Department of Veterans Affairs

Veterans Health Administration

Referral Coordination Initiative Implementation Guidebook

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1 EXECUTIVE SUMMARY

1.1 Referral Coordination Initiative Objective

The Referral Coordination Initiative (RCI) is the Veterans Health Administration's (VHA's) revised process to streamline the referral process. This change shifts the work of multiple clinical staff members to dedicated Referral Coordination Teams (RCTs) of administrative and clinical staff dedicated to RCI.

VHA is committed to improving referral timeliness and empowering Veterans with understanding the full range of their care options. In response to the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act implementation and the ongoing COVID-19 pandemic response, VHA's change to its referral process will improve timely access to care and the overall Veteran experience.

Veteran feedback suggests many prefer to receive internal/direct VA care, regardless of eligibility for community care. The RCT provides every Veteran a complete picture of their care options so he/she can make the most informed care decisions.

Without an improved consult/referral process, the scheduling of referrals will take more time than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive internal/direct VA care may instead be referred to care in the community. The terms **consult** and **referral** are used interchangeably throughout the guidebook. The intent is to have RCTs review clinically appropriate care options and community care eligibility (if applicable) with Veterans – then move referrals from a pending/unscheduled status to a scheduled status in a timely manner.

Clinical RCTs will guide Veterans through their full range of care options including internal/direct care in VA and care in the community. All staff should discuss benefits of receiving internal/direct VA care with every Veteran. The ultimate decision regarding where eligible Veterans will receive their care remains with the Veteran. Administrative RCTs then schedule VA or community care appointments based on Veteran eligibility and preference in a timely manner. The goal is to move to scheduled status within three (3) days for internal/direct VA care and three (3) days for community care.

RCTs at each VA medical facility will ensure Veteran care is accessible, convenient, and delivered in a timely manner. Veterans can expect:

- Access to RCT support and comprehensive information about care delivery options including face-to-face care, all available telehealth options and telephone
- Convenient, efficient care coordination upon initial entry into the specialty
- Referral scheduling that reflects eligible Veteran's preference for internal/direct VA care or care in the community

1.2 Purpose of Referral Coordination Initiative Guidebook

The Referral Coordination Initiative Guidebook is a centralized source of information to support local deployment of RCI. Department of Veterans Affairs Medical Centers (VAMCs) and Veterans Integrated System Networks (VISN) are encouraged to utilize the guidance documents within to tailor strategies locally to improve timeliness and standardize Veteran education on care options both within VHA and in the community. This guide is intended to be used by VHA staff.

1.3 Future Updates to Referral Coordination Initiative Guidebook

The Referral Coordination Initiative Guidebook is a living document that will be updated as frequently as monthly as new guidance and tools are developed to support this work.

2 REFERRAL COORDINATION INITIATIVE INTRODUCTION

2.1 What is Changing and Why?

Understanding the what, why, what is not, benefits and risks of this initiative clarify the reason we are making this change. We developed a change management tool to address these important questions called the Six Essential Questions.

1) What is Changing?

The Veterans Health Administration (VHA) is changing its existing referral process by implementing the Referral Coordination Initiative (RCI). RCI shifts the referral responsibility from providers to Referral Coordination Teams (RCTs) that include dedicated clinical and administrative staff.

2) Why is it changing?

VA is streamlining the referral experience to improve timely access to care, empower Veterans to make informed care decisions, and ensure only eligible Veterans who want to receive care in the community are being referred and scheduled into the community.

3) Why is it changing now?

Assessment of MISSION Act implementation and the ongoing COVID-19 pandemic response to health care delivery resulted in more Veterans being referred to the community than expected. Veteran feedback suggests many Veterans prefer to receive internal/direct VA care.

4) What is not changing?

VA will continue providing an exceptional Veteran experience and delivering the highest quality care and services aligned to each Veteran's needs and life goals – whether that is internal/direct VA care or care in the community. Eligibility standards for community care are not changing.

5) What are the benefits of this change?

RCTs align with VHA's modernization efforts to enhance referral timeliness and consistency, empower Veterans to make more informed choices about their care, and maintain high levels of Veteran satisfaction.

6) What are the risks of not changing?

Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive internal/direct VA care may instead be referred to care in the community.

2.2 Future State

Veterans have more options than ever to receive the best, timely care. RCI's streamlined referral process will empower every Veteran to make more informed care decisions and prevent delays in scheduling critical, high quality care.

The future state process is illustrated in Figure 1: RCT Process for Referrals.

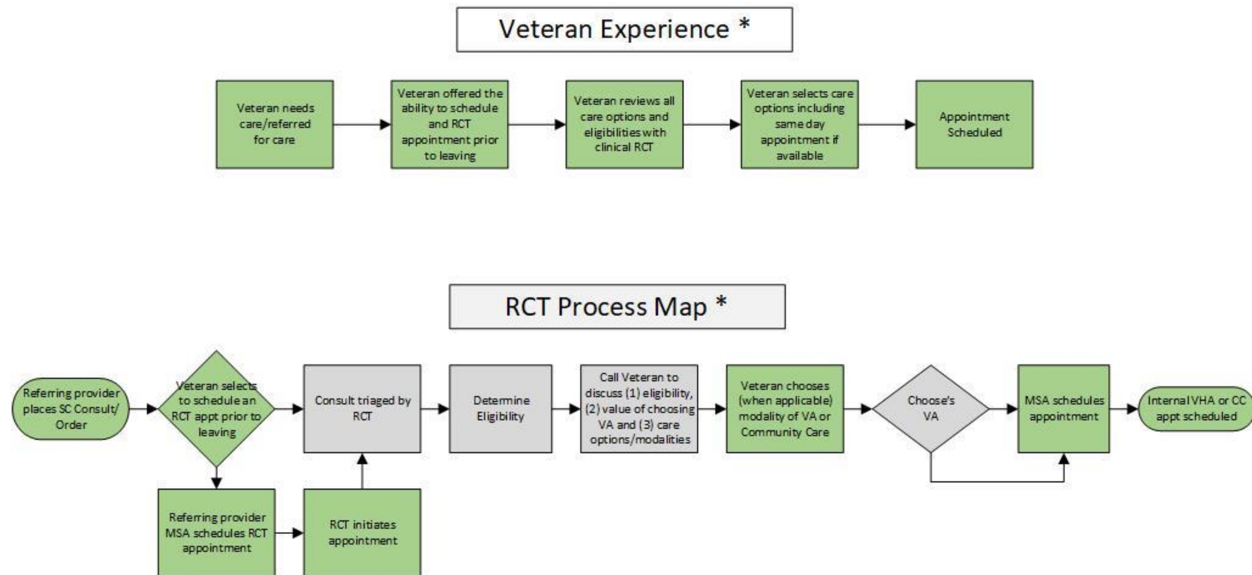


Figure 1: RCT Process for Referrals

Not all consults will result in a scheduled appointment. RCT to assess all care options including E-Consults, testing, medication refills, etc.

A more detailed process map is available for reference.

RCTs will work across Primary Care, Mental Health and Specialty Care Medicine/Surgery services. RCTs will:

- Provide each Veteran with information about all appropriate care options available, including in-person, virtual and telephone.
- Determine Community Care eligibility and secure Veteran appointments when appropriate.
- Coordinate with clinical and administrative staff who have training in both VA in-house and community care scheduling processes to eliminate unnecessary steps and people from the process – making it easier and quicker to schedule.

VHA aspires to achieve scheduling referrals on average within 3 days from time the referral is entered into the Electronic Health Record (File Entry Date) to first scheduled (1st scheduled) for both internal/direct care and community care. This is to assure that Veterans receive timely care regardless of where care is delivered. The Office of Community Care and the RCI team have developed a glidepath of scheduling timeliness milestones for community care that use

multiple process improvement tools to support VAMC's journey to reach the ultimate aspirational goal of 3 days for both internal/direct and community care scheduling.

2.2.1 Team Composition

The RCT will include dedicated clinical and administrative staff with the capability of coordinating care for internal/direct VA care and community care needs for Veterans. The clinical staff within RCTs should be nurses. Sites may use Doctor of Medicine (MD), Doctor of Osteopathy (DO), nurse practitioner (NP) and/or physician assistant (PA) during the transition to RNs on this team. These team members should be cross-trained to triage internal/direct VA care. Additional responsibilities include:

- Conduct initial triage on all consults/referrals.
- Run the Decision Support Tool (DST) or determine Community Care eligibility through alternative means.
- Call Veteran to review all available care options including internal/direct VA and community care when eligible.
- Document the conversation with the Veteran using the Consult Toolbox (CTB) tab when it is available (currently in production).
- Introduce the Veteran to the administrative staff member of RCT to schedule the appointment.

The **administrative staff** members should be schedulers or the equivalent. The RCT must have knowledge of the referral and scheduling processes both internal/direct VA and community care. Cross-training of the RCT includes proper understanding of specialty care services internal to the VA/VISN, scheduling processes internal to the VA/VISN as well as community care eligibility, services offered and timeliness of care in the community. The RCT must be able to speak to both internal VA and community care options and processes to get the patient scheduled in a timely manner.

2.3 VAMCs with Limited or No On-site Specialty Care

All VA Medical Centers (VAMC) are required to implement RCI. VAMCs with limited or no on-site specialty care should work with their VISN and VAMC leadership to develop a VISN-level inventory of available services as alternate care options for Veterans who are eligible for Community Care. VAMCs must develop appropriate service-level agreements between VAMCs for appropriate E-Consult reviews and/or in-person/virtual care appointments for Veterans who choose this alternate care option within VA. Reference the VISN Referral Coordination section for more details.

Another option for Veterans who are eligible for Community Care is virtual appointment using VA's Clinical Resource Hubs (CRHs). CRH can provide virtual specialty care to Veterans as an in-house alternative to Community Care.

2.3.1 Ideal Process for VAMCs with Limited or No On-site Specialty Care

Referring providers will inform the Veteran during his/her initial visit that the RCT will be contacting them within three (3) days to review their eligibilities and available care options, including internal/direct care in VA and in Community Care using available modalities including in-person, virtual and telephone care.

VAMCs must decide whether the RCT will be located at the site originating the referral or at a partner site (either a remote location or another VAMC). If the RCT is at the originating site, the referring provider enters an E-Consult or internal/direct consult. If the RCT is located elsewhere, the referring provider enters an E-Consult or inter-facility consult as appropriate.

In either case, the Veteran will have the option to meet with the RCT or arrange a future meeting with the RCT prior to leaving the referring provider's office. The RCT, regardless of where it is located, follows the RCT Process for Referrals (please review Figure 1: RCT Process for Referrals).

While each facility may develop strategies to address referral coordination, key minimum required strategies include:

- Implement Referral Coordination Teams.
- Eliminate direct entry of community care referrals by referring providers.
- Work with VISNs to establish a network of interfacility consults between VAMCs to support facilities with limited or no on-site specialty care services.
- Offer Veterans the ability to schedule a Clinical RCT appointment at check-out.
- Identify scheduling preferences for all Veterans who choose community care.
- Utilize RCI Clinical and Administrative staff model recommendations to support a dedicated RCT.

2.3.2 What This Means for Veterans

Local RCTs help Veterans make more informed decisions about their care while ensuring their appointments are scheduled in a timely manner for the care they need. RCTs determine all clinical care options and all potential community care eligibilities. VA will continue provide an exceptional experience and deliver high-quality care and serviced – whether the Veteran chooses internal/direct care in VA or care in the community.

With RCI, every referred Veteran can expect:

- A warm handoff from their referring provider's office to an RCT member either in-person, via VA Video Connect, or telephone
- An RCT point of contact to guide them through the referral process and their full care options
- A referral to move from a pending/unscheduled status to a scheduled status within three days for VA care and three days for community care

2.3.3 What This Means for Staff

In addition to providing a better experience for Veterans, RCI helps VA staff prioritize responsibilities. RCI will unburden referring providers from specialty care specific discussions around referrals and will allow them to focus on internal/direct patient care, initiating the "Choose VA" conversation with Veterans, and identifying future care needs of the Veteran.

Dedicated facility-level RCTs serve as an extension of Primary Care, Mental Health, and Specialty Care providers. They will review and triage referrals and discuss with the Veteran all available options for care locally, virtually, in other VA locations and community care based on eligibility.

RCT will allow Specialists to work at the top of their license, focusing on delivering internal/direct patient care for Veterans. In addition, all referrals going through the RCT/specialty care will eliminate the direct entry of community care consults from referring providers. This provides a more streamlined and thorough approach to the referral process, ensuring Veterans are offered care modalities that best meet their needs

RCI will help maintain funding of specialty care and subsequent resources that allow VA to deliver the highest quality care. RCI aligns with VHA's Modernization and High Reliability Organization efforts through commitment to good financial decisions that best serve Veterans – including decisions that impact VA's on-going ability to fund specialty care services Veterans rely on.

2.4 Support

Trainings, scripts, communications materials, dashboards, change management tools, and field-developed strong practices will be deployed to support this initiative. Further guidance on these materials will be provided in future iterations of this guide, as well as RCT meetings.

This iteration of the guidebook includes guidance on How to Get Started, RCT operations, **Error! Reference source not found.**, Best Medical Interest (BMI) information, DST changes, c ommunity care scheduling and examples for strong practices.

The email group for the RCI is VHARCI@va.gov.

3 ROLES AND RESPONSIBILITIES OF RCI

It takes a comprehensive and collaborative approach to implement RCTs at both the local and VISN level. We have outlined the general roles and responsibilities of various VISN and local facility staff to give you a better understanding of the RCI's collaborative nature. This list may not be exhaustive of all roles.

3.1 Executive Sponsors and Facility/VISN Leadership Support

Each VAMC and VISN will identify an Executive Sponsor to support the Referral Coordination Initiative. Executive Sponsors are responsible for ensuring their facility and VISN are fully supporting and moving RCI forward. Executive Sponsors remove barriers to improving processes identified by the project team as appropriate.

The Executive Sponsors should be a member of the Executive Leadership Team (ELT). We recommend the VISN Executive Sponsor be the Chief Medical Officer (CMO) (and the Chief Nursing Officer (CNO), if applicable, may also be appointed). We recommend the facility-level Executive Sponsor be the Associate Director for Patient Care Services (ADPCS), Chief of Staff (COS) or Deputy COS.

Process improvement is most effective when leaders:

- Demonstrate effectiveness in clarity of vision, decision making, relationship building, inclusion and conflict management.
- Enhance and cultivate leadership capabilities in project team.
- Empower the organization and teams to think, act, and move as a network.

From planning to post-implementation, the leadership will act as a network and utilize the six essential change management questions to establish accountability. The six questions are in 2.1 and Appendix A – RCT Six Essential Questions

3.1.1 Facility Executive Sponsors and Leadership

Facility Executive Sponsors serve as the catalyst to promote RCI buy-in and implementation at the facility level. Executive Sponsors oversee the development of a multidisciplinary Implementation Team. Staffing model suggestions are available in the Staffing, Reallocation of Resources, and Productivity Goals Section.

Facility Executive Sponsors' responsibilities include:

- Establish RCT oversight in a new and/or existing committee structure (please review the RCT Oversight Section for 508 compliance).
- Attend the facility's Referral Coordination recurring meetings.
- Ensure all relevant RCI matters (including progress, implementation updates, barriers, action plans to remove barriers, etc.) are recorded and routed through the facility's governance structure.
- Oversee and develop multidisciplinary RCTs.

3.1.2 VISN Executive Sponsors and Leadership

VISN Executive Sponsors serve as the catalyst to promote RCI goals and expectations to facility executive leadership team, service chiefs and other leaders as needed to ensure RCI is successfully implemented within the VISN. The VISN referral coordination leadership (VISN Executive Sponsor and Champion) oversees RCI implementation across all VISN facilities and development of VISN level teams as appropriate.

VISN Executive Sponsors' responsibilities include:

- Establish VISN RCI oversight in a new and/or existing committee structure (please review the RCT Oversight Section for 508 Compliance).
- Maximize VA resource utilization within VISN by overseeing resource capacity, efficiency and productivity.

Please review the Funding Referral Coordination Teams

Additional funding will not be provided for this initiative. We expect Executive Sponsors to develop the RCT by leveraging staff already supporting administrative and clinical areas that will benefit from the improved process to address (please review the Staffing, Reallocation of Resources, and Productivity Goals Section). Referral coordination is already being done at most sites, but it may not be coordinated based on the current process. Facilities and VISNs that do not have this staff on hand may need to add additional resources.

3.2 RCT Oversight

RCT oversight is critical to the success of Referral Coordination. Local facilities and VISNs need to oversee the RCI development, implementation and evaluation to ensure RCI progress is moving forward as expected. This can be accomplished through either establishing an RCT Oversight Committee *or* incorporating RCT oversight into an existing committee as a standing agenda/reporting item. Examples of existing committees include (Access Committee, OCC Oversight Council, Consult Steering Committee).

To meet the intent of RCT oversight, the following key stakeholders should be included in the development of a new committee or included in current committee structure:

- Executive Clinical Leadership
- Administrative Officer and/or Chief, Medical Service
- Administrative Officer and/or Chief, Surgical Service
- Administrative Officer and/or Chief, Primary Care Service
- Administrative Officer and/or Chief, Mental Health Service
- Administrative Officer and/or Chief Physical Medicine and Rehabilitation Service
- Administrative Officer and/or Chief, Neurology Service
- Administrative Officer and/or Chief, Strategic Planner
- Administrative Officer and/or Chief, Dental Service
- Administrative Officer and/or Chief, Healthcare Administration Service
- Administrative Officer and/or Chief of Staff or designee

- Administrative Officer and/or Chief, Community Care
- Group Practice Manager (GPM)

RCT oversight ensures RCI implementation is staying on track. Below are key actions to include in the committee meeting.

- Review, customize, and update charter to include RCT oversight (please review the RCT Oversight Section for 508 compliance)
- Establish regular reporting cadence for RCT implementation/progress.
- Develop a mechanism to track action items and ensure follow-up as suitable to the facility/VISN needs.
- Review key indicators and metrics presented by the implementation team (please review the Data and Measuring Success Section).

