Standard of Practice

Collaborative Care

Initial Approval: January 1, 2019 **Effective Date: January 1, 2019**

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

Additional Requirements of Collaborative Care

This Part sets out the requirements of collaborative care, in addition to those described in Sections 5 and 6 of the Regulation which are as follows:

5 When a member and one or more other health care providers are involved in the health care of a patient, the member must

(a) collaborate with other health care providers in the care of the patient and in the functioning and improvement of that health care;

(b) treat other health care providers with respect;

(c) recognize the skills, knowledge, competencies and roles of others involved in the patient's care;

(d) understand the member's role and the role of other health care providers involved in the health care of the patient;

(e) identify himself or herself to the patient or his or her representative and explain the member's role and responsibility;

(f) communicate effectively and appropriately with the other health care providers; and

(g) document, on the patient record, the member's contribution to the patient's care.

6 A member must comply with any policy about the performance of any reserved act or the provision of collaborative care that is in place in the practice setting where the member is involved in the health care of a patient if

(a) the member has been made aware of the policy; and

(b) the policy is not inconsistent with the Act or CPSM's regulations, standards of practice, by-laws, practice directions or code of ethics.

1. Patient Rights in the Referral Process

1.1. If a member or a patient suggests a referral to another health care professional, the member must discuss the purpose of the consultation with the patient.

1.2. When a member believes that referral to another health care professional is appropriate but the patient does not, the member must discuss and document in the patient's record the difference of opinion and the implications for the patient's care and

1.2.1. a member must continue to provide care within any limits imposed by the patient's decision; but

1.2.2. the member must not practice beyond his or her competence or provide care that the member does not believe is in the best interest of the patient.

1.3. Despite the Code of Ethics requirement that a member must respect a patient's reasonable request to be referred to other health care professionals or to receive a second opinion, a member is entitled to refuse to make a referral that, in his or her opinion, is unlikely to provide a clinical benefit to the patient.

1.4. A member must tell the patient about any fees that may not be covered by Manitoba Health if the referring member knows the consultant will likely charge fees that will be payable by the patient.

1.5. A member must recognize that the patient has the right to disagree with the choice of consultant or service to whom a referral is made, and the member must try to accommodate the patient's request.

2. Obligations of Referring Member

2.1. A member must make or confirm a request for a consultation, in writing, to the consultant or service unless the circumstances are urgent and the consultant agrees to accept care of the patient after oral discussion.

2.2. In the case of a referral for emergency care, the member must discuss the referral with the consultant or the emergency physician (if referral to an emergency department is being made) or otherwise ensure acceptance of care by the consultant or service.

2.3. A referring member must perform a preliminary work-up of the patient within his or her scope of practice and the available resources and ensure those results are available to the consultant or service.

2.4. If a consultation is requested solely for the purpose of providing information to a third party (for example an insurance company), the referring member must, at the time of

the request for consultation, clearly identify that the consultation is requested for that purpose.

2.5. Except in an emergency situation, a referral request by a member must be provided in writing and include at least the following information:
  2.5.1. the identity of the referring member;
  2.5.2. the identity of the patient, including the Manitoba Health number and contact information;
  2.5.3. the identity of the consultant or service to whom the patient is being referred;
  2.5.4. the date of the referral;
  2.5.5. the purpose of the referral as intended by the referring member, including whether an opinion only or transfer of care is requested;
  2.5.6. pertinent clinical information, including results of clinical investigations.

3. Obligations of Consultant Member

3.1. A consultant member or member's service must respond to the patient and member verbally or in writing to a request by a member for a non-urgent consultation within 30 days of receipt of the request and must notify the patient and the referring member of the anticipated appointment date.

3.2. If a request for a consultation is declined, the consultant member must provide reasons and whenever possible, provide suggestions to the referring member for alternative consultants or services.

3.3. If a consultant member agrees to see a patient, the consultant or a designate must contact the patient directly to schedule the appointment (including information such as the date, time, and place, and special instructions) and send a copy of that information to the referring member, unless otherwise agreed to by the referring member.

