CONTEXTUAL INFORMATION

For the Standard of Practice:

COLLABORATIVE CARE NON-EMERGENT CONSULTATION REQUESTS

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Contextual Information – Non-Emergent Consultation Requests

The Standard of Practice – Non-Emergent Consultation Requests establishes clear requirements for registrants to work collaboratively with other registrants when specialized knowledge or experience is sought in the treatment of a patient.

This standard must always be interpreted from the patient's perspective, with the primary focus on ensuring that the patient receives the best possible medical care. Every action and decision taken by the registrants involved should be guided by the intention to deliver good medical care to the patient.

Collaboration and Behavioural Expectations

Working alongside other registrants, health care providers, and institutions presents opportunities to significantly enhance the medical care provided to patients. At the same time, collaboration can sometimes be a source of frustration. However, each registrant is responsible for their own behaviour, and this Standard of Practice outlines the behavioural expectations for all registrants involved in patient care.

Benefits of Adopting Professional Behaviours

When all registrants adhere to the behaviours defined by the CMA Code of Ethics and Professionalism, many of the frustrations associated with providing collaborative care are reduced. As a result, both patients and registrants benefit from improved collaboration and professionalism in the delivery of care.

Supporting Registrants

To further assist registrants in understanding the requirements of the Standard of Practice, a set of frequently asked questions (FAQs) has been provided.

Q. 1 - What is the importance of "closing the loop"?

A. Effective communication is critical for good medical care. Lack of communication can negatively impact patient care.

A common concern expressed by registrants and patients is that they do not know what is happening with a particular matter. For example, a request for a consultation was sent, but there has been no acknowledgement of receipt or indication that it will be acted upon. The concept of closing-the-loop communication is a basic courtesy that acknowledges receipt of the request and provides meaningful information.

The Standard of Practice – Non-Emergent Consultation Requests requires you to provide a triage response with specific information within 14 days of receiving the request. In nearly all cases, the registrant who is being asked to help will be able to provide the specific information. There are

limited circumstances in which they will not be able to do so. The appropriate response is to acknowledge receipt of the request within the 14-day period and to advise that the required information will be provided by a specified date.

Establishing response timelines ensures that both the patient and the referring registrant are aware that a lack of response within 14 days indicates a potential issue requiring attention. The referring registrant will know whether the consultation request was not received or that an issue prevented the triage response from being sent.

Q. 2 - When I am seeking a consultation for my patient, what information do I need to provide?

When asking another registrant to assist with your patient's care, it is important to provide sufficient background information so they can understand the patient's needs and the purpose of the referral.

- Be clear and concise. Let them know whether you are seeking an opinion, transferring care, or have another reason for the consultation. Clearly state the relevant clinical question you want answered or why you want the consulting registrant to see the patient.
- Provide the relevant medical information that you have gathered that has brought you to the point where you have determined that you need assistance. It is not sufficient to refer a patient to an internal medicine specialist with a referral that merely states "abdominal pain".
- Do not send extraneous information. If your patient has a discrete medical issue, do not send their entire 20-year medical history and expect the consulting registrant to look through it all to determine what is relevant. Use your knowledge, skills, and judgment to assess what you believe is relevant and provide it in a clear, easily understood format.

Q. 3 - I have received a referral; what am I supposed to do to triage and acknowledge receipt?

A. The purpose of the requirement to respond within 14 days after receiving the referral is to provide an acknowledgement that it has been received. We've all heard someone say, 'I never received the fax.' This requirement helps ensure the referring registrant knows the referral has been received and reviewed.

Another important purpose of this requirement is to triage the referrals. This is meant to be a preliminary assessment of the referral.

- Is this a subject matter you consult on?
    - If not, let them know.
- Is there enough information provided to enable a preliminary assessment?
    - If not, let them know what additional information you require.
- Is the referral clear?
    - If not, seek clarity on where the uncertainty exists.