3.3 RCI Champions

Referral Coordination Champions are key to the success of RCI. They will drive the development, implementation and evaluation of the RCT. An RCI Champion will be appointed at each facility and at the VISN. We recommend facility Champions be the GPM and the VISN Champion be an RCI Manager and/or Business Implementation Manager (BIM).

3.3.1 Facility Champion

Facility Champion responsibilities include:

- Identify and lead RCI Implementation Team.
- Disseminate information and communication materials to staff.
- Help operationalize the RCTs.
- Identify, address, and report barriers to the Executive Sponsors.
- Track implementation progress and metrics (please review the Data and Measuring Success Section).
- Provide feedback to the local RCI implementation team and VISN RCI Leadership on overall initiative progress and ways to improve implementation moving forward.

3.3.2 VISN Champion

The VISN referral coordination leadership (VISN Executive Sponsor and Champion) oversees RCI implementation across all VISN facilities and development of VISN level teams as appropriate.

VISN Champion responsibilities include:

- Ensure consistency of RCT functions and use of RCT tools across facilities.
- Disseminate appropriate RCI materials.
- Develop VISN-level triage tools as needed.
- Develop and manage VISN RCT as appropriate.

3.4 Clinicians Related to the Referral Coordination Process

3.4.1 Referring Provider

The referring clinician are the first step in the referral process.

The referring clinician will:

- Participate with Specialty Care and RCT in the development and/or updating of service agreements.
- Follow established pre-referral guidelines/clinical pathways outlined in the electronic health record prior to entering a consult/referral.
- Enter consults prior to concluding the appointment, where applicable.
- Communicate with patient about the basic referral coordination process.
  - Referring provider enters referral.
  - RCT will review/triage/gather additional information and determine care options available both at VA and in community.
  - RCT will communicate with patient care options and allow Veteran to decide regarding where to schedule.
  - Provide Veteran with the RCT Fact Sheet (coming soon).

3.4.2 Facility Clinical Specialty Care Service

Facility clinical specialty services are responsible for providing subject matter experts to support RCTs. During the early phase of forming RCTs, facility clinical specialty services will work collaboratively with and train the RCT team to understand specialty care needs and services offered. They will build a collaborative relationship so that the RCT is an extension of the specialty service. They maintain ongoing collaboration and manage quality control with RCT clinical staff in the triage/scheduling process.

Facility clinical specialty services responsibilities include:

- Collaborate with RCT and referring providers to develop pre-referral guidelines, clinical pathways, modifications of consult templates as needed, and service agreements.
- Develop clinical triage tool that encompasses the collaborative RCT process (pre-determined clinical and scheduling guidelines utilized by the RCT for consult review, triage, documentation and scheduling).
- Provide specialty service training to the RCT Triage/Scheduling Team on the triage and scheduling of referrals in the designated services (please review the How to Get Started Section).
- Retain the overall responsibility of designated triage and management of referrals that do not easily conform to guidelines.
- Facilitate ongoing collaboration with RCT by working on day-to-day communication regarding triage and scheduling.

3.5 Referral Coordination Team

RCI establishes dedicated local and/or VISN RCTs to manage all consults/referrals. RCTs support the national standardization of how VHA addresses referrals and align with the future deployment of Cerner and efforts to standardize referral templates.

RCTs serve as the liaison between referring providers and specialty care services. They remove an administrative burden from clinicians, enabling them to spend more time focused on Veteran care by allowing non-Licensed Independent Practitioner (LIP) staff (Registered Nurses (RNs)) to clinically triage consults/referrals. RCTs improve timely access to care, empower Veterans to make more informed care decisions, and ensure only eligible Veterans who want to receive care in the community are referred and scheduled into the community.

3.5.1 Minimal RCT Composition

RCTs are required to be staffed with administrative and clinical support to quickly receive and manage Veteran referrals. The minimal composition will be a clinical team member and an administrative team member. RCT clinical staff guide every Veteran through all internal/direct VA and community care options, and RCT administrative staff then schedule appointments based on individual Veteran eligibility and preference.

Because of RCI's clinical nature, individuals who are licensed and qualified to assess patient's medical conditions either face to face, via telephone, by medical record review, etc., should be identified as the primary RCT coordinator. We highly recommended that an RN serves as the RCT clinical team member. Administrative support with Medical Support Assistant (MSA) staff is critical to the timely scheduling and coordination of appointments.

3.5.2 Clinical RCT Staff

The clinical RCT staff will receive and triage all referrals to the specialty service. This includes referrals both internal and those eligible for community care. **Consults/referrals need to go through the RCT first and should not go directly to community care.**

The RCT clinical staff should ideally be a RN. Sites may use MD/DO/NP/PA during the transition to RNs. They should be cross trained to triage both internal/direct VA and community care referrals.

Clinical RCT's responsibilities include:

- Perform initial triage on all consults.
- Run the DST or determine community care eligibility through alternative means.
- Call every Veteran to review possible options for care including internal/direct VA and community care if eligible.
- Document the conversation with the Veteran using the RCI Consult Toolbox (CTB) tab (currently in production).
- Complete a warm hand-off (defined in RCI Operations) to the Administrative RCT to schedule the appointment.

The RCT clinical staff uses a triage tool to guide decision making and determining all options of care available based on Veterans clinical need. Once the clinical triage is completed, the Clinical RCT guides the Veteran through their full range of care options based on recommendations from the triage tool. This can include a clinical conversation with the Veteran for complex care needs and options and/or an administrative conversation based on clear direction from the clinical triage note.

As previously mentioned, RCI's streamlined process is collaborative. The Clinical RCT collaborates with the following care team members as needed based on triage training protocols and training:

- Referring provider if additional information is needed
- Specialty providers during the daily triage process
- Veteran to present and discuss all appropriate care delivery options (e.g., telephone, VA Video Connect, traditional Clinical VA Telehealth (CVT), face-to-face, community care) based on referral triage
- Administrative RCT to schedule the Veteran referral appointment in a timely manner
- Community Care handoff when appropriate

Note: Communication and discussion with patients regarding VA care options can occur with both the clinical and Administrative RCT members. This is driven by the clinical nature of the specialty care request and considering the request's complexity or simplicity. To maintain an efficient RCT process, optimization of processes and having the right staff do the right task is essential in utilizing clinical and administrative staff to the full scope of their role. Depending on the specialty and complexity of care requested, it may not always require a Clinical RCT to communicate with patients their options for VA care. Please review the RCT Operations Section for more details.

3.5.3 Administrative RCT Staff

The RCT administrative staff will share with Veterans all their options for care during the scheduling process. This is driven by the RCT clinical plan/instructions documented on the consult. Administrative RCT should be a scheduler, MSA or equivalent.

Administrative RCT responsibilities include:

- Call Veterans to discuss care options and schedule appointments as indicated by the RCT clinical team member documentation.
- Use of DST to determine community care eligibility as appropriate.
- Document scheduling efforts utilizing CTB on the consult/referral.
- Document the discussion of VA wait times vs. community wait times when appropriate.
- Record a Veteran's community preferences, including if a Veteran chooses to self-schedule their community care appointment per Community Care Scheduling Enhancement Memo.
- Analyze the travel distance to select the most appropriate clinic location.
- Send the Veteran's appointment letter.

- Verify the Veteran’s contact information.
- Collaborate with RCT clinical team and with facility scheduling staff as needed.
- Ensure a warm and seamless handoff to Community Care when appropriate.
- Develop collaborative communication processes for the local facility RCT to reach out to VISN RCI or assistance.

3.6 Supplemental Role and Responsibilities Materials

- Example of Oversight Charter (Community Care)
- Example of Oversight Charter (Access and Consult Committee)

4 HOW TO GET STARTED

Identifying and putting together Referral Coordination Teams at both the local VAMC and VISN takes coordination, collaboration and teamwork! Local facilities and VISNs will work with the National RCI Implementation Teams, using the tools and training that has been provided to date. The facilities use the guidebook in conjunction with the RCI Implementation Checklist to ensure appropriate RCI implementation.

This section will outline steps to get your RCT off the ground. In the event there is VISN RCT structure in place, the local executive sponsors/champions will work collaboratively with VISN RCT to develop consistency between local and VISN RCT (refer to VISN Referral Coordination section).

4.1 RCI Implementation Checklist

The RCI Implementation Checklist was created to assist VAMCs with effectively implementing RCTs in a standardized manner, while still allowing for VAMCs to adjust as needed based on their unique needs. The checklist was created in collaboration with the Office of Veterans Access to Care (OVAC) and the Office of Community Care (OCC) and subject matter experts (SMEs) from respective medical centers. The checklist will allow VAMCs to strategically implement RCTs while ensuring that required elements are completed to successfully implement, execute and have oversight of the initiative.

The RCI Implementation Checklist captures high level tasks and sub-tasks, which are broken down by implementation phases. Below is a breakdown of the phases and number of tasks associated with each phase.

Table 1: RCI Implementation Phases and Tasks

RCI Implementation Phase	Number of Tasks
Planning	20
Execution	50
Oversight	14

VAMCs will be tasked with updating their RCI Implementation Checklist bi-weekly on the following site, using the template within the site. Instructions on how to update the checklist can be found here. A memorandum will be released communicating this requirement. The Access Office will be using the information submitted by the VAMCs to track implementation progress.

Watch 'RCI Implementation Checklist Training' here

Additional training and resources to assist with completing the RCI Implementation Checklist can be found here

4.2 Develop the RCI Implementation Team

4.2.1 Select Implementation Team Members

The RCI Champion will work with facility Executive Sponsors to establish an implementation team. This team is responsible for driving change at the facility in the development and implementation of RCT as outlined in this guidebook. This team meets routinely with an agenda and action items to progress implementation.

Recommended stakeholders are listed below:

- Chief of Staff/Deputy Chief of Staff
- Primary Care
- Mental Health
- Specialty Care
- Community Care
- Nursing
- Clinic Practice Management (CPM) Team
- GPM
- Health Administration Service (HAS)
- Administrative Leads
- Public Affairs Officer (PAO)
- Clinical Application Coordinator (CAC)'s (optional)
- Data Analytics Group (if applicable)

4.2.2 Develop Implementation Plan

The RCI implementation team will develop a facility implementation plan, utilizing the RCI Checklist, Guidebook and National RCI tools and guidance. Below are key actions to follow when developing the implementation plan:

- Review and compare current state at local site and recommended RCT process flow, roles and responsibilities. (Please review the Roles and Responsibilities of RCI
- Conduct a workload analysis and prioritize implementation by service line/specialty.
- Determine the best RCT model to implement for the facility.
- Develop a facility communication/change management plan for respective stakeholders.
- Develop a training plan for the key stakeholders (referring clinicians, RCT, specialty care service).
- Utilize transformational coaches and VISN RCI group at their facilities or VISNs.

4.2.3 Monitor and Communicate

The Champion or CPM team will support ongoing communication between all necessary groups, including facility leadership and VISN RCI leadership. This support includes the following:

- Establish routine meetings with ELT to provide updates and feedback.

- Attend frequent huddles with RCTs and RCT Oversight Committee to discuss key findings or trends.
- Arrange meetings with Primary and Specialty Care leadership to discuss the collaborative nature of RCT, roles/responsibilities of each area, etc.
- Routine communication with VAMC/VISN RCT Executive Sponsors and Champions to report program progress, risks and issues.
- Collaborate with VISN RCI leadership for consistency throughout VISN, building bridges with other facilities for services not offered locally.

4.3 Conduct Workload Analysis

4.3.1 Workload Analysis

To perform a workload analysis, it is recommended that the implementation team review the recommended RCT process. A more detailed process map is available.

After reviewing the recommended process map, the implementation team reviews and compares the local processes with the recommended RCT process with subject matter experts. Following the review of local processes, the implementation team performs a gap analysis. The team assesses the differences to identify attributes that are needed to develop a successful RCT. Some questions to consider are listed below.

When evaluating the current state:

- What is happening (volume of referrals leaving VA, which specialties)
- What is the impact (unique patients and consults going to the community, perception of the local VA)
- What is the financial impact to the VA (dollars going to the community)

When developing a future state:

- What should happen at your facility
- When it should happen
- What changes need to be made for it to happen
- Why is it better than the current situation *(timeliness of care, patient satisfaction*)
- Who will benefit (*quality of care, continuity of care, cost of care*)

Share the findings with appropriate stakeholders, capture input and use the information to inform the next steps on the checklist.

4.4 Prioritize RCT Implementation by Service Line/Specialty

Evaluation of internal specialty care resources and workload will help the facility determine the prioritization of RCT implementation for specialty care. Facilities are expected to follow the national guidelines/timelines for implementation of services. However, it is important to review a few critical items to determine where the greatest need exists:

1. Specialties with:
    a. Access issues/appointments with increased wait times (WT)
    b. The highest overall volume of referrals
    c. The highest community care demand
    d. The longer referral processing times
    e. Significant clinician time spent triaging
    f. Increased Veterans with drive time eligibility
    g. The highest volumes of community care referrals with Best Medical Interest (BMI) as the eligibility since beginning use of DST
    h. A strong clinical champion
    i. Strong academic affiliations
2. Modalities of care being offered (i.e., Telehealth, VA Video Connect (VVC), Face to Face, Telephone Clinics)
3. Time providers spend triaging consult (time that could otherwise be used to implement VVC, Telehealth, telephone appointments, procedures, etc.)
4. Specialty care services not offered by the local facility but potentially offered within VISN
5. Gap Analysis that includes staffing and clinical services offered at the facility and across the VISN
6. Patient Self-Referral Direct Schedule (PSDS) Clinics
    a. PSDS is a process where Veterans can call a Specialty Care clinic directly to schedule an appointment for routine care without needing a referral.
    b. If RCT leadership feels that PSDS is resulting in inappropriate referrals into the community and/or irresponsible utilization of care, it is appropriate to halt the direct scheduling and run through RCT.

4.4.1 Update CPRS Consult Menu

The local Computerized Patient Record System (CPRS)/Cerner consult menu should reflect available services/specialties in the VISN. The following steps need to be followed:

1. Work with Specialties and Community Care, Consult Committees, etc., to determine what unavailable services can be offered at the VISN or other VAMCs/the Department of Defense (DoD).
    a. Establish a process for Inter-Facility Consults (IFCs) and virtual care services where appropriate, and ensure these processes are reflected in the CPRS/Cerner order menus. If the service is offered within the VISN, the Community Care service/specialty consult should be removed from the consult ordering menu and or restricted to appropriate personnel only (i.e., RCT).
    b. Revisit service list monthly. If there are any changes, communicate changes to ordering providers.
2. Use VISN menu of services to determine which Community Care consults are needed on menus for all ordering clinicians and ensure that orders are on the menus for these specialties. Remove Community Care (CC) referral menu to drive the in-house referral option. There should be very limited referrals available to referring providers in order to promote use of RCT and available internal care options.
3. Establish order menu.
4. Work with Clinical Applications Coordinator to update consult menus for the RCI process (refer to the CPRS Technical Guide).

5. Work with Clinical Applications Coordinators to give the RCT clinical and admin staff appropriate alerts to automatically receive the consult/referral and the ability to write on and process the consult appropriately.
6. Train clinicians, schedulers, Specialties, and Community Care on updated consult menus and appropriate use of direct to community care consults.
   a. Train providers *before* the menus are setup.

4.5 Staffing, Reallocation of Resources, and Productivity Goals

This section will provide guidance on appropriate staffing roles and productivity goals. This guidance provides sites the flexibility to determine the best way to reach these desired outcomes given the structure and staff currently available at one's site and VISN.

Staffing ratios are dependent on the service and how each service utilizes their nursing allocation may alter the ratio. Multiple tools are needed to ensure efficiency of the RCT and will be provided as the guidebook is developed. To be successful, the team needs to have the following information easily accessible: (1) clear triage directions, use of a clinical triage tool (2) internal and external options available and applicable to the Veteran, and (3) simple scheduling instructions.

The RCT will be triaging and dispositioning the referral; informing the Veteran of their internal and external modalities of care options; and scheduling care. The recommended initial RCT triaging productivity target is approximately 25-45 referrals per day per clinical staff member (almost 10,000 referrals per year). Productivity measures may vary depending on the specialty given complexity of some services. For example, clinical triage of Oncology or Cardiology may take longer than Podiatry or Optometry. It is important to take this into account when establishing productivity metrics. Please review the Clinical Triage Recommendation Section below for the formula used to calculate this target. This productivity target is subject to change based on field level data. Changes will be reflected in future guidebook releases.

VAMCs are required to create RCTs that will be responsible for integrating relevant information across specialty services, with an aim to provide Veterans with the best and most timely care options. RCTs at each VA medical facility will ensure Veteran health care is accessible, convenient, and delivered in a timely manner. Veterans can expect:

- Access to RCT support and comprehensive information about care delivery options including face to face care, all available telehealth modalities and telephone
- Convenient, efficient care coordination upon initial entry into the specialty
- Referral scheduling that reflects the Veteran's preference for internal/direct VA care or care in the community (if eligible)

4.5.1 Clinical Triage Recommendation

Strong Practice: Approximately 25-45 referrals per day per clinical staff member or almost 10,000 referrals per year

Clinical staff can triage incoming referrals, provide scheduling guidance, discuss care options in the service, and be a resource within the service. We recommend looking at the volume of referrals that specialty service receives and assigning approximately 10-25 minutes per referral. Considering there are 510 minutes in an 8 ½ hour day, and 60 minutes are reserved for lunch and breaks throughout the day, there are truly 450 workable minutes throughout the day. This means that we could expect a nurse to handle up to 45 referrals per day or almost 10,000 referrals per year (when factoring in normal leave usage). This formula may be adjusted locally as needed but should be close to this target.

Ideal: 55-60 referrals per day as demonstrated by DoD Integrated Referral Management and Appointing Center (IRMAC) model

For more information on #RCT#, reference RCT Operations Section, subsection #RCT#.

4.5.2 Scheduling Recommendation

Forthcoming in future guidebook versions.

Preliminary information for some specialties is in the How to Get Started Supplemental Materials Section.

