properly with the consult request.

(12) If consult questions are not completed by a progress note, the results are attached to the consult request by other means such as pasting them into the administrative complete dialogue.

(13) Compliance with requirement for consult reviews, as specified by Health Information Management Service (HIMS), the Joint Commission, and any National audits.

m. **Facility CBI Officer.** The Facility CBI Officer is responsible for:

(1) Conducting a minimum of twice-yearly audits of consult management activities, in accordance with Consult Management auditing and monitoring procedures issued by the VHA Office of Compliance and Business Integrity.

(2) Reporting audit findings and recommendations to the facility Director, Consult Management Steering Committee, and VISN CBI Officer through the facility CBI Committee.

(3) Assuring audit recommendations are followed up on.

6. REFERENCES

a. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016.

b. VHA Consult SOP:

<https://dvagov.sharepoint.com/sites/vhaconsults/Consult%20SOPs%20and%20Directives/Forms/AllItems.aspx?id=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives%2FVHA%20Consult%20SOP%202%2D24%2D17%2Epdf&parent=%2Fsite%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives>. **NOTE:** This is an internal VA Web site not available to the public.

c. E-Consult Guidebook:

<https://dvagov.sharepoint.com/sites/vhaovac/cpm/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhaovac%2Fcpm%2FShared%20Documents%2FGuidebooks%2FE%2DConsult%20Guide%20Book%20V%203%2E0%2Epdf&parent=%2Fsites%2Fvhaovac%2Fcpm%2FShared%20Documents%2FGuidebooks>. **NOTE:** This is an internal VA Web site not available to the public.

d. Office of Community Care Field Guidebook:

<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. **NOTE:** This is an internal VA Web site not available to the public.

RECOMMENDED CONTENT FOR CARE COORDINATION AGREEMENTS

1. The Care Coordination 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 Care Coordination Agreement is available for reference by posting on the facility or Veterans Integrated Service Network (VISN) Web site, as appropriate.

3. The Care Coordination 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 Care Coordination 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 are stated. It is the expectation that patients will be discharged from the specialty clinic once consultation and any needed procedure and follow-up are 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 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.

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

Care Coordination 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 paragraph 3.a. of this appendix) packaged the right way (correct pre-work is included) (see paragraph 3.c. of this appendix).

(2) The receiver responsibilities are measured by auditing adherence to agreed-upon timeliness response standards (see paragraph 3.b. of this appendix).

e. CPRS consultation referral templates.

**CONSULT – GENERAL BUSINESS RULES USES OF THE CONSULTATION
PACKAGE****1. DEFINITIONS OF CONSULT REQUEST TYPES****a. Clinical Consultations.**

(1) **Outpatient Consultation.** An outpatient consultation is a request for clinical evaluation where the sending provider and receiving provider are in the same parent facility and the receiving provider is treating the patient in an outpatient setting. Note that outpatient consults include virtual care and can be ordered while patients are admitted to an inpatient unit or in the emergency department.

(2) **Inpatient Consultation.** An inpatient consultation is a request for consultative services expected to be completed during an inpatient admission, which must be completed, discontinued, or forwarded to outpatient prior to discharge. Note that some outpatient consults may be ordered on patients admitted to acute or long term inpatient units such as Community Living Center (CLC).

(3) **Inter-facility Consultation.** An inter-facility consultation is a request for service between different parent facilities. They must either be Outpatient Clinical Consultation or clinical communications. The results of the request must be returned to the requesting site through the inter-facility consult request and is complete when the result is available.

b. Administrative Uses of the Consult.

(1) **Outpatient Clinical Request/Transfer of Care.** An outpatient clinical request/transfer of care is a request for transfer of care between providers where the only necessary response is acceptance or acknowledgement of the referral. The consult package is used as an order or notification, e.g., in a referral to Primary Care or Mental Health by the Emergency Department (ED/UC). Clinical consultation and administrative requests are not included in this category.