- If this is a routine consultation, let them know approximately when they can be seen. **You are not required to book an appointment date at this time**. If you are able to, you can book the appointment, but it is not required. You are simply providing basic information about when they can be expected to be seen. For example, if your wait list is currently three months long, you can advise that they will most likely be seen within a specified range. This provides the patient and referring registrant with a reasonable expectation of a timeline so they can plan next steps.

- Upon reviewing the material, you may conclude that the patient needs an **expedited assessment**, or they need to be seen before you can reasonably see them. In these circumstances, you are responsible for advising them of the timeline they should be seen in. You should use reasonable efforts to assist in identifying a qualified registrant who can see them within that timeframe if you cannot.

- **If you cannot accept the referral**, advise why you cannot and suggest other qualified registrants who may be able to accept the referral. The patient needs specialized medical care, and although you are not required to find an alternative registrant, you are likely more knowledgeable about who may be able to assist than the referring registrant. For the patient's benefit, you are to suggest alternatives.

Q. 4 - Despite my best efforts, it will be impossible for me to provide the required triage response within 14 days. What do I do?

A. Be respectful and reasonable. Acknowledge receipt of the referral and advise when you expect to have a triage response. You are not obligated to provide reasons for the delay, but doing so can be beneficial.

Q. 5 - While I was away on a two-week vacation, I received a consultation request via fax, which my out-of-office email response did not reply to. I cannot complete the required triage response within 14 days. What do I do?

A. Advise the referring registrant that you just returned to the office and are triaging several referral requests. Hopefully, you will receive a response within 14 days but advise them that it may take slightly longer due to a backlog.

Q. 6 - I sent a consultation request over 14 days ago but have not received any response. What should I do?

A. The Standard requires a triaged response within 14-days; however, something may have occurred that prevented the response back in that timeframe. The first step is to confirm that you

sent the consultation request to the correct contact. If you did, reach out to the registrant (or their office) to confirm receipt of the consultation request and ask when a triaged response will be provided.

As always, be respectful and reasonable in your communication.

Q. 7 - Is there a template for a consultation triage response? Another form creates an administrative burden. Do I have to use it?

A. The Standard of Practice – Non-Emergent Consultation Requests has requirements on consulting registrants to triage and respond to the referring registrant within 14 days of receiving a consultation request.

The template/form is not as important as the communication itself.
The template is provided as an example of what may be used to meet this requirement. Many consulting registrants have their own templates that provide this information to the referring registrant.

➚ Download the template for a triage response

The triage response is to close the loop on the communication that the referring registrant sent. The primary purpose of the triage response is to let the referring registrant know that you have received the request and whether you can see the patient.

Why this is important
If you cannot see the patient, the referring registrant needs to know so they can consider an alternative plan for the patient. There can be many reasons for not seeing the patient, such as:

- You may not do that type of consultation
- You may have such a long wait list that it is not reasonable for them to wait that long to see you.

There have been situations where a referring registrant has waited more than three months to be told by the consulting registrant that the consulting registrant does not provide that type of consultation. The patient is not receiving good medical care if they wait three months to be told that the physician they were referred to does not perform this type of consultation.

Fourteen days is a reasonable time for the registrant to triage the request to determine whether it is something they do.

Q. 8 - I receive about 50 referral requests a day; I cannot possibly see patients and complete all these triage responses within 14 days. Is CPSM going to punish me for being unable to complete this imposed administrative burden?

A. Registrants are required to provide good medical care to patients. CPSM recognizes that registrants are experiencing tremendous stress and burnout due to unrealistic expectations

stemming from physician shortages. CPSM also recognizes that registrants want to help patients and do not want to turn anyone away whom they can help.

It is important for registrants to recognize their own personal capacity for volume of service. The Standard of Practice – Volume of Service states:

> "Excessive workload volume may result from overly long work hours, insufficient time to provide an acceptable standard of care per unit of service or being on call most or all of the time. Each of these risk factors may in turn result in chronic fatigue and place patients at unnecessary risk."

You are not expected to be a Superhero. You are permitted to say to the referring registrant, "I do not have the capacity to consider your consultation request."