4.5.3 Staffing Structure Consideration

The RCT should be made up of administrative and clinical team members. The clinical Full Time Equivalent Employee (FTE) recommendations for RCT members are RNs, PAs, Social Workers (SWs), and/or Advanced Practice Registered Nurse (APRNs)/NPs. Ideally it would be an RN and MSA used to provide frontline care to Veterans (Please review the Minimal RCT Composition Section). The administrative FTE recommendations for RCT members are MSAs, Advanced Medical Support Assistants (AMSAs) and/or other clerical administrative roles such as Licensed Practicing Nurses (LPNs), Health care Technicians (HTs).

To source the RCT member, we highly recommended for facilities to examine FTE utilization and re-allocate staff members first before establishing new FTE if re-allocation examination is inconclusive. When re-allocating, the facility should:

- Evaluate Community Care FTE
- Evaluate current Staff & Specialty Care Case Managers
- Evaluate current Reasonable Accommodation Clinical Staff
- Evaluate RN Staff vs. Inpatient Bed Days of Care (BDOC)/length of stay (LOS)/Occupancy
- Evaluate current Clerical/Admin FTE & Productivity

4.5.4 Alignment / Supervision of the RCT

The alignment and supervision of the RCT will be based on how the facility operates day-to-day. Some recommendations for RCT alignment and supervision are with Specialty Care Services, Clinic Practice Management Team (supervision vs. strong working relationship), or any other existing Care Coordination programs/team.

4.6 Identify Optimal RCT Model

The RCI implementation team should use their workload analysis and current process flows to determine the most appropriate RCT Model. Sites fall into three categories:

1. Category 1: They currently have the clinical support/nursing infrastructure in Specialty Care.
2. Category 2: They are a smaller site with limited Specialty Care, but often send much of their Specialty Care to another VA site.
3. Category 3: They are somewhere in in-between categories one and two, with limited clinical support/nursing infrastructure in place for Specialty Care they offer.

A description of the most common RCT models with pros and cons are listed in the following sections.

4.6.1 Centralized RCT Model

The Centralized RCT model houses the entire RCT team (administrative and clinical) under the same management structure, but they are built and function as an extension to the specialty care service. For the greatest success of this centralized model, the RCT management team works collaboratively with specialty care leadership team to ensure that the team is trained and functions as an extension of specialty care. This model builds a bridge between RCT and specialty care to ensure accountability and consistency in how VA services are utilized to the full extent.

Table 2: Pros and Cons of Centralized RCT Model

Pros	Cons
▪ Staff is co-located (physically or virtually), easing burdens on communication and messaging challenges ▪ Consistency in training, processes and functions ▪ Consistency in RCT practice due to singular focus consistent with RCI principles ▪ Improved collaboration between the central team and specialty care services ▪ Ease of determining best use of VISN resources for VISN RCI leadership	▪ Other services lose existing staff if no additional facility FTE added ▪ Services outside the central team may not share extensive understanding of RCT model to the same extent as centralized RCT staff

If this model is selected, the implementation team should schedule a meeting with facility leadership, including the COS, nurse executive and Specialty care service chiefs to coordinate development, implementation and education of this centralized model. Alignment of RCT under the COS or ADPCS is recommended.

4.6.2 Service Line/Specialty RCT Model

The Service Line/Specialty RCT model is when the RCT is embedded in the existing service line or specialty and duties are aligned with roles of RCT members.

If this model is chosen, the facility needs to determine who will provide oversight regarding the successful implementation of RCI, given the management structure potentially crosses multiple areas. The facility will need to bring together all key stakeholders to ensure each specialty service RCT is following the processes for admin/clinical functions as outlined in this guidebook. In addition, it is critical that the education of each RCT understand VISN resources available and how to connect with VISN RCI as appropriate.

Table 3: Pros and Cons of the Specialty Line/Specialty RCT Model

Pros	Cons
▪ Services do not lose any FTE ▪ Minimal/no organizational differences from existing footprint though duties will change	▪ Additional duties added onto potentially already overburdened staff, RCT may not be the primary focus of the staff member ▪ Potential for decentralized team members to see RCI as "just another duty" ▪ Lack of consistency in practice due to different levels of understanding of the RCI goals ▪ RCT functions under multiple management structures, which often silos teams and processes, making consistency difficult to manage ▪ Difficult to educate every specialty service regarding VISN resource availability

4.7 Form Referral Coordination Team

This section describes how to identify and form the RCT. VAMCs and VISNs have autonomy to staff the RCT based on current staff and specialties available locally. However, facilities must dedicate sufficient staffing to ensure successful RCI implementation across required specialties at their facility.

The composition of this team should follow the minimum composition recommend in the Roles Supporting Referral Coordination Minimal RCT Composition Section. Suggested staffing models can be determined with analysis of your process (Please review the Conduct Workload Analysis Section). The facility implementation team will make recommendations regarding the model that best fits the facility's needs and communicate this to Executive Sponsor.

The RCT will begin supporting our Veterans by triaging referrals and determining the care options available to address their care needs.

Please review the RCT Operations Section regarding the details of how the RCT will function. Below sections outline tools the RCT must use during the referral triage and scheduling process.

RCT Cross-Training

The RCT must have knowledge of the referral and scheduling processes both internal/direct VA and community care. "cross-training" of the RCT includes proper understanding of specialty care services internal to the VA/VISN, scheduling processes internal to the VA/VISN as well as community care eligibility and services offered. The RCT must be able to speak to both internal VA and community care options and processes to get the patient scheduled in a timely manner.

4.7.1 Required RCT Tools: Consult Toolbox (CTB) and Consult Tracking Management (CTM/CTM+)

Consult Toolbox (CTB)

RCT members must be able to forward a consult to community care (section 2.18 in the community care field guidebook) using CTB. TMS course ID: 4562418 is available to train the RCT on how to use CTB. RCT must also be able to capture patient preferences for community care, including if a Veteran chooses to self-schedule the community appointment. Please review Community Care Scheduling Section and/or (section 2.9-2.12 in the community care field guidebook); TMS course ID: 4558590 specifically focuses on how to capture preferences.

Consult Tracking Management (CTM/CTM +)

Staff are required to use CTM/CTM + **when it is available**. CTM is being sunset in the beginning of 2022. The benefits of CTM+ include:

- Provides a department/service view of RTCs.
- Displays and updates consult information in real time for both direct/internal and community care consults.
- Integrates with other VistA packages to provide up-to-date information on the same page.
- Creates workflow efficiency by eliminating paper or duplicative systems.
- Provides worklist view ensure every team member had up to data work list for consults they need to process.
- Improves patient satisfaction by providing tools to help ensure timely completion of consults.
- Monitors user performance and view numerous metrics pertaining to consult aging and bottlenecks.
- Includes consult tracking unique to Community Care workflows.
- Provides efficient, automated tools for tracking and managing RTCs.
- Provides additional features for enhanced progress note management.
- Provides enhanced scheduling features that allow viewing appointments by clinic.

Steps the Implementation team should take to setup CTM+ at the site include:

- Work with DSS on scheduling facility training after CTM+ is approved by the Network Director or Facility director and contract is awarded.
- Train staff on CTM+ and provide information brochure to impacted staff.
- Implement CTM+ in daily operations.

Find more information on technical aspects of CTM and recommendations for procurement. Additionally, any questions not addressed by the resources provided/linked to this guidebook should be directed to Alyssa Tsai (atsai@dssinc.com).

4.7.2 Local Facilitation of RCT Training

RCT training at the local level is crucial for RCT members to familiarize themselves with referring provider groups and more importantly, specialty care groups. The following steps should be followed to ensure the RCT is trained.

1. Identify local training point of contact, who will coordinate and report on training status of RCT to the implementation team.
2. Deploy training from the national RCT team.
    a. Clinical Training for RCT should follow the RCT Prerequisites: "Getting to know your Specialties" Prior to RCT Go-Live Section. An example of and RN orientation checklist is linked here and in the How to Get Started Supplemental Materials Section.
    b. Administrative Training for RCT guidance can be found on the National Standardized MSA Training SharePoint.
3. Deploy training from locally developed SOPs to customize the training to your specific VAMC/VISN.
    a. The building of a triage tool for each specialty is a crucial part of RCT Operations Section, it is the tool which directs RCT clinical staff on how to consider a patient in accordance with a specialty. More information on how to build and operate the tool, along with examples, can be found in the RCT Operations Section.
    b. Remember to include education of RCT members on beneficiary travel, special mode travel, and Veteran Transportation Service availability (Disabled American Veterans (DAV), shuttle services, etc.). This can vary by site or VISN.

4.7.3 RCT Prerequisites: "Getting to know your Specialties" Prior to RCT Go-Live

Each Specialty develops and arranges a comprehensive orientation for their designated RCT. If a centralized model is used, Specialty care and RCT management will work together to ensure all elements of RCT development are included. This should include the development of a clinical triage tool (Please review RCT Operations Section for details).

1. RCT reviews Specialty process and materials to thoroughly understand their Specialties and function as an extension or bridge to the Specialty.
    a. Suggested activities:
        i. Overview of the Specialty

1. Development of clinical triage tool (Please review the RCT Operations Section. List all services, procedures or other care that the Specialty provides
2. Services work-up orientation (i.e., what needs to be done when certain referrals are received: labs, procedures, other RCT coordination)

ii. Specialty Care Organizational Chart
iii. List and define roles of all the Specialty staff (admin, clinical support, physician, etc.)
iv. Current Clinic Staff schedules (i.e., How is the Specialty covered and operate?)
v. Current Service Agreements
vi. Current Referral Triage Process
vii. Scripted quality talking points (i.e., Why should a Veteran consider this VA specialty care clinic?)
viii. Note/Referral Templates
ix. Documentation expectations for the RCT
x. List of common errors in referrals, and how identify and properly re-disposition to correct Specialty

2. RCT shadows Specialty, developing a working relationship and building a cohesive team.
    a. Administrative and Clinical RCT (admin and clinical) observe current state including referral triage and scheduling process. Example activities include:
        i. Spending time in the specialty clinic with the team understanding clinic functions, services, etc.
        ii. Reviewing consults/referrals with the providers who have historically triaged consults. This provides the Clinical RCT clinical insight and training in how best to clinically triage and disposition referrals using the clinical triage tool.
        iii. Spending time with scheduling team members as appropriate to better understand scheduling and review coordination issues.
3. Specialty, National Program Office, and VISN leadership provide detailed "buffet" Menu of services the VA/VISN offers. The RCT uses this menu to determine the comprehensive range of services the VA offers both locally and at the VISN. RCT is completely aware of all options available to Veteran, within VA health care system and community. These options will be offered to the Veteran during the referral process.
    a. Options for care include:
        i. E-Consults
        ii. Local tele-specialty options
        iii. Telephone visits
        iv. VVC
        v. Face to face
        vi. Group visits
        vii. VISN referral options (i.e., VISN menu of services)
        viii. Other regional VA referral options (geographically close, but different VISN)
        ix. National tele-specialty options

x. Community options
xi. Other Options

4.8 Socialize and Educate Facilities

Socialization and education of RCI and the newly formed RCTs are critical steps in the implementation process. Ensuring the facility staff understand the critical role that RCT plays in the referral process is central to successful implementation. The RCT serves as a liaison between primary and specialty care, yet they are also an extension of the specialty care service designed to ensure patients are well prepared for their specialty care visit, at VA or in the community. VA is moving to operate more like multispecialty practices, with open lines of communication between different clinics to ensure our Veterans are receiving timely coordinated care. When appropriate, this care can be delivered by VA. When our Veterans will be better served in our communities, we will support that care. Further guidance will be developed to support this change management effort, but initially it is important to make sure these groups understand their roles and the future benefits of this process change.

Ideally facility socialization and education start before the RCT is formed and functioning. The facility Executive Sponsors/Champions and implementation team should lead this effort. Tools to use in the socialization/education process include:

- Please review the Internal/Staff factsheet (coming soon) and Scripts for Discussing Care Options Section, that are available in this guidebook.
- Executive Sponsors are encouraged to hold town halls or leadership sessions to communicate the importance of this initiative to all staff.

4.9 How to Get Started Supplemental Materials

- RCI Implementation Checklist Training
- Limited Specialties Webinar Recording
- How to Build a Triage Tool
- Service Agreement SOP (coming soon)
- Administrative RCT Training
- NEJM Catalyst Article: The Referral Coordination Team: A Redesign of Specialty Care to Enhance Service Delivery and Value in Sleep Medicine

5 OPTIMIZING REFERRALS

5.1 Consult Directive 1232

The consult directive 1232(2) published August 24, 2016 and associated SOPs (located in the supplemental materials) outline the requirements for the implementation and maintenance of the CPRS Consult application in VHA. Specifically, responsibilities for consult status timelines, responsibilities for sending and receiving services, business rules for consult set up and usage and oversight responsibilities are defined. The policy for the disposition and scheduling of consults for both Mental Health and Non-Mental Health services including provider review and minimal scheduling efforts are defined. The processes for disposition of low-risk consults are also outlined.

5.2 Developing Care Coordination/Service Agreements

A Care Coordination/Service Agreement is a written agreement made between any two or more parties, where one party sends work to the other, outlining the workflow rules. The agreements may exist within or between facilities. They are developed by consensus; signed by service chiefs from involved services; and reviewed or updated as changes are needed or as set forth by local medical center policy. Refer to the Care Coordination/Service Agreement SOP (coming soon).

The assumption should be made that the Chief of Staff has fully endorsed the use of Service Agreements and has relayed that endorsement and expectation of involvement to Service Chiefs. Additionally, GPM and Associate GPMs would be the ideal owners of this process.

The following checklist may be used to assist facilities in the implementation of Care Coordination/Service Agreements:

1. Utilize a standard template including the following elements:
    a. Service Overview
    b. Services Provided
    c. Staffing & Availability
    d. Services Not Provided
    e. Referral Process & Expected Timeliness
    f. Required Referral Information
    g. Criteria for Discharge
    h. Review & Renew Dates
    i. Signatures from Service Chief and Primary Care Chief
    j. Contact Information for Service
    k. Appendices (items the service wants included, but do not fit into the above categories)
2. Assess the current state of Service Agreements.
3. Existing Service Agreements should be:
    a. Transitioned to the standardized template.
    b. Reviewed for accuracy by current Service Chief and/or designee.
4. Prioritize Services without Service Agreements based on volume, complexity and costs.

5. Meet and/or communicate with Service Chief regarding potential stakeholders for the service.
6. Organize a kick-off meeting with stakeholders to:
    a. Provide objective of Service Agreements.
    b. Develop relationships.
    c. Create an understanding of consensus decision-making with involvement from Primary Care stakeholders.
    d. Assign responsibilities for sections within the Service Agreement.
7. Coordinate follow-up meetings with stakeholders with an identified deadline for the completion of the initial draft.
8. Meet and/or communicate with Primary Care Chief regarding potential Primary Care Providers for review of Service Agreements.
    a. Coordinate with assigned Primary Care Providers regarding input required and timeline of review of Service Agreements. A reasonable deadline must be established.
9. Follow-up with Specialty Service stakeholders on feedback provided from Primary Care.
10. Coordinate any additional meetings between Specialty Care and Primary Care stakeholders, if needed to come to consensus on Service Agreement.
11. Obtain signatures on Service Agreement from Service Chief and Primary Care Chief.
12. Publish Service Agreements to SharePoint.
13. Educate staff on availability, location and expectations of use of Service Agreements. Consider adding link to Service Agreement within Consult Template.

Refer to examples of Care Coordination/Service Agreements.

5.3 What Makes a Good Consult?

5.3.1 Referring Perspective

A consult template should be developed with the initiating provider, the receiving service, and the patient in mind to promote ease of entry, accuracy of clinical content, and timeliness of completion to ensure that the patient gets the right care at the right time in the right place.

A consult template should reflect a negotiated and mutually agreed-upon understanding of appropriate conditions for referral and necessary work-up prior to referral entry as embodied in the Care Coordination/Service Agreement.

A simple and streamlined consult template enhances communication within patient care teams. The contents of the consult template should be tested for usability to assure efficiency and ease of data entry while minimizing response burden.

The clinician will:

1. Choose the consult in the CPRS orders tab.
2. Within the consult, select STAT (within 24 hours) or Routine.
3. If appropriate, select a specific procedure or diagnosis within that consult so the specialty knows how to best route it.

4. Ensure adherence to Care Coordination/Service agreements, ordering any tests required for comprehensive specialty care. A consult template may or may not automatically prompt the clinician to place necessary orders.
5. The consult template should be uncluttered and easy to navigate. Basic requirements for triage and coordination of a consult are:
    a. Indication/clinical history
    b. Reason for request
    c. Does the patient agree to this referral and has patient been told that a member of the Referral Coordination Team will contact him/her?
    d. Indication of patient preferred modality of care (i.e., Video telehealth, E-Consult, Face-to-Face)

5.3.2 Example Consults

The following consult template was developed by Gastroenterology (GI)/OVAC and sent out nationally for a Screening Colonoscopy. It is very simple for the referring provider to fill out, contains information on the patient's other diagnoses and whether the patient has issues with sedation.

Reason for Request: COLONOSCOPY SCREENING OUTPT

Screening Colonoscopy

Does the patient have a primary 1st degree relative with history of colon cancer? * Yes No

Please identify if the patient has any of the following:
*
- [ ] Diabetes
- [ ] Anticoagulant use
- [ ] Severe Pulmonary Issues/Home O2 use
- [ ] Drug Use/ ETOH abuse
- [ ] PTSD
- [ ] None
- [ ] Other:

Has the patient had previous problems with sedation? * Yes No

Comment:

* Indicates a Required Field | Preview | OK | Cancel

Figure 2: Screening Colonoscopy Consult Template

Cardiology Echocardiogram (ECHO) consult which:

- Contains the reason for ordering the ECHO

- Has a data object to pull in the most recent ECHO / Catherization
- Asks for the reason the patient had a previous ECHO

Template: Cardiology ECHO

☑ <----CLICK HERE TO BEGIN

Select the Primary for performing ECHO:*

☐ Assess venricular function

☐ Assess valvular function/ new onset murmur

☐ TIA/Stroke (bubble study)

☐ Shortness of breath

☐ F/U study with onset of new symptoms

☐ Other:

Last ECHO: ECHO AND CATHERIZATIONS

No data available

Has patient received ECHO in last year (VA or Community Care)?