(2) **Scheduling Order/Administrative.** A scheduling order/administrative is a request for scheduling within the service from the provider that does not meet the criteria for Clinical Consultation. An example is a cardiologist consulting for a cardiac catheterization they will perform. Another example is a request for laboratory or radiology services that are reported via another mechanism with separate view alerts. This also includes administrative orders such as travel or escort.

c. **Non-VA Care Coordination (NVCC).** A Non-VA Care Coordination (NVCC) consult is a request for hospital care and/or medical services to be purchased in the community when the care/services cannot be physically furnished by VA facilities; the Veteran cannot safely travel due to medical reasons; care cannot be furnished in a timely manner in VA facilities; or care cannot be furnished due to geographic inaccessibility. Non-VA consult/referrals are designated as administrative consults but

are completed as a clinical consult with a consult result note (NON-VA CARE CONSULT RESULT NOTE) in Computerized Patient Record System (CPRS) and the scanning and attachment to this note title of any report or clinical documentation provided by the Community Care provider or facility. NVCC consults should be flagged as administrative based on guidance from the Office of Community Care (OCC). Refer to the Office of Community Care Field Guidebook:
<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>.

d. **Clinical Procedures with Vendor Interface.** Clinical procedures with vendor interface is a request for a clinical service when interface with a vendor is necessary.

e. **Future Care Consult.** Future care consult is a request for clinical evaluation when the expectation is that the care is delivered beyond 90 days.

f. **E-Consult.** An e-consult is a clinical consultation involving a chart review which does not entail a face to face examination of the patient.

2. CLINICAL CONSULTATIONS

Clinical Consultations require the use of the Consultation Package. The Requestor receives clinical information in response to sending the consult for two-way communication.

a. **Outpatient Consultation.**

(1) **Build Requirements:**

(a) **Consult service name.** Must include 'Outpatient'. 'Outpatient' can be abbreviated as 'Outpt'.

(b) **Consult Service Names that Cannot be Used in Combination.** One naming convention or flag must be used for each consult service. Outpatient Consult Services should not include these names in the title: 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care'. The name should not include 'NON-VA CARE.' Do not place characters directly adjacent to the words 'Outpatient' or 'Outpt' without a space, such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services.

(c) **Document Class.** Note titles used to respond to consults must be built in the 'CONSULTS' document class within the Text Integration Utility (TIU) package (except for procedures).

(d) **Urgency Fields:**

1. The only two approved urgency statuses are Stat and Routine.

2. If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(e) Notifications. 'Consult/Request Resolution' notification must be turned on and mandatory.

(2) Status Changes.

(a) Pending. Consult is automatically placed in pending status the status of the consult must be changed within 2 business days reflecting the appropriate action:

1. Active (Received);
2. Scheduled;
3. Completed;
4. Discontinue;
5. Forward; and
6. Cancel.

(b) Active. Consults which are pending more than 2 business days must be received into Active status. If a patient no-shows or the appointment is canceled, the status will revert to Active status.

(c) Scheduled. Required using Veterans Health Information Systems and Technology Architecture (VistA) scheduling menu options to link the consult request to the scheduled appointment except for types of appointments that are not usually scheduled.

(d) Cancel (Deny) Inappropriate Consults. Used by receiving service when:

1. Consult pre-work is inadequate as outlined in care coordination agreement; and
2. When service is not available.

(e) Edit (Resubmit). Used by requesting service when adequate information has been added as outlined in care coordination agreement or when additional information has become available prior to the appointment.

(f) Discontinue. Used when the consult is:

1. Duplicate request;
2. Care will be provided through a Non-VA Care Consult;
3. Community Care appointment has been scheduled;
4. Patient is deceased;

- 5. Patient refuses care;
- 6. Care already provided in the community; or
- 7. Provider documented instructions to discontinue consult.
- 8. Patient fails to respond to initial minimum scheduling attempts (See Appendix C)
- 9. Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics.

(g) Forward. When receiving service assumes the responsibility of handing off the request to the appropriate specialty service.

(h) Add comment. Add comment may not deliver a notification to all staff depending on notification set up/preferences.

(i) Significant Findings. The Significant Findings uses the same alert pathway as consult completion, which will result in a notification to the ordering provider. The Significant Findings action is used by a Service/ Specialty to mark a consult has having significant findings. When the Sig Findings flag is set to "Y" an asterisk is placed next to the consult in the review display.

(j) Complete via CPRS Consult progress note. When appropriate documentation is available within CPRS and linked to the consult.

(k) Administrative Complete. When patients with an established relationship with the receiving specialty has been lost to follow up and the patient is rescheduled; when consults are greater than 5 years old and it is being done as part of consult maintenance review.

(l) Partial results. Automatic status change when consult has been linked to a note that is not signed or co-signed.

b. Inpatient Consultation.

(1) Build Requirements.

(a) Consult service name. Must include 'Inpatient'. 'Inpatient' can be abbreviated as 'Inpt'.