The concept underlying Collaborative Care is that when you receive a request for help, you have a degree of responsibility for that patient (you have been "tapped in"). Your initial responsibility to the patient is to determine within 14 days if you can or cannot provide medical care. If your workload volume is so excessive that you cannot provide that response the answer is clear that you must not accept them as a patient.

Q. 9 - I often receive referral requests with incomplete information or uncertain requests. How can I possibly assess within 14 days whether I can see the patient?

A. You can only triage a request based upon the information provided. There will be situations when you are provided with limited information, making triage difficult, or when no clear reason is stated for the consultation. At this point the triaging ends and you simply reply that you cannot proceed further to consider the request without specific information. Your responsibility is to provide this response within 14 days and to specify what you require to complete the triage.

The 14-day clock will reset when you receive the information you requested.

Q. 10 - What does "advise the referring registrant of my normal sequencing of patient referrals" mean?

A. The length of time it takes to see a patient after the request is received will vary from registrant to registrant and it may also vary for a registrant from one year to the next. The referring registrant and patient do not know your wait times. All you are asked to do is advise them of the *approximate time* before you see the patient. This could be three weeks, three months, or three years. You can provide an approximate range.

Q. 11 - What do I do if I receive a call about transferring a patient and my program/facility doesn't have the capacity to accept the patient?

A. You have a responsibility to assist the referring registrant with finding appropriate resources for their patient. You are not responsible for finding the appropriate resource, but you most likely have more knowledge about existing resources than the referring patient, so provide them with what assistance you can.

Q. 12 - What is my responsibility when discharging a patient from my care back to their primary care provider?

A. You should ensure that information is provided in a timely manner to the primary care provider about the discharge, including medications, any investigations or monitoring required (and who will be responsible for this), and what follow-up is required.

In situations where the patient does not have a primary care provider and may need to visit a walk-in clinic for follow-up, pertinent information should be provided to the patient.

Q. 13 - After receiving a referral letter/request, the registrant receiving the request deems that more information or additional testing is required, before seeing the patient:

1. **Who is responsible for requesting the tests?**

   If within the referring registrant's scope
   If the consulting registrant determines that the patient requires additional testing prior to triaging and that requesting the test is within the referring registrant's scope of practice, the referring registrant should proceed to request the test to expedite patient care.

   If not within the **referring registrant's scope**
   If the referring registrant feels this is not in their scope of practice, it will be the consulting registrant's responsibility to request the test.

   Clear communication between the referring and consulting registrants is key to ensuring both registrants know their roles.

2. **Who is responsible for managing the results?**

   If the consulting registrant determines that the patient requires additional testing and the result is abnormal and relevant to the reason for the consult, it would be in the patient's best interest for the consulting registrant to see them in an expedited manner.

If that is not possible, the consulting registrant could liaise with the referring registrant, and treatment or care could occur in the interim, if the referring registrant agrees.

If this is outside the referring registrant's scope of practice, the consulting registrant should make every effort to provide care within an acceptable time frame.

Q. 14 - The consulting registrant saw my patient and advised that a test or diagnostic imaging is necessary in the future for monitoring the condition. Who is responsible for requesting the follow-up test/imaging?

A. After a consulting registrant sees a patient and deems the patient stable, but in need of follow-up testing at a future date, the consulting registrant could request the referring registrant to arrange this. However, this must be agreed upon by both the referring and consulting registrants.

There are instances in which the patient may have been referred to a consulting registrant, and the referring registrant is no longer in the circle of care. The responsibility for follow-up and repeat testing would fall onto the consulting physician.

Q. 15 - As the consulting registrant, I requested a test and the results have a finding that is not within my scope of practice. Whose responsibility is it to arrange appropriate care?

A. If an abnormality is found that is not within the scope of practice of the consulting registrant, it is reasonable for the consulting registrant to communicate this to the referring registrant and clearly state what part of the test result they will deal with and what part of the abnormal result they need the referring registrant to deal with.

Clear communication and delineating expectations are key. Ignoring abnormal results or assuming the referring registrant will deal with the outstanding abnormality is not acceptable patient care.