○ No

◉ Yes, Select Primary reason for performing ECHO in less than 1 year: *

☐ Prosthetic valve

☐ Recent admission with a cardiac condition

☐ Severe native valvular disease

☐ Acute Aortic Syndrome or Aortic Dissection

☐ Endocarditis

☐ Pericardial Effusion

☐ Change in NYHA Class for Heart Failure

☐ Other: (Enter brief justification- do not type refer to note)

All | None | * Indicates a Required Field | Preview | OK | Cancel

Figure 3: Cardiology ECHO Consult Template

5.4 Update Consult Menu

The local CPRS/Cerner consult menu should reflect available services/specialties in the VISN. The following steps need to be followed:

1. Work with Specialties, Community Care, Consult Committees, or other oversight committees, to determine what unavailable services can be offered at the VISN or other VAMCs/DoD.
    a. Establish a process for IFC and virtual care services where appropriate, and ensure these processes are reflected in the CPRS/Cerner order menus. If the service is offered within the VISN, the Community Care service/specialty consult should be removed from the consult ordering menu and or restricted to appropriate personnel only (i.e., RCT).
    b. Revisit service list monthly. If there are any changes, communicate changes to ordering providers.
2. Determine which Community Care consults are needed on menus for all ordering clinicians and ensure that orders are on the menus for these specialties. (More scripting information can be found in the Scripts for Discussing Care Options Section.
    a. Remove referrals from the Community Care (CC) referral menu to drive the in-house referral option so those clinics can have a chance to meet the Veteran's clinical needs and only forward to CC if a Veteran is CC eligible and opts-in
3. Establish order menu
4. Work with Clinical Applications Coordinator to update consult menus for the RCI process (refer to the CPRS Technical Guide).
5. Work with Clinical Applications Coordinators to give the RCT clinical and admin staff appropriate alerts to automatically receive the consult/referral and the ability to write on and process the consult appropriately.
6. Train clinicians, schedulers, Specialties, and Community Care on updated consult menus and appropriate use of direct to community care consults.
    a. Train providers *before* the menus are setup.

5.5 Optimizing Referrals Supplemental Material

- Consult Processes and Procedures Directive 1232 (2)
- Consult Tips of the Week
- Consult FAQs
- Consult Timeliness SOP (coming soon)
- Consult Business Requirements (coming soon)
- Unable to Schedule SOP (coming soon)
- Minimal Scheduling Effort SOP (coming soon)

6 VISN REFERRAL COORDINATION

6.1 VISN Referral Coordination Program

This section will outline the key strategies to fully engage VISNs in RCI development implementation. VISN Referral Coordination has two elements to consider:

1. VISN RCI oversight, guidance and assistance to local facilities that offer limited specialty care
2. VISN RCT Operations

6.2 VISN Oversight and Offering Limited Specialty Care Support

VISN RCI oversight, guidance and assistance to facilities offering limited Specialty Care are key to the overall success of referral coordination. VISN RCI leadership should provide a clear understanding and expectation for facilities to incorporate use of VISN resources prior to sending patients to community care. In addition, they will establish consistent standards and processes that will assist and support the local RCT in fully utilizing VISN resources.

VAMCs that do not offer a wide array of Specialty Care services to address Veteran's health needs will require additional coordination. In such situations, the RCT (local or VISN) must look for all VA care options across the VISN to ensure that the patient is offered all internal/direct VA care and community care options available prior to making a decision. VA offers a variety of face to face, telehealth, VA Video options, all of which must be considered and offered to Veterans during the referral coordination process. Ensuring that local facility RCTs have access to a How to Put Together VISN Menu of Services Section and the ability to connect with VISN RCT (if available) to assist in offering the wide array of VA services available will provide Veterans with the best possible options to meet their healthcare needs.

VISN RCI Leadership will:

- Ensure streamlined processes for inter-facility consults (IFCs) and handoffs between facility. Consider use of a "Business Rules" within the VISN to communicate VISN processes and expectations. An example of this is provided (VISN20 Care Routing Business Rules).
- Establish VISN RCT as a hub for the local RCT to assist in the knowledge and use of specialty care resources across the VISN. This will assist in building collaborative relationships between local RCT and VISN resources.
- Collaborate with VISN ICC, CRH and OCC is needed in the development activities of IFC process, Menu of Services, Service Agreements, etc.
- Develop service agreements between primary care, RCT and specialty care services that outline the roles/responsibilities to ensure smooth handoffs across the VISN. Examples of these are in the How to Get Started Supplemental Materials Section.
- Support increased use of Telehealth Options, VA Video Connect (VVC) – offer this to all VISN facilities for services with limited specialists.
- Evaluate the current IFC process and determine how to improve this. Consider future state with Cerner implementation.

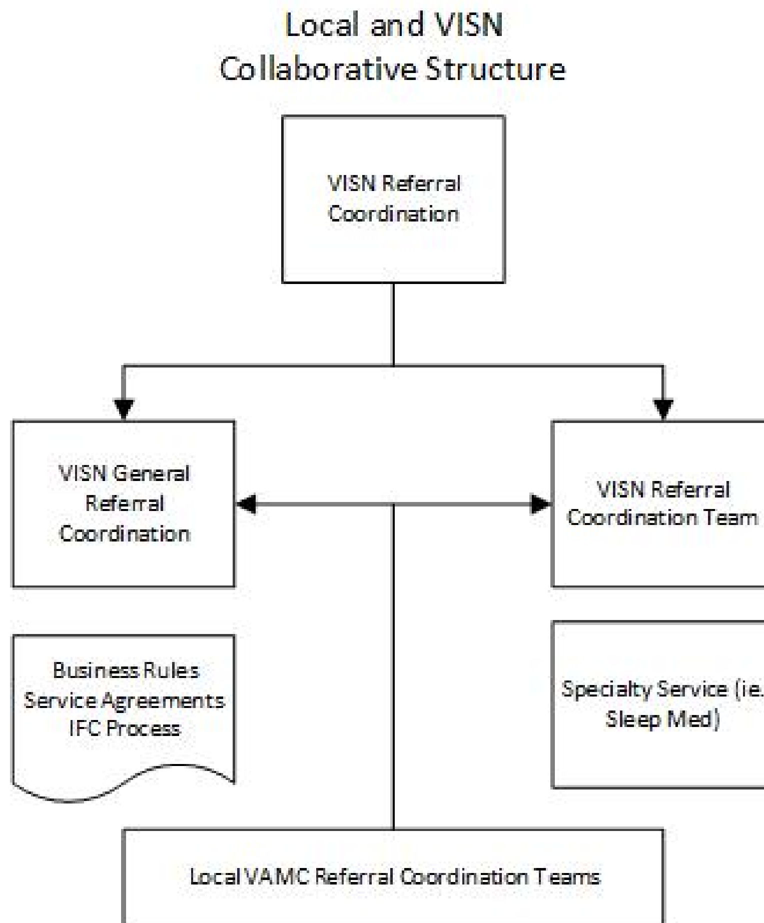


Figure 4: VISN RCI Collaborative Relationship with Local RCT

6.2.1 How to Put Together VISN Menu of Services

Engage VISN Integrated Clinical Community (ICC) lead for specialty care to work with facility specialty care section chiefs to identify services offered at each of the facilities within the VISN. Other key stakeholders to include in this process are VISN CC leadership and VISN RCT leadership. This engagement will ensure collaboration and consistency in development of the menu of services as well as education and implementation of this RCT tool. Please reference an example of a VISN Menu of Services format.

6.2.2 How to Use VISN Resources

Ways to utilize VISN resources include:

- RCTs can use of VISN Menu of Services to ensure all options of care are presented to patients.
- RCTs can use a VISN Access Dashboard to help facilities determine wait times across the VISN. This will need to be modified in the transition to Cerner.

6.2.3 How to Hand-off Referrals (IFCs) Between Facilities

VISNs should ensure there are clear processes around IFC use (in business rules) between facilities. Include the local RCT in the IFC process to promote collaboration and timely handoffs.

6.3 VISN RCT

The VISN RCT model centralizes specialty referral triage and scheduling, for a particular specialty. The model allows VISN RCT to search all facilities within the VISN for timely care that best fits the Veteran's needs. This model can be used for specialty services that are scarce or limited within the VISN and/or are complex and require a good working knowledge of VISN-level resources.

A specially trained team of nurses and administrative AMSAs work closely with the Veterans, each other, and the clinical services at each facility to meet the Veteran's needs. This model is a great example of how to provide referral coordination and internal/direct VA services to those facilities who do not provide specialty care service(s) at their local facility. This model has a strong interdisciplinary approach, working daily with providers at the local facilities as an extension of the local facility specialty service. The team uses a VISN Clinical Triage Tool that guides the decision making of the nurse and provides pertinent information for the admin/scheduler regarding what services are offered at each facility.

VISN RCT goals include:

- Optimize the number of Veterans receiving specialty care within the VA network.
- Maximize opportunities for care through alternative care modalities, including VA Video Connect, Telehealth, Phone Clinic and traditional face to face.
- Maximize utilization of existing clinical resources across a VISN.
- Optimize referral triage and appointment schedule process.
- Provide consistency across the VISN utilizing established tools.
- Decrease provider time spent triaging referrals.
- Ensuring patients have accurate information regarding VA and community resources.

When VISN RCT is established for a specialty across the VISN, local RCT is not needed for that specialty, as the VISN has chosen to provide a VISN approach to referral coordination. VISNs can use this approach for complex specialties and specialties where there are limited resources in the VISN. VISN Referral Coordination acts as the hub while the local facility RCT act as the spoke. The VISN Referral Coordination Hub should establish a routine meeting with the local RCTs to promote and provide open communication, continuity of care, consistency across VISN, collaboration, bridge building and open sharing of services. This will ensure VA is offering Veterans quality and timely care within VA.

6.4 Strong Practice/Brief History VISN Care Routing/Referral Coordination

VISN Care Routing was launched in VISN20 in 2014 in response to managing waitlist challenges. The VISN Care Routing Team serves as a central hub to assist facilities in the coordination of complex patients and scarce specialty resource needs, providing consistent communication regarding services available within the VISN. VISN Care Routing Business Rules were developed to ensure all facilities were functioning as an integrated network and to promote seamless and timely transitions of care from facility to facility. Multiple tools have been developed to assist in the Care Routing process, including: Access Dashboard, Care Routing Inquiry Process, Cancer Care Interdisciplinary Team and Change in Services Process.

In 2018, VISN20 Care Routing worked with OVAC to pilot the Specialty Care Routing Triage & Scheduling Model, which resulted in the VISN20 Sleep Medicine pilot, based on the DoD Integrated Referral Management & Appointing Center (IRMAC) model.

What started as Care Routing in 2014 has now transitioned as the national Referral Coordination Initiative that can be implemented at local facilities as well as VISN. VISN Referral Coordination is critical to support the local RCT to maximize utilization of specialty care resources across the VISN when local facilities cannot provide the service. This includes utilizing all care modalities (e.g., face to face, Telehealth (CVT and VVC), telephone clinic and E-Consult). VISN RCT can look across the VISN and schedule patients at any facility within the VISN, per patients request. RCI promotes providing Veterans with options for internal/direct care within VA as well as in the community. RCT provides patients with VISN level resources so they can make the best-informed decision for care.

Referral Coordination Division
Organizational Chart

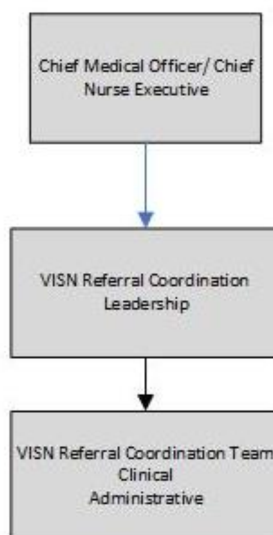


Figure 5: Referral Coordination Division Organization Chart

6.4.1 VISN Referral Coordination Roles and Responsibilities

VISN RCT roles and responsibilities mirror those listed in Roles and Responsibilities of RCI Section. However, there are a few slight differences when a VISN RCT is established, which requires coordination and collaboration across multiple facilities.

VISN Referral Coordination Leadership

Responsible for oversight of RCT triage and scheduling functions for designated services and facilities within VISN, including but not limited to:

- Manage and supervise VISN RCT, ensuring adequate staffing, space, and equipment to meet VHA referral triage timelines.
- Coordinate with local specialty services to implement processes, using a phased approach, in the designated services and facilities.
- Collaborate with local RCT in development of hand offs when appropriate to VISN RCT.
- Collaborate with facility leadership to maintain RCI consistency throughout VISN.

Facility Leadership

Responsible for collaborating with VISN Referral Coordination Leadership.

Facility Clinical Services

Responsible for collaborating and training the RCT in their specialty clinical services, including:

- Develop pre-referral guidelines/clinical pathways and the RCT triage tool in the designated specialty.
- Provide specialty training to the RCT team to develop them as extension of the service
- Collaborate with VISN Referral Coordination MD and Program Manager providing guidance and oversight when provider input is required.

Designated clinical services retain overall responsibility of triage and management of referrals that do not easily conform to triage guidelines.

VISN Clinical RCT

Responsibilities are the same as local Clinical RCT. However, the VISN Clinical RCT routinely communicates/collaborates with local facility specialty service and other RCT teams as needed to identify VISN resources/services available.

VISN Administrative RCT

Responsibilities and recommended staff (typically an AMSA) are the same as local RCT. However, the VISN Administrative RCT can schedule across multiple VISN facilities to offer and schedule internal/direct care within VA whenever possible. They collaborate with community care when the Veteran chooses this VISN option to ensure timely transition and handoff for scheduling.

6.5 How to Get Started

This section is like the VAMC in the How to Get Started Section. However, there are a few things to consider when building a VISN RCT. The following steps will help you systematically walk through how to identify and create a VISN RCT.

6.5.1 Assess Need – What Makes Sense at VISN and What Can Stay Local

RCI success relies on identifying the appropriate specialty service to launch VISN Referral Coordination Triage/Scheduling. This requires a "current state" assessment across the VISN of specialty care services.

6.5.2 Identify Key Stakeholders

Stakeholders are responsible for strategic planning, reviewing specialty data, decision making and identification of leadership team, steering committee and workgroups.

VISN Level Stakeholders:

- VISN CMO
- VISN BIM
- VISN Primary Care Committee
- VISN Specialty Care Access Team/ICC/Clinical Resource Hub
- VISN Telehealth Coordinator
- VISN Chief Nurse
- VISN Health Administrative Service (HAS) Leadership
- VISN CAC
- VISN Project Manager

Facility Level Stakeholders:

- Facility Chiefs of Staff
- Facility Specialty Care Leadership
- Facility HAS
- Facility Telehealth Coordinator
- Facility Chief Nurse
- Veteran
- Veteran Experience Office (VEO)
- Union Leadership

6.5.3 Complete Current State Assessment

Assess the current state by reviewing the following topics:

- What specialty care services are scarce across the VISN?
- What local RCT's currently exist?
- Where is there a large volume going into community care?
- How much time do providers spend triaging referrals?

- What types of modalities is the service currently using (e.g., telehealth)?
- Data gathering (community care volume, clinic timeliness, provider time triaging)
- Current/upcoming initiatives
- Cerner/electronic health record (EHR)
- MISSION Act
- On-Demand Appointments
- VA Online Scheduling
    - New Scheduling Software

6.5.4 Develop Business Case

Develop a business case by considering the following:

- What might Referral Coordination do for my VISN?
- How will my VISN support expansion of RCT at the VISN?
- What resources are needed for planning?
- What needs will be met by implementing VISN Referral Coordination?
- How will local RCT and VISN RCT team work together?
- Create a presentation to VISN Clinical Services and Resource Management.

6.6 Develop and Plan

Once VISN RCT concept is approved, we recommend holding a face-to-face Strategic Planning Kickoff Meeting with key stakeholders from VISN and local facilities. A kick-off will not increase buy-in, but it also develops and cultivates working relationships with the team invested in VISN RCT.

6.6.1 Identify VISN Leadership Team

The Leadership Team is responsible for oversight of launching VISN RCT and should include VISN and local facility team members and have no more than 10 individuals. Team should meet weekly initially to discuss implementation timeline, progress of workgroups, identification of barriers and decision making.

6.6.2 Identify VISN Steering Committee or Overseeing Body

The Steering Committee is responsible for guiding decisions related to what specialties are implemented VISN-wide and for the overall guidance on VISN level decision making. This committee can include a larger number of individuals, with everyone ideally involved in the initial planning sessions. This meeting group should come together monthly to review progress, problem solve barriers and ensure VISN RCT is moving forward.

6.6.3 Identify Individual Workgroups

Individual workgroups are needed to manage the large-scale change and implementation of RCT at the VISN level. These groups should be multi-disciplinary with an identified lead and clear workgroup charter with timelines. There is a considerable amount of “pre-work” that must

be done prior to launching the VISN RCT. This "pre-work" is assigned to the workgroups listed below. The number of workgroups can be adjusted based on the identified need in your VISN.

6.7 Workgroups

Develop clear and concise Workgroup Charters for each group.

Example of Referral Guidelines Workgroup Charter: Develop clinical pre-referral guidelines and referral templates that clearly communicate to the referring provider what is expected prior to referral. Guidelines will be consistent across the VISN, providing uniformity and consistency for the referral coordination team triaging from site to site.