(b) Consult service names that cannot be used in combination. One naming convention or flag must be used for each consult service. Inpatient Consult Services should not include these names in the title: 'Outpatient', 'Outpt', 'Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care'. The name should not begin with 'NON-VA CARE'. Do not place characters directly adjacent to the words 'Inpatient' or 'Inpt' such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services.

(c) Document class. Note titles used to respond to consults must be built in the 'CONSULTS' document class within the TIU package (except for procedures).

(d) Urgency Fields:

1. The only two approved urgency statuses are Stat and Routine.

2. If the consult Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(e) Notifications. 'Consult/Request Resolution' notification must be turned on and mandatory.

(2) Status Changes.

(a) Pending. Consult is automatically placed in pending status the status of the consult must be changed within the timeframe specified in the VA medical facility policy.

(b) Active. Consults which are pending more than 2 business days from consult creation must be received into Active status. If a patient no-shows or the appointment is canceled, the status will revert to Active status.

(c) Scheduled. May be used using Vista scheduling menu options to link the consult request to the scheduled appointment.

(d) Cancel (Deny) Inappropriate Consults. Do not use.

(e) Edit (Resubmit). Do not use.

(f) Discontinue. Used when the consult is received by:

1. Duplicate request;

2. Care will be provided through a Non-VA Care Consult;

3. Community Care appointment has been scheduled;

4. Patient is deceased;

5. Patient refuses care;

6. Care already provided in the community; or

7. Provider documented instructions to discontinue consult.

8. Patient fails to respond to initial minimum scheduling attempts (See Appendix

C)

9. Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics.

NOTE: *If the consult request was not addressed during the inpatient stay and the requesting provider determined there is a need to receive the service as an outpatient, the hospitalist or PCP (local policy to dictate) will enter an outpatient consult.*

(g) Forward. When receiving service assumes the responsibility of handing off the request to the appropriate specialty service for care to be provided during the inpatient stay.

(h) Add Comment. Add comment may not deliver a notification to all staff depending on notification set up/preferences.

(i) Significant Findings. The Significant Findings uses the same alert pathway as consult completion, which will result in a notification to the ordering provider. The Significant Findings action is used by a Service/ Specialty to mark a consult has having significant findings. When the Sig Findings flag is set to "Y" an asterisk is placed next to the consult in the review display.

(j) Complete via CPRS Consult Progress Note. When documentation is complete and linked to consult.

(k) Administrative Complete. Can be used after appropriate clinical review occurs and not able to be placed in either completed or discontinued status.

(l) Partial Results. Automatic status change when consult has been linked to a note that is not signed or co-signed.

c. Inter-facility Consultation.

(1) Build Requirements.

(a) Consult Service Name. Must include 'Inter-facility'. 'Inter-facility' can be abbreviated as 'IFC'.

(b) Consult Service Names that Cannot be Used in Combination. One naming convention or flag must be used for each consult service. Inter-Facility Consult Services should not include these names in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'CP', 'FC' or 'Future Care'. The name should not begin with 'NON-VA CARE'. Do not place characters directly adjacent to the words 'Inter-Facility', 'Inter Facility', or 'IFC' without a space, such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services.

(c) Document Class. Note titles used to respond to consults must be built in the 'CONSULTS' document class within the TIU package (except for procedures).

(d) Urgency Fields.

1. The only two approved urgency statuses are Stat and Routine.

2. If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date

(e) Notifications. 'Consult/Request Resolution' notification must be turned on and mandatory.

(2) Status Changes.

(a) Pending. Consult is automatically placed in pending status the status of the consult must be changed within 2 business days reflecting the appropriate action:

1. Discontinue;

2. Cancel;

3. Scheduled; and

4. Completed.

(b) Active. Consults which are pending more than 2 business days must be received into Active status. If a patient no-shows, or the appointment is canceled, the status will revert to Active status.

(c) Scheduled. Required using VistA scheduling menu options to link the consult request to the scheduled appointment except for types of appointments that are not usually scheduled.

(d) Cancel (Deny) Inappropriate Consults. Used by receiving service when:

1. Consult pre-work is inadequate as outlined in care coordination agreement;

2. When the service cannot be provided;

3. Not to be used to alleviate capacity issues - opposite of d/c for receiving and sending; and

(e) Edit (Resubmit). Do not use.