3.4. If a consultant member arranges to see a patient without a referral, the consultant must not insist on a request for consultation from the patient's primary care physician.

3.5. Except in the circumstance of receipt of consultations through a process whereby a service assigns the patient to a consultant, a member who is a consultant must make information available about the process by which referrals are accepted; for example, by telephone, facsimile, secure e-mail or verbally and the member should generally be available to respond to requests for consultations.

3.6. A consultant member must, as soon as possible but generally within 30 days of having seen a patient for the first time, report in detail to the referring member all

pertinent findings and recommendations with respect to a patient seen by the consultant.

3.7. If the consultant's conclusions require further investigation or treatment, the consultant must provide an interim report to the referring member and a final written report at the conclusion of the consultant's involvement.

3.8. Unless a patient explicitly requests otherwise, a consultant member's report must include, when applicable:

3.8.1. the identity of the consultant;
3.8.2. the identity of the patient;
3.8.3. the identity of the referring member and, if different, the identity of the patient's primary care physician;
3.8.4. the date of the consultation;
3.8.5. the purpose of the referral as understood by the consultant;
3.8.6. information considered, including history, physical findings, and investigations;
3.8.7. diagnostic conclusions;
3.8.8. the treatments initiated, including medications prescribed;
3.8.9. recommendations for follow-up by the referring member;
3.8.10. recommendations for continuing care by the consultant;
3.8.11. recommendations for referral to other consultants, but, except in the case of an emergency, such referral must only be made with the approval of the referring member;
3.8.12. the advice given to the patient.

Nothing in this section prohibits a consultant from referring a patient directly to another consultant if it is in the best interests of the patient's health to do so expeditiously. In the case of a direct referral from one consultant to another, the referring consultant must immediately inform the initial referring member of the direct referral.

3.9. If a patient explicitly requests all or some information not to be disclosed, the consultant member must advise the referring member that the patient withholds consent for release of information.

3.10. If the consultant member requires further investigation before reaching a definitive diagnosis, the consultant must not delegate arrangement and follow-up of those investigations to the referring member without prior agreement with the referring member.

3.11. A consultant member must obtain directly from the patient informed consent for any procedure and cannot rely on the referring member to obtain the consent.

3.12. A consultant member must explain to the patient the consultant's role, if any, in the continuing care of the patient and the advisability of follow-up care by the consultant.

3.13. A consultant member must contact the referring member at the time the patient is returned to the referring member for ongoing care and provide written information as soon as possible thereafter to assist with the patient's continuity of care.

4. Referral for Non-Traditional Therapy

4.1. A member, acting honestly and without conflict of interest, may refer a patient to a practitioner who provides non-traditional therapy when there is no reason to believe that a referral would pose a greater risk to a patient's health or safety than the traditional or prevailing practice.

5. Institutional Settings - Transfer of Care

5.1. Except in circumstances where the institutional setting has a procedure in place to ensure transmission of information required for continuity of care, a member who:

- 5.1.1. transfers care to another member either within the same institutional setting or to another institutional setting must ensure the accepting member has the necessary clinical information to assume care, including a summary of laboratory test results, active medical problems and a treatment plan for the patient.
- 5.1.2. discharges a patient from an institutional setting with the expectation of follow-up care by another member outside that institutional setting, or provides care in an emergency setting and has ordered tests which require follow-up or recommended follow-up care by another member, including the patient's primary care physician, must:
  - 5.1.2.i. prepare a legible summary of laboratory test results, active medical problems and treatment plans at discharge for the accepting member before the follow-up care appointment is expected to occur;
  - 5.1.2.ii. if the follow-up care is required within two (2) weeks of discharge, contact the accepting member directly to facilitate the patient's follow-up care appointment and to transfer necessary medical information.

5.2. Subsection 1 is not intended to make the member responsible for delays in the transcription and delivery of the discharge summary that are not under his or her control.