List of workgroups:

- **Referral Guidelines/Pre-Work Team:** Develop guidelines, referral templates, and clinical triage tool.
- **RCT – Triage and Scheduling Workgroup**: Assemble the VISN RCT team, role of Clinical RCT member, role of Administrative RCT member, documentation of triage, SOPs, etc.
- **Care Delivery/Telehealth Workgroup** (CVT, VVC, Telephone, and Store and Forward): Develop VISN Telehealth Service Agreement (TSA) and support expansion of VVC across facilities.
- **Communications Workgroup:** Identify and develop training tools for local/VISN staff, and market and promote the VISN RCT.
- **Clinical Applications Coordinator (CAC) Workgroup**: CACs are key stakeholders in strategic planning and are part of the workgroups. They must partake in the initial strategic planning and early assessment of what systems/processes are already in place and what needs to be built. Tools requiring CAC involvement include: Referral Guideline Menus, CPRS/EHR Templates, Note Titles, and assigning VISN referral coordination staff as recipients to alerts and Interfacility Consults.
- **Data Workgroup**: Conduct baseline data gathering; ensure metrics are in line with RCI; perform ongoing data management/validation, patient/provider satisfaction, and data quality validation.

6.7.1 Pre-Work

Prework consists of:

- **Pre-referral Guidelines/Clinical Pathways:** The referring provider must follow these guidelines to patient information and required studies/tests *prior* to entering referral. These guidelines are specific to the specialty service that are developed by the Referral Guidelines team and then embedded in the EHR. Consistent guidelines across the VISN for a given specialty provide consistency for the referring providers, referral coordination staff and the receiving specialty service. Depending on where your VISN is with Cerner implementation, you must collaborate with Cerner/EHR team during this phase.

- **Electronic Health Record Referral Templates:** EHR referral templates include auto-populated patient information as well as templated questions prompting the input of pertinent clinical information needed by the triaging clinical team. The Referral Guidelines team developed these templates, which are embedded in CPRS/Cerner. Consistent templates across the VISN ensure consistency for referring providers, referral coordination staff and the receiving specialty service. They should be clear and simple but provide enough clinical information for the both the triaging and receiving team. (Note that these will change with Cerner Implementation.)
- **Clinical Triage Tool:** The Clinical Triage Tool contains pre-determined clinical guidelines and scheduling guidelines for clinical and Administrative RCT to use for referral review, triage, documentation and scheduling of care. This is a specialty-specific tool that the Triage Team and Referral Guidelines team build collaboratively. This is a decision-making tool for both the clinical and administrative staff, providing consistency from facility to facility in the triage/scheduling process. This tool takes time to build and can be a "living document" that is edited as the program evolves. Specialty providers throughout the VISN must provide input into this clinically based decision-making tool. RCI has/will provide basic triage tool templates and a "how to build a triage tool."
- **VISN Service Agreement:** This document outlines the expectations of the referring provider, VISN referral coordination team and specialty providers as patients are shared across the continuum of care. The Referral Guidelines team develops the VISN Service Agreement, which provides a common understanding of roles, responsibilities and expectations for sharing patients within a VISN.
- **VISN Telehealth Service Agreement (TSA):** This document is required to initiate Telehealth Services. A VISN-level TSA can be developed for a specialty for consistency across the VISN.

6.8 Develop Performance Monitoring Plan in Line with RCI Expectations

Monitoring the progress of VISN Referral Coordination triage/scheduling is integral to understanding the overall impact that RCT has on the VISN and local facility specialty care programs. RCI success depends on monitoring timeliness of VA care, community care demand and quality of nurse triages. Leadership must identify VISN level data management for the VISN RCT in collaboration and support of the local facility RCT metrics.

Examples of performance monitors include:

- Quality
    - Accuracy of Nurse Triage
    - % Provider Agreement with Nurse Triage
    - % Order/Plan change
    - % Order/Plan deferred to provider
    - Quality should be assessed in two periods: 1) initial training, and 2) continuing review.

        - Initial Training: Initial training may include a higher level of provider oversight in the early phases, which likely includes provider co-signature on triage notes until the providers feel nurses competent to triage independently, per triage tool.
            - Continuing Review: After the initial training period ends, nurses no longer co-sign specialists for review, unless the triage tool requires it based on patient complexity, but ongoing audit and feedback is essential to maintain triage accuracy and quality.
- Timeliness and Access
    - Time to scheduling contact
    - Time to appointment
- Community Care Demand
    - Community Care Referral volume pre/post VISN RCT
- Provider Time
    - % provider spent triaging referrals
- Patient/Provider Satisfaction
    - Patient perception of timeliness to care
    - Patient perception of knowing next steps in care
    - Patient perception of being treated with respect
    - Provider perception of VISN RCT impact on provider time

6.9 Implement and Monitor

Once the workgroups have completed the pre-work, VISN RCT training should begin. The Communications Workgroup will have identified key stakeholders for training and created training slides for the following example audiences:

- Referring Providers - VISN Primary Care Committee
- Specialty Providers – VISN Specialty Team Committee
- Facility Scheduling
- Community Care
- VISN RCT

VISN RCT functions are very similar to the local RCT. However, the VISN RCT can look across the VISN for specialty care resources that are not available locally and provide patient's with expanded VA options for care. The VISN Clinical RCT has easy access to the specialists within the VISN for clinical inquires and triaging who are readily available to assist local RCT when local services are not offered. The VISN Administrative RCT can schedule at local facilities across the VISN, offering VVC or other appropriate modalities.

VISN RCI implementation includes routine VISN Referral Coordination meetings, which are led by the VISN RCT manager and include the VISN Referral Coordination representative and Local RCT representative for each facility. These meetings provide a consistent forum for questions, identification of barriers, problem resolution, team building and refining processes across VISN.

6.10 Monitor and Improve

Ongoing evaluation of the VISN RCT is critical to the success of this program. The VISN Leadership Team and/or Steering Committee meet regularly to assess VISN RCT's overall impact. This includes routine evaluation of the baseline data as well as ongoing data. The routine VISN RCT and local RCT team meetings will provide valuable input on the day-to-day operations of the VISN and local RCT interactions and handoffs of care.

- VISN leadership should identify changes needed to meet goals and objectives.
  - VISN and Local RCTs will likely recommend updates to the triage tool; updates to standard operating procedures; and workflow process improvement.
- Collect data and generate performance reporting.
  - As VISN referral coordination expands, continue to use the RCI Data Portal to publicly guide timeliness of care and community care utilization.

VISN leadership, facility leadership and national RCI leadership communication and reporting is critical to the ongoing success of RCI. There needs to be appropriate overseeing bodies that tie together VISN and local RCT's.

6.11 VISN Referral Coordination Supplemental Materials

- Example of VISN Service Line Agreement
- Example of VISN Menu of Services
- Example of VISN Telehealth Service Agreement
- How to Build a VISN Triage Tool
- Example of Referral Coordination Business Rules – V20

7 RCT OPERATIONS

RCT operates within the RCI framework and provides resources for a standardized approach to receive, triage, review and gather clinical information in the health record; to identify barriers to scheduling the referral; and talking to Veteran's about their care options.

The process map below depicts the recommended RCT operations process from RCT receipt of consult/referral all the way through RCT conversation and scheduling decision with the Veteran.

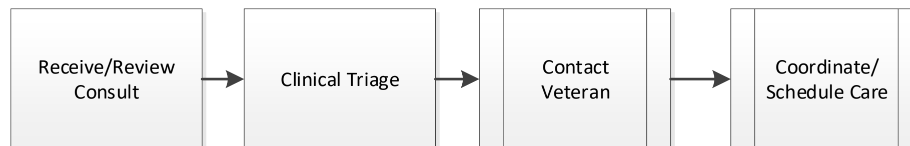


Figure 6: RCT Operations Process Map

7.1 Receive/Review Consult/Referral

The Clinical RCT initially receives the consult/referral to determine the urgency/appropriateness of the referral and potential care options.

Initial assessment of the consult/referral includes:

- Referral reason clearly stated and was routed to the correct specialty.
- Referral is not a duplicate.
- Referral contains appropriate pre-work.

It the referral is not appropriate for the RCT based on the above elements, the RCT may disposition the referral in various ways. Each way should be documented in the referral for tracking purposes. The most common ways are listed below.

- Convert referral to E-Consult.
- Provide a return to clinic order if patient already established in specialty.
- Forward the referral to the correct specialty service, documenting the reason for forwarding.
- Reach out to referring provider for clarifying information needed.
- Cancel referral clearly documenting reason for cancellation.

7.2 Clinical Triage

7.2.1 Overview

RCT's clinical triage of the consult/referral ensures that all clinical information is clear and available in the medical record when the patient is seen in VA's specialty care or in the community. RCT promotes efficiency by ensuring Veteran health care is accessible, convenient, and delivered in a timely manner. Part of this work includes ensuring proper pre-work and clinical information is available once the referral appointment is made.

When triaging specialty care referrals, RCTs conduct a medical chart review to gather clinical information and determine the most appropriate level of care for the Veteran. First, the EHR will alert RCT clinical team members to the specialty care consult. Work with your local CAC on how to setup automatic alerts for CPRS. For alerts in the Cerner platform, the RCT will need to create their worklist such that they will be the first to receive all referrals for their specialty. The Clinical RCT uses an approved triage tool for consistency in the clinical triage and scheduling process. Instructions how to create and use the triage tool are in the Clinical Triage Tool Section.

The Clinical RCT member should use the COVID-19 CTB priority tabs to capture the appropriate referral priority for scheduling purposes (mandatory use for priority 1 and 2). The use of the #RCT# is in addition to the clinical triage comments and use of COVID-19 CTB priority tab. Also refer to Prioritization for Consultations Procedures and Appointments.

Specialty care services often require medical testing prior to a medical visit. Since each facility and specialty has unique testing requirements and availability, it will be up to each specialty service to determine which tests are essential to complete prior to a medical visit. In addition, each specialty service will determine how recent the testing should be and whether the Veteran would need new testing prior to an appointment. This information should be listed in the triage tool. The RCT will document the triage actions on the consult/referral utilizing a template and/or CTB that will provide a clear and consistent summary of the triage, conversation with the Veteran and the plan/next steps for the patient.

7.2.2 Medical Record Review

The Clinical RCT uses the clinical triage tool in the medical record review process to track what clinical information is needed during the triage process. Upon receipt of the referral, the Clinical RCT first determines the urgency of the consult/referral and if testing has been completed in the EHR. If testing is not indicated as complete in CPRS/Cerner, the RCT should search in Vista imaging, Radnet or in the Joint Longitudinal Viewer (JLV) to see if the Veteran had testing in the community or at another VA/DoD location. If there is incomplete information on the consult/referral, the Clinical RCT may need to reach out to the referring provider for additional information.

During the review of medical records, the Clinical RCT can determine complex coordination needs, barriers to care coordination and community care eligibility to understand the Veteran's best available care options.

7.2.3 High Risk and Complex Veteran Considerations

High Risk Veterans can be defined in a multitude of ways, including having one or more of the following characteristics: high intensity medical management, suicide risk, homelessness, frequent ER user, polypharmacy, frequent PCP visits, frequent admissions, and medication non-adherence. Find further information regarding the CAN Score and the Patient Care Assessment System (PCAS) with the supplemental material on High Risk and Complex Patients.

7.2.4 Eligibility

Veteran Community Care eligibility criteria became effective June 6th, 2019 under the VA MISSION Act of 2018. Find key aspects of community care eligibility and the six eligibility criteria can be found in the MISSION Act factsheet. All Veterans should be offered VA care options regardless of community care eligibility, so they have a choice in where they receive care.

7.2.5 Tools to Use (Required and Optional)

- The Consult Toolbox (CTB) should be used by the RCT to forward consults to community care as well as capture Veterans preferences. Refer to Community Care field guidebook for instructions on how to use CTB.
  - RCT members must be able to forward a consult to community care (section 2.18 in the community care field guidebook) using CTB. RCT must also be able to capture patient preferences for community care (section 2.9-2.12 in the community care field guidebook).
- The Consult Tracking Manager (CTM/CTM +) must be included in daily RCT operations when it is available. Refer to the How to Get Started Section to determine if your VISN has CTM and review information on how to setup CTM locally.

7.2.6 Documentation

The Clinical RCT responsible for triage completes the RCT brief templated note in the consult with a clear plan for the next step. This keeps it all in one place, so when the patient/referral arrives to their appointment, all the information is on the referral string. The consult should be dispositioned (scheduled, forwarded, cancelled or completed) within three business days (excludes weekends but not holidays). The Consult Timeliness SOP is coming soon.

Documentation of clinical triage provides transparency in the medical record as outlined above. Documentation occurs in the consult/referral itself to promote clarity and ease of finding information relative to the consult/referral. We recommended that the RCT use a standardized note template/format directly on the consult and/or via CTB.

Example of RCT Triage Template:

- Patient referred for X (reason for referral):
- Pre-work and/or diagnostic studies completed and/or available in CPRS/JLV/Vista Imaging:
- Special Considerations:
- Patient discussion:
- Plan:
- Patient Preferences: (if patient chooses community care) [capture in CTB]
  - Provider Preference
  - Day of week and time of day
  - Scheduling preference (i.e., self-schedule or VA schedule)

Find more information on general guidance on why to disposition a referral can be viewed.

7.2.7 #RCT#

The Referral Coordination Initiative Project team has worked to develop a tab within the Consult Toolbox (CTB) 2.0 to allow for appropriate tracking of consults reviewed by the clinical members of the Referral Coordination Teams (RCTs) within the facilities. The RCI tab within CTB 2.0 is tentatively scheduled to be released late July or August, therefore an interim process has been developed in order to appropriate monitor consults that are reviewed by the clinic member of the RCT.

The guidance below captures the process for documenting the review of consults (for tracking purposes only) by the clinical member of the RCT:

Upon receiving a consult or when adding a comment based on clinical review, the clinical member of the RCT will add a **#RCT#** comment that the consult was addressed by a clinical RCT member.

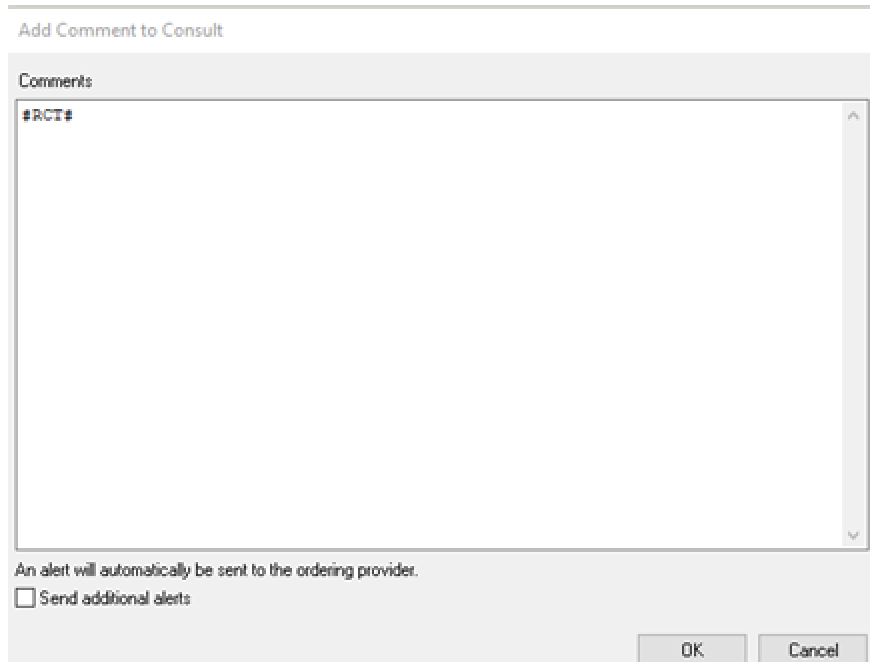


Figure 7: Add #RCT# Comment to Consult

Figure 8: Receive Consult with #RCT# Comment

The use of the #RCT# comment is for tracking purposes, but appropriate consult review and documentation actions must still take place as outlined above.

The comment must be captured only by the clinical member of the RCT. Per the current process, the clinical member of the RCT will review the consult for clinical appropriateness and provide scheduling guidance to the administrative staff within the team.

A report is being created and will be added to the RCI Dashboard to capture the number of consults with a #RCT# comment added for appropriate monitoring.

7.2.8 Clinical Triage Tool

A clinical triage tool is a pre-determined clinical and scheduling guideline used by RCT for consult review, triage, documentation and scheduling. It is built collaboratively with specialty providers, referral coordination nurses and administrative team and provides a clinical algorithm for nurse decision making in determining appropriate care routing modalities. This triage tool also includes scheduling guidelines and scripting for administrative staff when scheduling appointments. This tool is not part of the EHR; RCT uses this tool for decision making and routing of care.

Reasons to use a triage tool include:

- Allows nurses to clinically triage consults/referrals based on an approved MD algorithm (triage tool).
- Allows specialty providers to re-direct their time to things only a provider can do (e.g., clinic visits, procedures, and VVC).

- Provides consistency in the referral and scheduling process – everyone using the same document.
- Provides clear expectation of documentation in the record summarizing referral triage, plan and scheduling.

Creating a triage tool is a collaborative process that includes physicians, nurses and admin staff. Details about how to build a triage tool "how to slides" and a "base triage tool" examples are linked here and in the Supplemental Materials Section.

Example triage tools by specialty:

- Cardiology VA
- Gastroenterology IRMAC
- Sleep Medicine VA
- General Surgery IRMAC
- Cancer IRMAC
- Cancer/Oncology VA
- Hem-Oncology IRMAC
- Pulmonary IRMAC
- Dermatology VA

7.3 Contact Veteran

Once the clinical triage of the consult is completed, Clinical RCT can **hand it off to the Administrative RCT to call** the Veteran and schedule. The conversation with the Veteran to discuss VA options for care can happen both with the clinical and Administrative RCT. Each facility determines the workflow and who best to have the conversations. Regardless of who has the conversation, it must happen; patients must be given an option for internal/direct VA care vs. Community Care (when eligible); and staff clearly documents the discussion in the EHR.

Contacting the Veteran and offering internal/direct VA care options is critical. We need to ensure that patients have all care options available to them whether internal/directly in VA or community care, and ultimately, they have a choice. If they are eligible for community care, we cannot assume they will choose that based on distance or wait time measures. They make the final choice once all options presented to them.

If a facility does not offer a specialty, the local RCT needs to discuss internal/direct VA care options within the VISN, as the service may be offered via Telehealth or VVC. A Menu of Services Example can be found in the Virtual Care Supplemental Materials Section.