(f) Discontinue. Sending facility: Use when:

1. Duplicate request;

2. Care will be provided through a Non-VA Care Consult;

3. Community Care appointment has been scheduled;

4. Patient is deceased;

- 5. Patient refuses care;
- 6. Care already provided in the community; or
- 7. Provider documented instructions to discontinue consult.
- 8. Patient fails to respond to initial minimum scheduling attempts (See Appendix C)
- 9. Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics.

(g) Forward. When receiving service assumes the responsibility of handing off the request to the appropriate specialty service.

(h) Add Comment. Add comment may not deliver a notification to all staff depending on notification set up/preferences.

(i) Significant Findings. The Significant Findings uses the same alert pathway as consult completion, which will result in a notification to the ordering provider. The Significant Findings action is used by a Service/ Specialty to mark a consult has having significant findings. When the Sig Findings flag is set to "Y" an asterisk is placed next to the consult in the review display.

(j) Complete via CPRS Consult Progress Note. When appropriate documentation is available within CPRS and linked to the consult.

(k) Administrative Complete. When a consult is used solely as a request to reschedule an established patient without asking a new clinical question; when consults are greater than 5 years old and it is being done as part of consult maintenance review.

(l) Partial Results. Automatic status change when consult has been linked to a note that is not signed or co-signed.

3. ADMINISTRATIVE USES OF THE CONSULT PACKAGE

Optional Use of the Consult Package – Can be used for inpatients or outpatients for one way communication

a. Outpatient Clinical Request/Transfer of Care.

(1) Build Requirements.

(a) Consult Service Name. Specific note titles are not required since the administrative flag is selected for the specific services in the VistA File 123.

(b) Consult Service Names that Cannot be Used in Combination. One naming convention or flag must be used for each consult service. Administrative Consult Services should have an Administrative Flag set. They should not include these names

in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care'.

(c) Document Class. No note is specifically required prior to completing consult.

(d) Urgency Fields.

1. The only two approved urgency statuses are Stat and Routine.

2. If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(e) Notifications. Facility/Service decision.

(2) Status Changes.

(a) Pending. Consult is automatically placed in pending status - the status of the consult must be complete within 30 days noting the action requested was completed.

(b) Active. Consults which are pending more than 2 business days must be received into Active status. If a patient no-shows, or the appointment is canceled, the status will revert to Active status.

(c) Scheduled. Required using VistA scheduling menu options to link the consult request to the scheduled appointment except for types of appointments that are not usually scheduled.

(d) Cancel (Deny) Inappropriate Consults. Do not use.

(e) Edit (Resubmit). Do not use.

(f) Discontinue. Do not use.

(g) Forward. Do not use.

(h) Add Comment. Add comment may not deliver a notification to all staff depending on notification set up/preferences.

(i) Significant Findings. Do not use.

(j) Complete via CPRS Consult Progress Note. Do not use.

(k) Administrative Complete. With appropriate comment when the need is addressed.

(l) Partial Results. Automatic status change when consult has been linked to a note that is not signed or co-signed.

b. Scheduling Order/Administrative.

(1) Build Requirements.

(a) Consult Service Name. The administrative flag is selected for the specific services in the VistA File 123. Administrative consults used only for the purpose of scheduling an appointment must include 'Appt Req Only' in the consult service name.

(b) Consult Service Names that Cannot be Used in Combination. One naming convention or flag must be used for each consult service. Administrative Consult Services should have an Administrative Flag set. They should not include these names in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care.'

(c) Document Class. No note is specifically required prior to completing consult.

(d) Urgency Fields.

1. The only two approved urgency statuses are Stat and Routine.

2. If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(e) Notifications. Facility/Service decision.

(2) Status Changes.

(a) Pending. Consult is automatically placed in pending status the status of the consult must be complete within 30 calendar days noting appropriate action on the order.

(b) Active. Consults which are pending more than 2 business days must be received into Active status. If a patient no-shows, or the appointment is canceled, the status will revert to Active status.

(c) Scheduled. Required using VistA scheduling menu options to link the consult request to the scheduled appointment except for types of appointments that are not usually scheduled.

(d) Cancel (Deny) Inappropriate Consults. Do not use.

(e) Edit (Resubmit). Do not use.