We have provided scripting to help facilities with Veteran conversations to ensure the right conversations are happening and documented clearly in the EHR. Please review Scripts for Discussing Care Options Section to guide you through the process.

7.3.1 Determining Who Should Contact the Veteran

If the Clinical RCT contacts the Veteran

During the clinical triage of the consult/referral, Clinical RCT may need to call patient to gather additional clinical information and discuss care options for the high risk and more complex specialties. This allows the Clinical RCT to address any clinical questions the patient may have as well as thoroughly explain VA resources both locally and across the VISN that would best meet the patient's needs. The Clinical RCT will then hand off the scheduling activities to the MSA once the patient has decided on VA or community care. Examples of high-risk specialties that would likely require a phone call from the Clinical RCT include Oncology, Neurosurgery, complex Cardiology, etc.

If the Administrative RCT Contacts the Veteran

The Administrative RCT will call patient to offer VA options for care and/or community care options *when* the Clinical RCT determine it is appropriate, based on clinical complexity requested. This should be documented by the Clinical RCT on the consult/referral triage summary directing the MSA to call patient. This process will decrease the number of phone calls the patient receives as they will get one phone call from MSA providing both VA/Community Care Options AND the ability to schedule during the same phone call. Example of this could be a referral for some of the lower risk specialties such as Podiatry, Optometry, Audiology, Physical Therapy, Primary Care.

Handoffs between Clinical and Administrative RCT

There are multiple options for handoffs between the clinical and administrative RCT to begin the scheduling process. A warm handoff is considered to be an immediate handoff between two parties via phone or IM. Warm handoffs are is considered to be ideal, however, depending on local processes, smooth and timely handoffs can be accomplished in the following ways:

- Alert system in the EHR consult/referral system (i.e., via CTB).
- Transfer call to MSA while patient is on the phone.
- Enter or forward consult/referral to community care when this option is selected.
- STAT Referrals (internal/community care) requires a telephone conversation to for handoff and disposition.

Teams/Skype and other messaging systems can be used for informal hand-offs in addition to formal hand-offs listed above.

During the discussion with the patient, the RCT needs to communicate VA resources that patients may need with scheduling their appointments, such as transportation options. See below for guidance relative to transportation services.

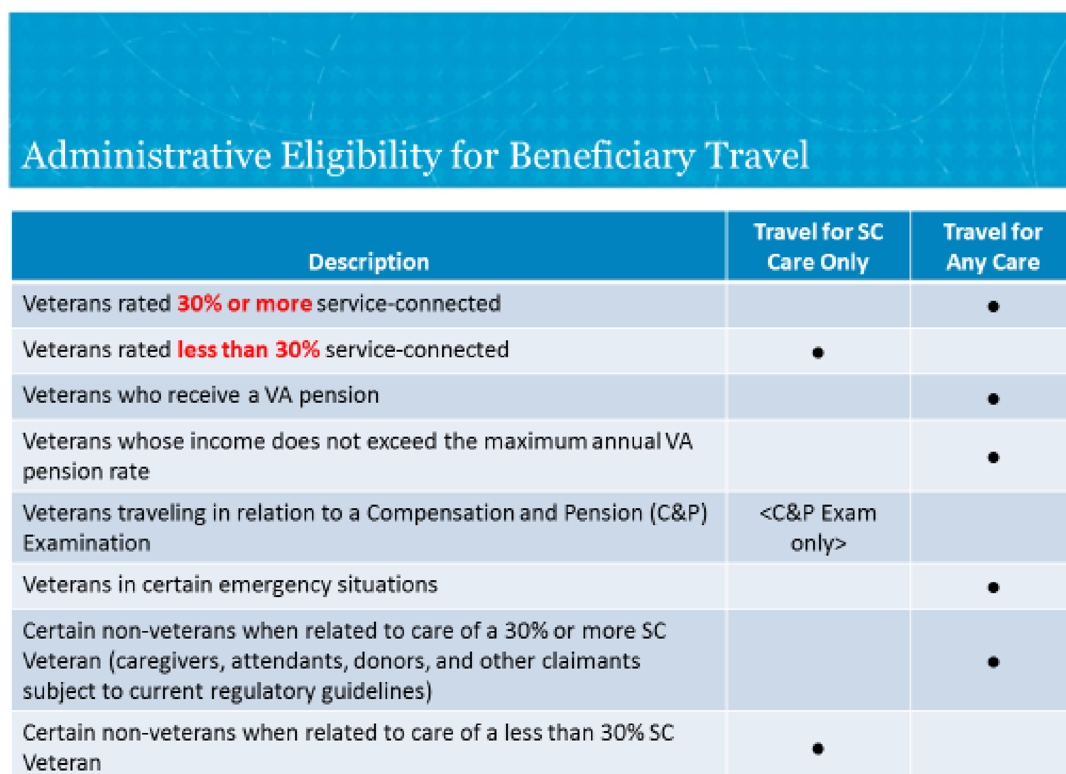
7.3.2 Solutions for Transportation

RCTs identify their local and VISN opportunities for transportation needs of Veterans when seeking to keep this care within VA's health care system and mitigate and/or reduce travel expenses.

RCTs collaborate with their local Beneficiary Travel point of contact(s) to pinpoint what modes of transportation are available to your VAMCs.

Several national programs within the Veterans Transportation Program (VTP) offer transportation assistance to Veterans obtaining health care at VAMCs or an outpatient clinic across the country. When a Veteran does not have any other means of transportation, they are eligible for VTS transportation.

RCTs should check with their local Beneficiary Travel Office for additional guidance regarding Veteran's eligibility requirement (see below) and other travel benefits that may be available within their respective VISN and/or Network.



Administrative Eligibility for Beneficiary Travel

Description	Travel for SC Care Only	Travel for Any Care
Veterans rated **30% or more** service-connected		•
Veterans rated **less than 30%** service-connected	•	
Veterans who receive a VA pension		•
Veterans whose income does not exceed the maximum annual VA pension rate		•
Veterans traveling in relation to a Compensation and Pension (C&P) Examination	<C&P Exam only>	
Veterans in certain emergency situations		•
Certain non-veterans when related to care of a 30% or more SC Veteran (caregivers, attendants, donors, and other claimants subject to current regulatory guidelines)		•
Certain non-veterans when related to care of a less than 30% SC Veteran	•	

Figure 9: Administrative Eligibility for Beneficiary Travel

Veterans Transportation Program

VA's VTP offers Veterans many travel solutions to and from their VA health care facilities. This program offers these services at little or no costs to eligible Veterans through the following services:

1. Beneficiary Travel (BT)
2. Veterans Transportation Service (VTS)
3. Highly Rural Transportation Grants (HRTG)

7.3.2.1.1 Veterans Transportation Service

VTS provides safe and reliable transportation to Veterans who require assistance traveling to and from VA health care facilities and authorized non-VA health care appointments. VTS also partners with service providers in local communities to serve Veterans' transportation needs. Partners include:

1. Veteran Service Organizations (VSOs)
2. Local and national non-profit groups
3. Federal, state and local transportation services

Find a VTS location near you. (Find a VTS location near you.)

7.3.2.1.2 Beneficiary Travel

The BT program reimburses eligible Veterans for costs incurred while traveling to and from VA health care facilities. The BT program may also provide pre-approved transportation solutions and arrange special mode transportation (SMT) at the request of VA. Veterans may be eligible for common carrier transportation (such as bus, taxi, airline or train) under certain conditions. All BeneTravel eligible veterans must have a referral confirming a Medical need for wheelchair or common carrier transports.

7.3.2.1.3 Highly Rural Transportation Grants

HRTGs provide grants to VSOs and State Veteran Service Agencies. The grantees provide transportation services to Veterans seeking VA and non-VA approved care in highly rural areas. These grants are available in counties that have fewer than seven people per square mile. HRTGs are specific to VISNs if needed.

Learn more about the HRTG program and VA's grants program. (Learn more about the HRTG program and VA's grants program.)

7.4 Coordinate/Schedule

Once internal/direct VA care and Community Care options have been discussed with the patient and they have decided, it is time to begin coordination of scheduling. There will be documentation on the consult/referral from the Clinical RCT providing direction to the Administrative RCT regarding scheduling.

There are basically three options for scheduling:

1. Local VA facility
    a. Administrative RCT will review the scheduling instructions documented by the Clinical RCT to determine the next steps in scheduling.
    b. Administrative RCT reviews/establishes appointment modality (face to face (F2F), VVC, etc.) per triage tool and/or Clinical RCT documentation/direction.
        i. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note

requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

   c. Administrative RCT reviews/establishes Veteran scheduling preferences for internal/direct VA care (provider, date, time, location).
   d. Administrative RCT calls to schedule appointment (refer to contact Veteran and scripting sections).
   e. Administrative RCT documents all scheduling activities on the consult/referral via CTB.

2. Another facility within the VISN.
   a. Clinical RCT forwards the consult to the preferred VA facility/service via the IFC process.
   b. Receiving VA facility/service Clinical RCT reviews the consult, annotates consult priority and applies scheduling process listed in the Local VA facility section.
3. Community Care – If a patient has opted to use their community care eligibility after being presented all options, the RCT must gather and document the following information during the patient discussion in order to streamline community care scheduling. MEMO Community Care Scheduling Enhancements.
   a. RCT must also capture patient preferences using the CTB for community care, reference Veteran Community Care Scheduling Preferences Section and/or (section 2.9-2.12 in the community care field guidebook).
      1. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.
   b. RCT members should forward a consult to community care (section 2.18 in the community care field guidebook) using CTB.

7.5 RCT Promising Practices

Strong practices have emerged over the past two years for RCT development and implementation. We have local and VISN level strong practices that you can refer to as you implement RCT at your facility/VISN. Please refer to Promising Practices Section on the RCI SharePoint details.

7.6 RCT Operations Supplemental Material

- Eligibility Factsheet
- Referral Disposition Instructions
- Care Assessment Need Information
- Special Consideration Solutions Table
- Veterans Transportation Service Information
- HRTG Program and Grants Information
- Referral Triage Tools

8 SCRIPTS FOR DISCUSSING CARE OPTIONS

The scripting provided is a reference for RCTs to discuss referral care options with Veterans. These scripts will be revised and expanded based on user feedback. The scripts are guidelines. Veterans should know their options include appointment slots across the VISN. VAMCs/VISNs have authority to standardize messaging based on services available and care modalities that meet their Veterans' care needs.

8.1 Referring Provider Scripting

8.1.1 Veteran Has No Specific Questions

The referring provider needs to inform the Veteran on what to expect for referral coordination next steps.

Referring provider script: "Mr./Ms. (*Veteran's name*), I will place a referral for (*specialty*) service and a member of the Specialty Referral Coordination Team will contact (*add facility specifics on who/how the Veteran will be reached*) you to discuss options available to you in the VA and in the community. You can then decide what option is best for you. Your appointment (*is/is not*) urgent and so I recommend when you talk with the Referral Coordination Team, you keep that in mind when making your appointment. Can I answer any questions for you at this time?"

8.1.2 Veteran Requests Community Care Referral Based on Eligibility

Referring provider script: "Mr./Ms. (*Veteran's name*), you may be eligible for community care. Our goal is to inform you of all your health care options. I will place a referral for your specialty care and a member of our Referral Coordination Team will contact you to discuss all options available to you in the VA and in the community. This allows you to decide what option is best for you. In my opinion, your appointment (*is/is not*) urgent and so I recommend when you talk with the Referral Coordination Team, keep that in mind when making your appointment. Can I answer any more questions for you at this time?"

8.1.3 Veteran Requests Community Care Referral Based on Best Medical Interest

Referring provider script: "Best medical interest takes into consideration several eligibility criteria that examines medical hardship. This will determine if you are eligible to receive community care. Based on these criteria, I see that you (*do/do not*) meet the best medical interest eligibility criteria." (*State reason based upon nature or simplicity of service; frequency of service; need for an attendant; potential improved continuity of services; or travel difficulty*).

Referring provider script: "Mr./Ms. (*Veteran's name*), you may be eligible for community care based upon best medical interest criteria. I will place a referral for (*specialty*) service. We have a member of the Specialty Referral Coordination Team here at (*facility name*) who will review your referral and determine what testing or level of care you may need. The Referral Coordinator {*add facility specifics on who/how the Veteran will be reached*) will contact you to discuss

options available to you in the VA and in the community. Then you can decide what is best for you. Your appointment (*is/is not*) urgent, and so I recommend when you talk with the Referral Coordination Team, you keep that in mind when making your appointment. Can I answer any questions for you at this time?"

8.2 Referral Coordination Team: Administrative and Clinical Scripting Framework

1. Greet and deliver individualized script to Veteran.
2. Inform Veteran of all options available to the Veteran.
    a. Recommendation(s) from Provider
        i. Clinically appropriate modality
        ii. Clinically appropriate timeline
        iii. Recommendation to receive care in VA vs Community
    b. Availability of VA appointments (in local or VISN)
        i. Telehealth at a VA clinic, community telehealth access point or at home, IFC, DoD
        ii. Travel: Bene-Travel, VTS, DAV etc.
    c. If Veteran is eligible for Community Care
        i. Expectation of Wait Times
        ii. Possible locations and associated drive times
        iii. Veteran scheduling preferences (location, time, date, provider) including if the Veteran chooses to self-schedule
3. Capture Veteran input of available options.
4. Veteran and RCT agree upon disposition.

8.3 Referral Coordination Team: Administrative and Clinical Scripting

Prior to contacting Veteran, team member runs DST to check eligibilities.

8.3.1 Administrative RCT or Staff with Scheduling Keys – Veteran Engagement

1. "Good Morning/Afternoon, my name is (*staff member name)* and I am calling from the Referral Coordination Team at the (*facility name*) VA Medical Center. Who am I speaking with today?"
2. "Your provider recently entered a referral for you to see a (*specialty*) specialist. We reviewed the request and want to schedule you for an appointment. We have a variety of options for this appointment including (*offer modalities identified in the consult*), and you (*are/are not*) eligible to be seen in the community. The dates and times we have available are (*dates/times for the modality*)."
3. **If Veteran elects to schedule with VA:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name, date/time, via face-to-face visit/Telehealth*). I will also send you a reminder of your appointment date and time. I can send a reminder to you via letter, email or text. Which reminder is best for you? Thank you for choosing VA for your health care provider. Have a great day!"
4. **Scripts for Community Care Eligibility for Community Care with Veteran**

a. **Veteran is not eligible to be seen in the community**: "I am sorry Mr./Mrs. (*name*), but at this time you do not meet the eligibility requirements (*state requirement*) for community care. However, we are happy to schedule an appointment for you at the VA and can do this right away. Once the appointment is made, I will also send you a reminder of your appointment date and time. I can send a reminder to you via letter, email or text. Which reminder is best for you?
b. **Veteran is eligible to be seen in the community**: "Mr./Ms. (*Veteran's name*), we have a couple options available for you to consider today. We can see you at VA as soon as (*date*). However, you also have the option to receive your care in the community based on your (*Veteran's specific eligibility*) eligibility. I want to discuss these options with you so you can make an informed decision about the best option to meet your health care needs. As I mentioned, we can schedule a (*specialty*) appointment for you at VA on (*date, time*). Based on what we know currently, we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community. Your provider recommended your appointment be (*as soon as possible, at your earliest convenience, at the VA, in the community*). You should know by choosing VA, we can better coordinate your overall care because we have the results of any services or tests in your health record. If you choose to go to the community, we will need your help to obtain a copy of your records so that your doctors have documentation of the care you received outside VA. You are our number one priority, and we can assist with either option you choose. How would you like to proceed today?"
    i. **Veteran elects to schedule VA Face to Face appointment:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. Thank you for choosing VA for your health care. Have a great day!"
    ii. **Veteran elects to schedule VA telehealth appointment:** "Mr./Ms. (*Veteran's name*), I will need to assess your technologies to determine if a telehealth appointment is possible. Do you have smartphone (*iPhone/Android/Samsung/Tablet*)? If yes, please download VA Video Connect App from the App Store. The morning of the appointment, you will receive an email with a link that will connect you to the appointment with your provider. If no, our provider will contact you via telephone for the scheduled appointment time."
        1. **Into the home:** [Administrative RCT obtains/updates email field] "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. For your video visit, you will choose a private location such as home or work to meet over video with your VA Provider using secure, encrypted technology on your internet-connected smartphone, tablet or computer. A member from the specialty or a telehealth coordinator will contact you for a test call before your (*specialty*) appointment."
        2. **Into a community telehealth access point:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*)

on (*date/time*). I will also send you a reminder of your appointment date and time. At your telehealth visit in the private room at (*Walmart/VFW/other*) an attendant will be on site to securely connect you to a virtual provider."

3. **Into the virtual clinic:** "Excellent, I have scheduled your appointment for (*specialty*) with (*provider name*) on (*date/time*). I will also send you a reminder of your appointment date and time. At your telehealth visit, a VA technician will use modern technology to do an exam or connect you to a virtual provider."

iii. **Veteran elects to schedule Community Care appointment:** "I understand you are interested in community care, and I am happy to assist you with that process. I will need to enter some information into your file and will then send your information to the Community Care staff. They will contact you to arrange the appointment (*gather facility specific Veteran Scheduling preferences*)."