(f) Discontinue. Used when the consult is:

1. Duplicate request;

2. Care will be provided through a Non-VA Care Consult;

3. Community Care appointment has been scheduled;

4. Patient is deceased;
 5. Patient refuses care;
 6. Care already provided in the community; or
 7. Provider documented instructions to discontinue consult.
 8. Patient fails to respond to initial minimum scheduling attempts (See Appendix C)
 9. Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics.
- (g) Forward. Used when the consult is received by wrong service.
- (h) Add Comment. Add comment may not deliver a notification to all staff depending on notification set up/preferences.
- (i) Significant Findings. Use as needed.
- (j) Complete via CPRS Consult Progress Note. A note would be used to complete an administrative consult for clinical procedures (either attached to the admin consult, as a CP consult or an alerted progress note).
- (k) Administrative Complete. When care plan has been initiated in CPRS or when request has been met. Facilities must establish a policy that outlines timeframe for cleanup.
- (l) Partial Results. Automatic status change when consult has been linked to a note that is not signed or co-signed.

4. COMMUNITY CARE CONSULTS

Please refer to the OCC Field Guidebook at the link below:
<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. **NOTE:** This is an internal VA Web site that is not available to the public.

5. CLINICAL PROCEDURES WITH VENDOR INTERFACE

a. **Definition.** A request for a clinical service when interface with a vendor is necessary. Sites may consider these clinical or administrative depending on the consult service request.

b. Build Requirements.

(1) **Consult Service Name.** Consult service title must include the prefix 'CP'. CP consult titles may also have the words Future Care or FC in the title.

(2) **Consult Service Names that Cannot be Used in Combination.** One naming convention or flag must be used for each consult service. Clinical Procedure Services should not include these names in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', or 'IFC'. The name should not begin with 'NON-VA CARE'. Do not place characters directly adjacent to the name 'CP' such as placing a dash immediately after or placing it in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services.

(3) **Document Class.** No note is specifically required prior to completing consult.

(4) Urgency Fields.

(a) The only two approved urgency statuses are Stat and Routine.

(b) If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(5) **Notifications.** Facility/Service decision.

c. Status Changes.

(1) **Pending.** Consult is automatically placed in pending status the status of the consult must be changed within the timeframe specified in the facility policy.

(2) **Active.** Consults which are pending more than 2 business days must be received into Active status. If a patient no-shows or the appointment is canceled, the status will revert to Active status.

(3) **Scheduled.** Required using VistA menu options to link the consult request to the scheduled appointment except for types of appointments that are not usually scheduled.

(4) **Cancel (Deny) Inappropriate Consults.** Do not use.

(5) **Edit (Resubmit).** Do not use.

(6) **Discontinue.** Used when service:

(a) Duplicate request;

(b) Care will be provided through a Non-VA Care Consult;

(c) Community Care appointment has been scheduled;

(d) Patient is deceased;

(e) Patient refuses care;

(f) Care already provided in the community; or

(g) Provider documented instructions to discontinue consult.

(h) Patient fails to respond to initial minimum scheduling attempts (See Appendix C)

(i) Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics

(7) **Forward.** Do not use.

(8) **Add Comment.** Add comment may not deliver a notification to all staff depending on notification set up/preferences.

(9) **Significant Findings.** The Significant Findings uses the same alert pathway as consult completion, which will result in a notification to the ordering provider. The Significant Findings action is used by a Service/ Specialty to mark a consult has having significant findings. When the Sig Findings flag is set to "Y" an asterisk is placed next to the consult in the review display.

(10) **Complete via CPRS Consult Progress Note.** When image/procedure report is available in VistA Imaging and stub note is created and signed in CPRS.

(11) **Administrative Complete.** Use as needed with appropriate comment when the need is addressed.

(12) **Partial Results.** Automatic status change when consult has been linked to a note that is not signed or co-signed.

6. FUTURE CARE CONSULTS

Mandatory use of the Consult Package in cases where a decision is made at a consult will be needed 90 days into the future.

a. **Definition.** A request for clinical evaluation when the expectation is that the care is delivered beyond 90 days.

b. Build Requirements.

(1) **Consult Service Title.** Consult Service title must include 'Future Care' or 'FC' in the title. In addition, the FC consult sender will complete the "Earliest Appropriate Date" field of the consult request with appropriate future date of requested care.

(2) **Consult Service Titles that Cannot be Used in Combination.** One naming convention or flag must be used for each consult service. Future Care Services should not include these names in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', or 'IFC'. The name should not begin with 'NON-VA CARE' Do not place characters directly adjacent to the words 'Future Care' or 'FC', such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services.

(3) **Document class.** Note titles used to respond to consults must be built in the 'CONSULTS' document class within the TIU package (except for procedures).