8.3.2 Clinical RCT or Administrative RCT Do Not Have Scheduling Keys – Veteran Engagement

1. "Good Morning/Afternoon, my name is (*staff member name*), and I am calling from the Referral Coordination Team at the (*facility name*) VA Medical Center. Who am I speaking with today?"
2. "Your provider recently entered a referral for you to see a (*specialty*) specialist. We have reviewed the request and want to schedule you for an appointment. We can see you at the VA Medical Center as soon as (*date, time, via F2F visit/Telehealth*), and you (*are/are not*) eligible to be seen in the community."
3. **If Veteran opts to schedule with VA:** "I am going to connect you with our scheduler who will assist you with scheduling your appointment at the (*facility name*) VA. I am going to transfer your call to (*Mr./Ms. name of Administrative RCT*) who will schedule your appointment based upon your preferences. Thank you for choosing VA for your health care. Have a great day!"
   a. **Veteran is eligible to be seen in the community**: "Mr./Ms. (*Veteran's name*), we have a couple options available for you to consider today. We can see you at VA as soon as (*date*) date. However, you also have the option to receive your care in the community based on your (*Veteran's specific eligibility*) eligibility. I want to discuss these options with you so you can make an informed decision about the best option to meet your health care needs. As I mentioned, we can schedule a (*specialty*) appointment for you at VA on (*date, time*). Based on what we know currently, we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community. Your provider recommended your appointment be (*as soon as possible, at your earliest convenience, at the VA, in the community*). You should know by choosing VA, we can better coordinate your overall care because we have the results of any services or tests in your health record. If you choose to go to the community, we will need your help to obtain a copy of your records so that your doctors have documentation of the care you received outside VA. You are our number one priority, and we can assist with either option you choose. How would you like to proceed today?"

i. **Veteran elects to schedule VA Face to Face appointment:** "I am going to connect you with our scheduler who will assist you with scheduling your appointment at the (*facility name*) VA. I am going to transfer your call to (*Mr./Ms. name of Administrative RCT*) who will schedule your appointment based upon your preferences. After the appointment is made, a letter will be mailed to you as a reminder of your appointment date and time. Thank you for choosing VA for your health care."

ii. **Veteran elects to schedule VA Telehealth appointment: "**Mr./Ms. (*Veteran's name*), I will need to assess your technologies to determine if a telehealth appointment is possible. Do you have a smartphone (*iPhone/Android/Samsung/Tablet*)? If yes, please download VA Video Connect App from the App Store. The morning of the appointment, you will receive an email with a link that will connect you to the appointment with your provider. If no, our provider will contact you via telephone for the scheduled appointment time."

    1. Veterans may indicate a preference for telehealth into the home but may lack a device, connectivity or the literacy to use technology. A note requesting assessment through the new Digital Divide referral can be sent to their PACT to determine device/connectivity needs.

iii. **Veteran elects to schedule Community Care appointment:** "I understand you are interested in community care, and I am happy to assist you with that process. I will need to enter some information into your file. I will then send your information to the Community Care staff who will contact you to arrange the appointment (*gather facility specific Veteran Scheduling preferences*)."

8.4 Referring Provider or RCT Team: Veteran Needs Can Be Addressed via E-Consult

Referring Provider/Referral Coordinator Script: "Mr./Ms. (*Veteran's name*). This is (*Provider name, or Referral Coordinator calling for Provider name*). A referral for (*specialty*) service was placed and (*specialty provider*) contacted me. After review of your information, we feel we can treat you without you having to visit the specialty clinic. We recommend the following (*treatment plan*)."

8.5 MISSION Act Information

Current Mission Act Information and Scripting:

- Mission Act General Information
- Eligibility FAQs
- Call Handling and Documentation

8.6 Veteran Does Not Answer the Phone

Scripts for answering machine messages will be included in future releases of the guide. VAMCs and VISNs will need to identify how Veterans can best reach the RCT. It is recommended the Veteran's PACT be the initial point of contact provided if a telephone number is needed so as not to add another phone to monitor.

9 DATA AND MEASURING SUCCESS

9.1 Impact Measures

Initial anecdotal feedback from RCTs, Patient Advocates and providers should be collected by the Executive Sponsors to assess immediate impact. The purpose of the initiative is to improve timely access to care, empower Veterans to make more informed care decisions, and ensure only eligible Veterans who want to receive care in the community are referred and scheduled into the community.

To measure success, VHA will be monitoring the following RCI outcome measures:

Table 4: RCI Key Performance Indicators

Focus Area	Measure	Goal
Decrease consult scheduling time	Consult Scheduling Timeliness - Average days from File Entry Date (FED) to first scheduled by first scheduled date	▪ Aspirational goal of 3 days for both Internal/Direct Care and Community Care
Improve Veteran satisfaction	VSignals (Community Care survey)	Increase percentage of respondents with “agreement” score
Ensuring Veterans understand their full range of care options	Percent of Veterans engaging with RCT (metric in development)	90% of referrals reviewed by RCT
Maintain VA’s ability to fund internal/direct VA specialty care services	▪ Community Care cost ▪ Referral Volumes for internal/direct VA vs community care ▪ Understanding population of Veterans who Choose VA (metric in development)	Intended to be used for VISN/VAMC leadership to identify possible resources

9.2 Analyzing Data to Monitor Progress

Data that can be used to monitor progress includes those listed under How to Get Started and Operational Measures.

How to Get Started:

- VA and Community Care Referral Trends (see example in next section about how to use this data to choose which specialties to start with)
- Understanding Changes in CC Volume (by Consult title)
- Understanding Changes in VA Volume (by Stop Code)

Operational Measures:

- Community Care Eligibility Distribution

- Improving Timeliness: Referral Cycle Time
- Increasing Care Options: Face-to-face, E-Consults, Virtual, Telephone, Interfacility, etc.

The RCI Data Portal provides links to reports that support management of RCI access principles by providing a consolidated view of internal and Community Care measures in the same visuals. The Implementation Team should thoroughly analyze report results to determine the effectiveness and efficiency of current operations and reporting reliability. The implementation team should also analyze trends to observe reporting result changes over time and to determine the root causes behind inadequate performance.

Supplement detailed reports are currently available for both internal/direct and community care referral management individually. This data portal will evolve as new data measures become available. RCI Data Supplement is in development to provide data definitions and additional training. For guidance on Community Care specific reports, review Chapter 6 of the OCC Field Guidebook.

Each facility should take a multi-disciplinary approach to selecting which specialties to incorporate into the RCT first. Considerations include specialties with highest overall volume of consults, highest community care demand and longer consult processing times. Additionally, facilities can consider specialties that may already be operating with an RCT-like process, specialties with a strong clinical champion, or specialties with strong academic affiliations.

Below is an example of how to look at the data if you would like to focus on specialties that have the highest community care demand.

How to Determine Specialties with the Highest Demand

4. **Step 1:** Identify yearly referral volume by specialty (Internal & Community Care)
    a. Access the RCI Data Portal
        i. Select Volume by Specialty
        ii. Filter data for latest Fiscal Year and facility
        iii. Sort data largest to smallest
            1. All Internal VA Referral Volume by Service/Stop Code
            2. All Community Care Referrals volume by consult title
        iv. Use the Data to develop Staffing Plans
            1. Prioritize specialty services by Referral Volume (Community Care, Internal, or Community + Internal)
            2. Identify Total Referral Volume (Community Care + Internal) and divide annual volume by 10,000 to identify approximate FTE required to timely and appropriate address referrals.
                a. Example: 17,000 VA Cardiology Referrals + 3,000 Community Care Referrals = 20,000 divided by 10,000, which shows 2.0 FTE required
5. **Step 2:** Prioritize specialties that have the highest rate of referral to community care
6. **Step 3:** Using audience from How to Get Started Section to identify appropriate staffing

9.3 Data and Measuring Success Supplemental Material

- RCI-Power BI-Dashboard
- RCI Data Portal
- Data Portal Supplement
- OCC Field Guidebook - Chapter 6
- Recording: VSSC Office Hours 030221 RCI Dashboard Presentation

10 APPROPRIATE USE OF DECISION SUPPORT TOOL (DST)

In the new process, the referring provider is not required to use DST but may choose to render a Veteran Community Care eligible under MISSION ACT authority of Best Medical Interest (BMI) eligibility and document the reason if they feel there is a strong clinical indication. Specialty clinics or RCT utilize this tool when determining where the Veteran is eligible to seek care. The RCT will take more ownership of making this determination if the DST was not previously run by the referring provider. The primary care team must still determine primary care community care eligibility before including provider, nurse and scheduler when scheduling primary care appointments.

DST will allow the RCT to view relevant data within the existing CPRS consult order workflow. This helps guide the conversation with the Veteran to decide if a consult should be referred to the local VA facility, a near-by VA facility via Inter-Facility Consults (IFC), or to a community provider by providing information about the following:

1. Veteran's static community care eligibility (hardship, living in a state without a full-service VA or grandfathered into community care from the legacy Choice program) for accessing care in the community
2. Drive time standards and drive time eligibility associated with the requested consult service.
3. Average wait times for the requested clinical service at VA facilities near the Veteran's place of residence and average wait times for community care appointments (note that average wait times may not be used to determine wait time eligibility)
4. Veteran's stated preference for community care (Opt-in/Out or To Be Determined/Deferred)

10.1 DST Checklist for RCT

1. The RCT must be familiar with E-Consult and Telehealth protocols as well as access to the face-to-face clinic grids and Telehealth schedules to determine the appropriate options available when having a conversation with the Veteran about his/her care choices.
2. Community Care Eligibility
   a. If none exists, consider what the best method is to meet the Veteran/referring provider's needs including overbooking an appointment based on local protocols.
   b. Use VSE or VistA appointment packet for wait time and do **not** run DST if wait time eligible. Otherwise, if DST was not run by the ordering provider, you must run DST using a VCCPE consult to identify other community care eligibilities.
3. Best Medical Interest (BMI)
   a. If the referring provider entered a referral and used DST to render the veteran community care eligible based on best medical interest, the RCT should still review with the veteran ways in which the veterans care needs might be met within the VA including an E- consult, telehealth or face-to-face visit. If the veteran chooses to receive his/her care within VA, the appointment is made and #COO # is placed in the comment section of the appointment. If the veteran opts into community care, scheduling preferences are obtained and documented

using the CTB. Offer the Veteran the opportunity to self-schedule and to select a specific provider using the community provider locator (CPL). Using the CTB, forward to Community Care using the Best Medical Interest forwarding reason. Guidance on how to forward an existing internal consult to community care can be found in the Office of Community Care Field Guidebook, Chapter 2, subsection 2.18.

b. If the referring provider entered a referral and placed considerations for BMI in the body of the referral but did NOT use the DST to render the Veteran CC eligible based on BMI, RCT determines if the care requested can be addressed via an E-Consult, Telehealth, or a face to face visit. Supporting documentation should be available in the body of the consult to support the need for the episodic medical hardship/BMI.
    i. If care can be addressed via E-Consult, send to the Specialty Care provider to complete as an E-Consult and inform the Veteran of the pending recommendations from the specialist. If care can be addressed via Telehealth, discuss with the Veteran and document. If the Veteran's care needs can be addressed by a face to face visit within the wait time standard, the appointment is made.
    ii. If care cannot be addressed via E-Consult or Telehealth, review the referral with the Veteran, discussing the available care options within VA as well as care in the community. If the clinician reviewing the consult agrees that based on the considerations for BMI noted by the referring/ordering provider in the body of the consult and their own judgement that it is in the Veteran's best medical interest to seek care in the community, the Veteran is given the option for community care. The Veteran's decision is captured on the consult along with the Veteran's community care scheduling preferences. The Veteran is informed that these preferences will be used to schedule the community appointment. Using the CTB, forward to Community Care using the Best Medical Interest forwarding reason. Guidance on how to forward an existing internal consult to community care can be found in the Office of Community Care Field Guidebook, Chapter 2, subsection 2.18.

4. Drive Time – Can the care need be addressed via an E-Consult or is Telehealth a viable option?
    a. If care can be addressed via E-Consult, send to the Specialty Care provider to complete as an E-Consult. Then inform the Veteran of the pending recommendations from the specialist. If care can be addressed via Telehealth, discuss with the Veteran and document opt-in/out decision in the Consult Toolbox (CTB). If the Veteran opts out, schedule the appointment in the appropriate VA clinic and ensure that #COO# is captured in the appointment comments.
        i. If care cannot be addressed via E-Consult or Telehealth, discuss transportation options to receive internal/direct VA care.
        ii. If none are acceptable, capture the Veteran's scheduling preferences in CTB and forward to community care using CTB and choose Drive Time as the forwarding reason.
5. Wait Time – Is there local guidance for the scheduler to consider an overbook?

    a. If yes, scheduler should book the Veteran in clinic according to the local overbook guidance within the wait time standard. If the overbook request is denied or is for after the wait time standard, the Veteran is still eligible for community care.

6. Wait Time – Can the Veteran/referring provider's needs be met via an E-Consult or Telehealth?
    a. If yes, send to the Specialty Care provider to complete as an E-Consult. Then inform the Veteran of the pending recommendations from the specialist. For telehealth options, discuss with the Veteran and document opt-in/out decision in the CTB. Schedule the appointment in the appropriate VA clinic and ensure that #COO# is captured in the appointment comments.
    b. If no, capture the Veteran's scheduling preferences in the CTB and forward to Community Care using CTB and choose Wait Time as the forwarding reason.

10.2 Best Medical Interest General Information

It is important to keep the following information regarding BMI in mind while making the BMI determination:

- BMI is **not** required and should only be recommended when there is a true medical hardship for the requested episode of care rendering the Veteran eligible to receive care in the community.
- BMI is **not** to be used for Veteran or provider preference or convenience.
- BMI is a MISSION Act eligibility.

If a referring provider believes that BMI should be utilized for a true medical hardship and documents this in the DST, it does **not** mean the Veteran must receive their care in the community. Once RCT reviews the referral, the Veteran should make an informed choice to either remain with VA for his/her care or utilize community care based on his/her BMI eligibility as well as other factors such as other modality options or appointment availability.

10.3 Types of BMI

There are two types of BMI: Episodic Medical Hardship and General Hardship.

1. Episodic Medical Hardship (labelled "BMI-Per Episode of Care" in CTB) is only for a single, specific episode of care.
    a. The referring or primary care provider is not required to run DST unless he or she has determined BMI is clinically appropriate for a true medical hardship. The referral would then be routed to the RCT to review the referral with the Veteran including the BMI request. The referring or primary care provider can only capture BMI using DST at the time of entering the referral. DST will not allow end users to capture the BMI eligibility on a signed referral.
    b. When the referring or primary care provider recommends BMI be considered without running DST, he or she should document this in the body of the referral with justification. **This is not considered a true BMI eligibility** but rather a suggestion that the RCT or specialty provider would consider when discussing care options with the Veteran.

2. General Hardship (labelled “BMI-Hardship” in CTB) can be either for six months or one year, depending on the Veteran need, for all care referred to the community.
    a. General Hardship BMI is determined via a Community Care-Hardship Determination referral placed by VA provider and reviewed by the facility Chief of Staff or designee. If hardship determination is approved, community care or VA referrals must be placed as appropriate for all subsequent care needs for the approved length of time.
    b. Just because a Veteran has an approved hardship eligibility, it does **not** mean the Veteran must have all their care in the community. The Veteran has the option to have some (or all) of their care at the VA for each referral placed. If the DST has **not** been run to place BMI or there are no BMI considerations within the body of the referral from the referring provider, the Clinical RCT can discuss with the Veteran if there is a reason for BMI. The Clinical RCT would need to document the justification via added comment on the referral. Once that is done, the LIP from the RCT team, if applicable, or VA provider, would need to provide their concurrence as an added comment on the referral that BMI is appropriate. Once that has occurred, the RCT can forward the referral to Community Care, using the appropriate consult forwarding reason within CTB.

10.4 BMI Definitions

Within the DST, there is a **required** free text box under each BMI option for referring provider to document the justification for choosing the specific BMI option. This should be documented upon the referral entry.

- **Nature or simplicity of service:** To be considered if the requested medical services can more easily and safely be provided in the community and would be medically burdensome for the Veteran to receive the care in the nearest VA. Examples include routine optometry exam or hearing evaluation.
- **Frequency of Service:** To be considered if the frequency of the requested care is often enough to be a medical or clinical burden to the Veteran to have to travel to the nearest VA to receive. Examples include physical therapy, chemotherapy, and radiation therapy.
- **Need for an Attendant:** To be considered when an attendant is required for a specific episode of care. An attendant is any person who provides required aid and/or physical assistance to the Veteran, for a Veteran to travel to a VA medical facility for hospital care or medical services. The provider must consider the care/procedure being requested and/or the Veteran’s medical condition when determining the need for an attendant. This definition is consistent with the definition of this term in VA’s beneficiary travel regulation (see 38 CFR 70.2.), but that definition at § 70.2 is dependent on separate eligibility under the Beneficiary Travel program.
- **Potential for Improved Continuity of Care:** To be considered if the requested service were to occur in VA it would disrupt an established treatment plan with a community provider who delivers stable, consistent care to the Veteran during a specific episode of care. Examples could be: Recent surgery or active chemotherapy. A Veteran who had a knee replacement two years ago or who is previously established with a community provider and wants follow-up with their community provider would require a new referral

with a new determination of BMI eligibility for a new episode of care if medically indicated.

- **Difficulty in Traveling:** To be considered if a Veteran has significant difficulties traveling to a VA facility even if the estimated average drive time is less than the drive time standard (30 mins for PC and MH and 60 mins for SC) and doing so would result in clinical compromise to the Veteran's health. Providers should consider the accessibility of the requested service in the community and exhausted VA provided transportation options (e.g., Social Work Service (SWS) referral) when making this determination.

10.5 Supplemental Materials

- Office of Community Care Field Guidebook (FGB)
- Consult Forwarding Procedures, FGB Chapter 2, subsection 2.18

11 COMMUNITY CARE SCHEDULING

When the RCT determines that the Veteran is eligible for and opts in for community care, the RCT *must* ensure the information listed in this section is documented in the consult before the consult is forwarded to community care. For consults/ that are directly ordered to community care (for services not offered in the VA facility), the PACT or RCT front-line staff will ensure that Veteran preferences identified below are documented at the time the Veteran checks out of the internal, VA appointment. Ensuring this information is documented will support expedited scheduling of the community appointment for the Veteran and avoid unnecessary Veteran contacts.