(4) Urgency Fields.

(a) The only two approved urgency statuses are Stat and Routine.

(b) If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(5) **Notifications.** 'Consult/Request Resolution' notification must be turned on and mandatory.

c. Status Changes.

(1) **Pending.** Consult is automatically placed in pending status - the status of the consult must be changed before the "earliest appropriate date."

(2) **Active.** Optional. The need for the 'active' status change should be decided by each facility based on local need.

(3) **Scheduled.** Required using VistA menu options to link the consult request to the scheduled appointment except for types of appointments that are not usually scheduled.

(4) **Cancel (Deny) Inappropriate Consults.** Used by receiving service when consult pre-work is inadequate as outlined in care coordination agreement; when service is not available and NVCC consult will be entered for the same reason.

(5) **Edit (Resubmit).** Used by requesting service when adequate information has been added as outlined in care coordination agreement or when additional information has become available prior to the appointment.

(6) **Discontinue.** Used when:

(a) Duplicate request;

(b) Care will be provided through a Non-VA Care Consult;

(c) Community Care appointment has been scheduled;

(d) Patient is deceased;

(e) Patient refuses care;

(f) Care already provided in the community; or

(g) Provider documented instructions to discontinue consult.

(h) Patient fails to respond to initial minimum scheduling attempts (See Appendix C)

(i) Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics

(7) **Forward.** When receiving service assumes the responsibility of handing off the request to the appropriate specialty service.

(8) **Add Comment.** Add comment may not deliver a notification to all staff depending on notification set up/preferences.

(9) **Significant Findings.** The Significant Findings uses the same alert pathway as consult completion, which will result in a notification to the ordering provider. The Significant Findings action is used by a Service/ Specialty to mark a consult has having significant findings. When the Sig Findings flag is set to "Y" an asterisk is placed next to the consult in the review display.

(10) **Complete via CPRS Consult Progress Note.** When appropriate documentation is available within CPRS and linked to the consult.

(11) **Administrative Complete.** When patients with an established relationship with the receiving specialty has been lost to follow up and the patient is rescheduled; when consults are greater than 5 years old and it is being done as part of consult maintenance review.

(12) **Partial Results.** Automatic status change when consult has been linked to a note that is not signed or co-signed.

7. E-CONSULTS

Best practice where possible that allows consult question to be answered without face to face examination of the patient. It is always the discretion of the receiving service whether a consult can be answered as an e-consult.

a. Build Requirements.

(1) **Consult Service Title.** Consult Service title must include e-consult in the title. In addition, the consult sender will complete Clinically Indicated Date field of the consult request with appropriate date of requested care.

(2) **Document Class.** Note titles used to respond to consults must be built in the 'CONSULTS' document class within the TIU package (except for procedures).

(3) Urgency Fields.

(a) The only two approved urgency statuses are Stat and Routine.

(b) If the consult is Stat, there must be a documented discussion between ordering and receiving provider as to when the patient will be seen. In all other circumstances, the consult should be completed in accordance with the clinically indicated date.

(4) **Notifications.** 'Consult/Request Resolution' notification must be turned on and mandatory.

b. E-consult Variations.

(1) Ordering provider orders an e-consult believing that the consult question can be answered without an in-person visit. Not all sites allow this.

(2) Receiving provider can determine that the consult question can be answered without an in-person visit.

(3) Ordering provider fails to order prerequisite tests or treatments and the receiving provider completes the consult as an e-consult with instructions to obtain prerequisite tests or provide prerequisite treatment.

(4) Ordering provider orders an in-person consult but the receiving provider may determine that the consult question can be answered through a phone call or Secure Messaging interaction.

(5) Note that consults that were initially ordered for an in-person visit, can be completed as an e-consult at the discretion of the receiving service without the need to forward to an e-consult.

(6) It is not necessary to document patient consent prior to completing the e-consult.

c. Status Changes.

(1) **Pending.** Consult is automatically placed in pending status - the status of the consult must be changed before the "earliest appropriate date."

(2) **Active.** E-consults must be "received" so that they acquire the status of Active if they are not completed within 2 business days.

(3) **Scheduled.** An e-consult may be forwarded to a general consultation where an appointment could be scheduled.

(4) **Cancel (Deny) Inappropriate Consults.** Used by receiving service when an appropriate e-consult question was not asked or in insufficient information was provided.

(5) **Edit (Resubmit).** Used by requesting service when adequate information has been added. Discontinued consults should not be resubmitted if they are more than 90 days old.

(6) **Discontinue.** Used when

(a) Duplicate request;

(b) Care will be provided through a Non-VA Care Consult;

- (c) Community Care appointment has been scheduled;
 - (d) Patient is deceased;
 - (e) Patient refuses care;
 - (f) Care already provided in the community; or
 - (g) Provider documented instructions to discontinue consult.
 - (h) Patient fails to respond to initial minimum scheduling attempts (See Appendix C)
 - (i) Patient no shows or cancels one or more times and fails to respond to minimum scheduling attempts reschedule (See Appendix C). Rescheduling attempts are not required for low risk clinics
- (7) **Forward.** When receiving service assumes the responsibility of handing off the request to the appropriate specialty service. E-consults may be forwarded to a general consult and general consults may be forwarded to an e-consult. General consults can also be completed as an e-consult without having to forward to an e-consult.
- (8) **Add Comment.** Add comment may not deliver a notification to all staff depending on notification set up/preferences.
- (9) **Significant Findings.** The Significant Findings uses the same alert pathway as consult completion, which will result in a notification to the ordering provider. The Significant Findings action is used by a Service/ Specialty to mark a consult has having significant findings. When the Sig Findings flag is set to "Y" an asterisk is placed next to the consult in the review display.
- (10) **Complete via CPRS Progress Note.** When appropriate documentation is available within CPRS and linked to the consult.
- (11) **Administrative Complete.** When patients with an established relationship with the receiving specialty has been lost to follow up and the patient is rescheduled; when consults are greater than 5 years old and it is being done as part of consult maintenance review.
- (12) **Partial Results.** Automatic status change when consult has been linked to a note that is not signed or co-signed

MINIMAL SCHEDULING EFFORT REQUIRED FOR OUTPATIENT APPOINTMENTS

1. The steps outlined below are the minimum requirements that must be used in the scheduling and rescheduling of any non-mental health appointment and/or New Enrollee Appointment Request (NEAR). Section 6 below, addresses mental health appointments. Facilities, services, or individual providers may determine that additional contact attempts are necessary based on clinical needs.

a. **Step One.** The scheduler must make a minimum of two documented contact attempts – one by telephone call and one by letter. The letter may be mailed the same day as the phone call is made. Email may not be used for this purpose.

b. **Step Two.** Schedulers must wait a minimum of 14-calendar days from mailing the contact letter before taking further action to allow the patient time to respond.

c. **Step Three.** The scheduler is permitted to discontinue contact attempts if the patient fails to respond within 14-calendar days of the letter being mailed. The scheduler is permitted to discontinue the consult without provider review after failed scheduling efforts.

d. **Step Four.** The scheduler is permitted to discontinue a consult without provider review if the associated appointment is cancelled by the patient one or more time and fails to respond to minimal re-scheduling efforts. After the second cancellation re-scheduling efforts are not required.

e. **Step Five.** The scheduler is permitted to discontinue a consult without provider review if the patient fails to report (“No-Show”) one or more times and does not respond to minimal re-scheduling efforts. After the second No-Show re-scheduling efforts are not required.

f. **Step Six.** Patients who fail to report (“No-Show”) or cancel an appointment in VHA-designated low-risk clinics do not require re-scheduling efforts. This includes both appointments associated with and without a consult request. **NOTE:** Refer to VHA Directive 1232(2) Consult Processes and Procedures, dated August 23, 2016, for the required procedure. Refer to the Consult Management SOP at: <https://dvagov.sharepoint.com/sites/vhaconsults/Consult%20SOPs%20and%20Directives/Forms/AllItems.aspx?id=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directives%2FVHA%20Consult%20SOP%202%2D24%2D17%2Epdf&parent=%2Fsites%2Fvhaconsults%2FConsult%20SOPs%20and%20Directive> for a list of these clinics. **NOTE:** This is an internal VA Web site that is not available to the public.

g. **Step Seven.** Non-mental health appointments cancelled by patients using VA Online Scheduling or VEText do not require the clinic to initiate contact with the patient to reschedule. To assist staff, the VSSC Patient Generated Cancellations report identifies appointments cancelled through these technologies. The report is located at the following link:

<https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fAccess%2f>

[2fAppointment+--Patient+Generated+Cancellations&rs:Command=Render.](#)

NOTE: This is an internal VA Web site that is not available to the public.

h. **Step Eight.** VA Online Scheduling (VAOS) appointment requests are permitted to be scheduled without calling the Veteran when the appointment date and time requested are available and the patient has indicated “No” to the prompt “VA to call regarding this request.” In all other instances, including but not limited to a Return to Clinic (RTC) Order, Consult, or Patient Centered Recall Reminder, a follow-up call to the Veteran must be made as outlined in Step One.

i. **Step Nine.** Scheduling efforts must be documented using the following process:

(1) In response to an RTC order, document contact attempts in Computer Patient Record system (CPRS) Admin Notes and discontinue the RTC order selecting the option “removed/no longer necessary” at the APPT/VETERAN Disposition prompt.

(2) In response to a consult, document contact attempts, and discontinue the consult (provider review not required) using the consult toolbox standard text for “failed mandated scheduling effort” or enter the reason into the consult comments.

(3) In response to a patient centered care reminder, document as “failure to respond” at the PtCSch Disposition prompt.

(4) In response to a VA Online Scheduling (VAOS) appointment request, document as “cancelled – unable to reach Veteran/ Servicemember” in Scheduling Manager at the cancel request prompt.

(5) In response to a New Enrollee Appointment Request, enter the status of the application as “In process.” Document all contact efforts in the comments field.

2. For mental health appointments, (inclusive of consults, return to clinic orders, and failure to report (no-show)), the minimum scheduling effort for scheduling/rescheduling totals of four attempts; three documented contact attempts by telephone on separate days, followed by a letter. The letter is permitted to be mailed the same day as the first call. VA medical facilities, services, or individual providers may determine that additional contact attempts are necessary based on clinical needs.

(a) The minimum scheduling effort and documentation process applies to all mental health appointments.

(b) Schedulers must wait a minimum of 14-calendar days from mailing the contact letter before taking further action to allow the patient time to respond.

(c) The scheduler is permitted to discontinue the consult or return to clinic order after failed scheduling efforts, unless the provider determined that additional contact attempts are necessary based on clinical needs (see 6). Refer to 5.i. for documentation and disposition requirements. Patients who have a CPRS category 1 High-Risk Flag (HRF) for suicide require provider review prior to discontinuation of the consult or return to clinic order.

(d) Mental health appointments cancelled by patients using VAOS or VEText are rescheduled at the request of the patient and do not require the clinic to initiate contact to reschedule except for those Veterans with a High-Risk Flag (HRF) for suicide. Veterans with a HRF for suicide require the clinic to follow the procedures outlined in paragraph 6.g. VA medical facilities, services, or clinics are permitted to require additional rescheduling efforts for selected self-canceling patients based on clinical needs. Refer to section 4.g. for the VSSC Patient Generated Cancellations report that identifies appointments cancelled through these technologies.

(e) Staff must use contact methods appropriate to the specific situations such as homeless outreach or certified mail when it is not possible to reach the patient by telephone.

(f) The telephone attempts must be conducted by a staff member who has access to document in CPRS, to include but not limited to clerks, Licensed Practical Nurse, Peer Support Specialist, and health technician.

(g) Attempts to contact patients who cancel or fail to report (no-show) who have a CPRS category 1 High-Risk Flag (HRF) for suicide alert must be made by appropriately-trained staff who possess a scope of practice including evaluation and triage of high-risk behaviors.

(h) When applicable, VA medical facility's local standard operating procedures, must be followed in cases where further contact attempts or actions are required based on clinical needs.

3. Appointment requests discontinued by a VA medical facility after failed scheduling attempts or cancelled by the patient either online or by text may be rescheduled. The rescheduled appointment "Patient Indicated Date (PID)" is updated with the patient's requested date. **NOTE:** *Where possible, the rescheduled date should be made as close to the PID of the previous appointment request. Please follow appropriate business rules associated with VHA Directives 1230(1) and 1232(2).*

4. To offer a patient an earlier appointment due to available capacity or when the clinic cancels the appointment and offers the patient an earlier appointment:

a. Contact the patient to offer an earlier appointment.

b. If the patient accepts, the scheduler selects "Cancel by Clinic" for the original appointment and enter the text "earlier appointment." The rescheduled appointment will retain the original patient indicated date (PID).

c. If the patient declines the offer for an earlier appointment when called due to earlier capacity, no action is required.

d. If the patient declines the offer for an earlier appointment when called due to clinic cancellation, the appointment is rescheduled to a later date and retains the PID of the cancelled appointment.