11.1 Community Care Referral Checklist

Prior to the consult being forwarded to community care, the RCT will review the consult for completeness and document the following information in the consult:

1. Capture clear documentation of the community care eligibility either using the DST or using CTB and selecting the correct forwarding reason.
2. Ensure a clinical review was completed and documented by either an MD, NP, PA or DO or RCT/Specialty Care RN under direction of one of the above.
3. Consider a standard episode of care (SEOC) and, if appropriate, select using CTB's "authorizations tab." (This step can be delegated to the facility community care office.)
4. Capture clear documentation of the clinical need by the referring provider.
5. Capture the Veteran's community care appointment scheduling preferences to include preferred provider or "no preferred provider", day of the week or "any", and time of day or "any" using CTB unless the Veteran decides to self-schedule. If so, only preferred provider or "no preferred provider" is needed.
6. Inform the Veteran that these preferences will be used to schedule his/her community appointment.

11.2 Veteran Community Care Scheduling Preferences

Capturing a Veteran's community care scheduling preferences is mandated to expedite appointment coordination. Multiple attempts to contact the Veteran delay community care scheduling. Capturing preferences prior to check-out or before the consult is forwarded to community care minimizes delays and ensures the Veteran receives timely care in the community.

Capturing Veterans preferences for community care scheduling occurs after the Veteran's eligibility has been verified and the Veteran has opted-in for community care services.

Capturing scheduling preferences will be completed for all community care consults regardless of who is doing the scheduling (VA or Contractor) or how the Veteran prefers to be scheduled. When an eligible Veteran opts into community care, scheduling staff *must* capture the Veteran's scheduling preferences as shown in CTB. Additional guidance can be found in the OCC Field Guidebook, Chapter 2, subsection 2.19.

Staff members who are responsible for consult management such as the RCT will document the Veteran's community care scheduling preferences in the following scenarios:

- When the Veteran is eligible and opts into community care after discussing the options offered internal/directly within VA, the RCT will capture Veteran community care scheduling preferences for the following scenarios prior to an internal consult being forwarded to community care
- At the time of check-out for consults ordered directly to community care for services not available at the medical center

When a Veteran is eligible for community care due to wait time and opts in, the VAMC staff member who forwards the internal consult to community care should place the date of the next available internal VA appointment on the consult/referral prior to forwarding to community care.

11.2.1 Types of Preference Information to Capture

Scheduling staff *must* capture the following information for Veteran preferences for scheduling community care appointments (the minimum information required is bolded unless the Veteran chooses to self-schedule in which case only the community provider preference (or "no preferred provider") is required):

1. **Community Provider Preference (or "no preferred provider")**
2. **Day of the Week (or "any")**
3. **Time of Day (or "any")**
4. **Scheduling Preference (VA or Veteran self-scheduling)**
5. Communication Preference (text, phone, email, standard mail, MHV Secure Messaging)
6. Mileage Veteran is willing to travel

Each Veteran *must* be informed that this information will be used to schedule the appointment with the preferences provided this information *must* be documented and agreed upon by the patient to not be considered blind scheduling.

11.2.2 Accessing the Consult Toolbox to Capture Scheduling Preferences

Frontline staff and RCT *must* use the VA CPL in CPRS to identify the preferred provider.

Facility community care staff *must* continue to use Provider Profile Management System (PPMS). For contingency purposes, staff (not including facility community care staff) may use the VA.gov Facility Locator to identify the preferred provider. If the Veteran does not have a preferred provider, the staff must select "no preferred provider" using the CTB.

Staff can capture Veteran community care scheduling preferences using either the Community Care Functions or Scheduler Options within the Consult Toolbox (CTB).

The staff member will need to speak to the Veteran prior to entering the scheduling preferences in the CTB. The staff member will need to know the method in which the patient will be

scheduled to complete the preference. Methods include VA scheduling, Third Party Administrator scheduling or Veteran self-scheduling (VSS).

Figure 10: Community Care Functions

Figure 11: Scheduler Options

Select the “MSA PT Contacts” Tab in the Community Care Function (not Scheduler Function) in CTB to access preferences. Review and record the necessary information.

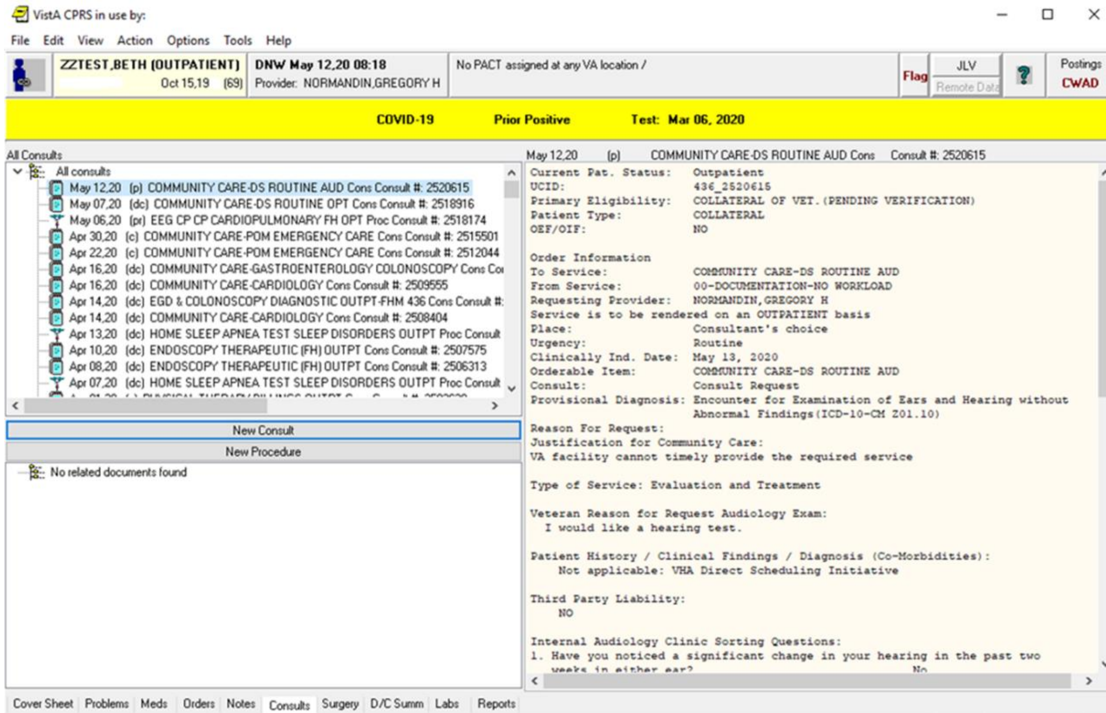


Figure 12: VistA CPRS Consult

Once the correct consult has been highlighted, move to the tabs line and select “Action” then “Consult Tracking,” then “Add Comment.” A comment box will open. This process is the same for a direct/internal VA consult that will be forwarded to community care and for a consult that is originally created as a community care consult.

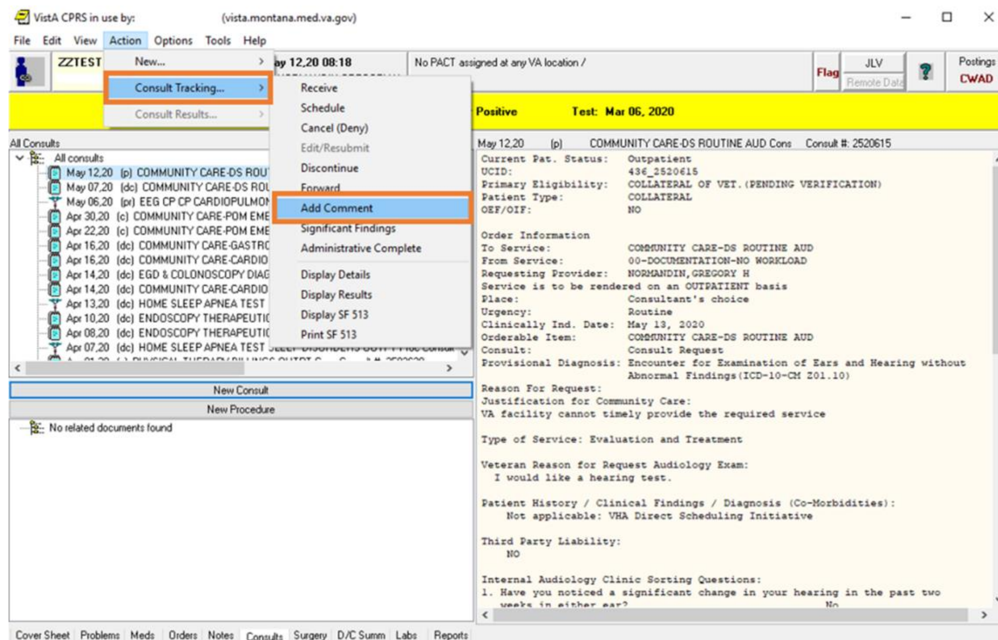


Figure 13: VistA CPRS Action Toolbar

Once the pop-up box is displayed, select the “Community Care Functions” to open CTB where the preference screen can be accessed.

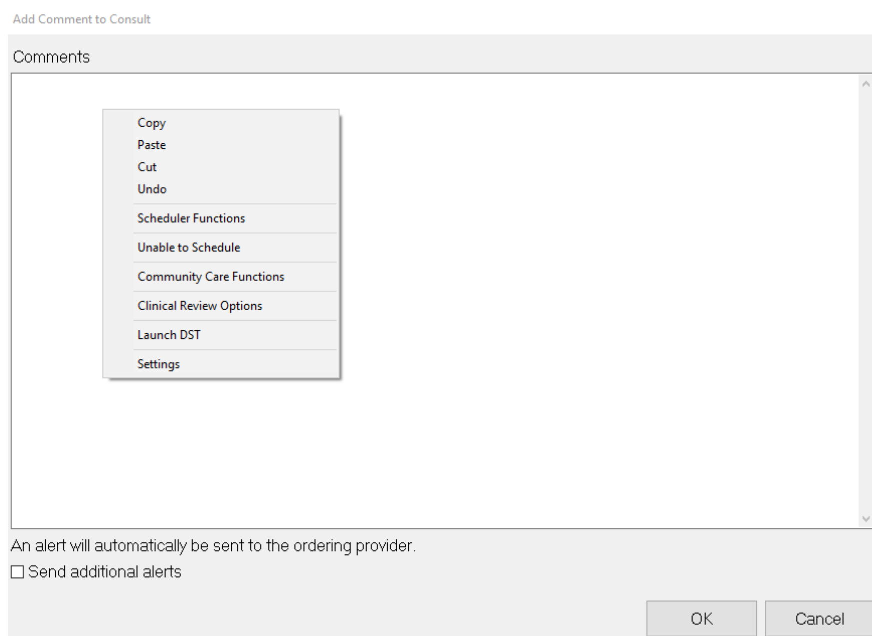


Figure 14: CTB Community Care Functions Option

Select the “MSA PT Contact” tab and complete the “Veterans Preferred Provider Information” section using the drop-down menu. If a Veteran chooses to self-schedule only the preferred provider or “no preferred provider” is required.

11.2.3 Entering Veteran Preferences

1. Step 1: Check “Update record with above information” box
2. Step 2: Select “OK” at the bottom of the window

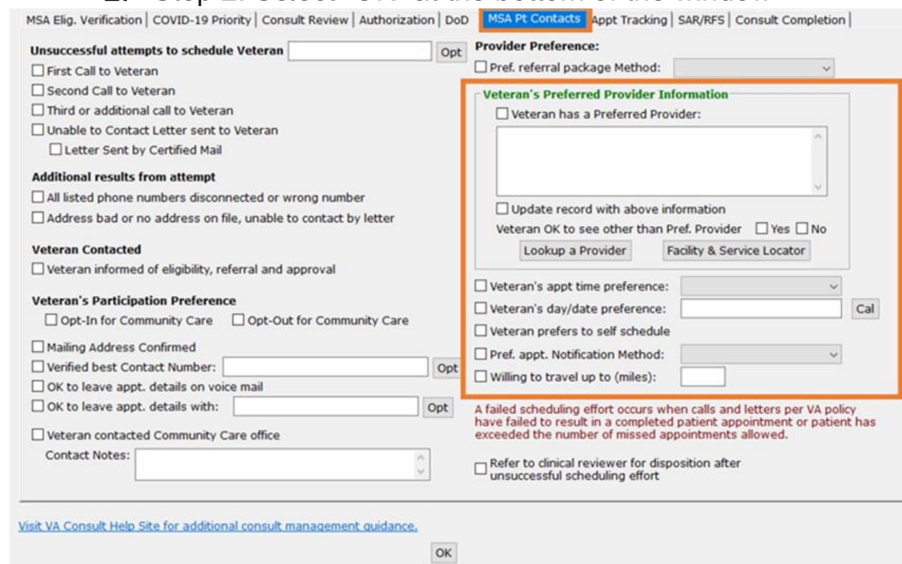


Figure 15: MSA Patient Contact Tab

11.3 Options for Community Care Scheduling

Veterans will have the two options to determine how their community care appointment will be scheduled: VA Scheduling and Veteran Self-Scheduling. Veteran preference for scheduling will be documented using the guidance identified in the OCC Field Guidebook, Chapter 2, subsection 2.19.

11.3.1 VA Scheduling

VA will schedule the community appointment on behalf of the Veteran using the community care scheduling preferences documented by RCT.

11.3.2 Veteran Self-Scheduling

The Veteran may elect to self-schedule his/her own appointment.

VSS begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider. The Veteran can provide this preference to self-schedule to the clinic Medical Support Assistant (MSA), RCT or the facility community care staff. The community care VSS process is encouraged, but not mandated. VSS allows Veterans to schedule directly with community providers.

When VSS is selected, staff *must* capture this scheduling preference the CTB Consult Review Tab.

Additionally, RCT *must* use the VA Community Provider Locator (CPL) in CPRS to identify Veteran's preferred provider and to ensure the preferred provider is in network.

It is important to note for care that is available within VA, the Veteran's preference to self-schedule for community care should be captured after an RCT member has discussed all care options with the Veteran (virtual care, face to face, and community care) and the Veteran has opted-in for community care. Once it is identified that the Veteran has elected to self-schedule his/her community appointment, the Veteran *must* be informed that he/she will receive a self-scheduling letter in the mail with the approved community provider information so he/she can contact the community provider to schedule the community appointment. If the preferred in-network provider is known, the Veteran may also elect to wait three days to call the provider to schedule prior to receiving the letter in the mail.

In addition, the front-line staff or RCT *must* clearly communicate to the Veteran that he/she *must* contact the facility community care office to inform them of the appointment date/time for documentation purposes in a timely manner. More information is in the OCC Field Guidebook, Chapter 3, subsection 3.16.

Note that self-scheduling may not be appropriate for some Veterans with active Behavioral Patient Disruptive Flag (BPDF), based on the Veteran's individual needs. If the Veteran has an active BBDF, elevate the request to the facility community care clinical staff to contact the facility's Disruptive Behavior Committee (DBC) chair to learn the safety implications (to other patients, to the provider, and/or to the Veteran) of scheduling the Veteran with a community

provider. DBC Chair contact information can be found at: Workplace Violence Prevention Program (WVPP) POC Search Page; ensure you reach out to the "DBC Chair" for your facility versus other POCs. If there are safety implications, VA staff should schedule the Veteran following the process outlined in OCC Field Guidebook, Chapter 3, subsection 3.15. "How to Schedule Using CCN When VA is Scheduling on Behalf of the Veteran."

11.4 Community Care Scheduling Supplemental Material

- The Office of Community Care Field Guidebook (FGB)
- Policy Appendix

12 USE OF ELECTRONIC CONSULTS (E-CONSULTS)

Recently updated reimbursement rules have expanded payment for non-synchronous care such as Electronic Consults (E-Consult). While some Veterans prefer in-person visits and some types of services will require in-person visits, the availability of electronic records supports wider access to specialists' expertise without the necessity of a face-to-face patient visit. Electronic record review and consultation can spare Veterans unnecessary travel and provide them convenient access to specialty care.

The Office of Specialty Care Transformation developed the E-Consult initiative to improve access to specialty care for Veterans and their primary care providers. E-Consults allows referring providers to request review of the record, obtain interpretation of the information, and receive recommendations. They also allow the specialist to receive workload credit for non-face-to-face visits done by chart review.

12.1 What is an E-Consult?

E-Consults are referrals designed for Veteran/provider questions about advice for diagnostic and therapeutic issues. They can also be used to better prepare a Veteran for a face-to-face visit by arranging for the completion of necessary tests in advance of the visit with a specialist.

E-Consults should be completed within three business days (excluding weekends but not holidays) of the File Entry Date. Learn more about the process in the E-Consult Guidebook Version 3.

E-Consults are a kind of asynchronous care sometimes referred to as "chart only consult" or "virtual consult." Within VA, an E-Consult does not require direct communication (phone or written) with the referring provider and can be completed just through a review of the chart and a written note. E-Consults are also considered one subset of asynchronous care.

12.2 All Sites Should Promote E-Consults as an Avenue of Care

To optimize Veteran choice and improve access to care, all specialties should provide E-Consults. This requires the local site to develop a referral process in CPRS with note titles and encounter locations that include "E-Consult" to be tracked appropriately. Veterans are not billed for copay. Workload is tracked as described below. We strongly encourage specialty care services to consider active consult management, identifying face-to-face requests that can be completed as an E-Consult and vice versa.

All services within the medical center should receive communication about any new E-Consult opportunity. Staff should promote E-Consults as a rapid, efficient way to obtain documented diagnostic or management recommendations without a face-to-face visit. Examples of good outcomes should be marketed to all services to promote use of E consults. Staff should promote E-Consults in Care Coordination agreements between Primary and Specialty Care Services.

12.3 Advantages of E-Consults

A consultant's review of the records can take place without structured scheduling, allowing the consultant flexibility to complete tasks at a convenient time. Because the Veteran does not need to travel, the inconvenience and costs of scheduling and arranging transportation are eliminated. While support staff may, at times, expedite requests from the referring provider or the specialist, when compared to a traditional consultation, the burden on support staff is generally reduced. Consults can be completed without the delay of scheduling and the response time to the consultation can be much less than in a traditional consultation. Consultants whose expertise is highly specialized may be accessible from long distances for those Veterans who cannot travel to/from medical centers.

12.4 E-Consults Take Time to Perform

Providers who perform E consults should have time to perform referrals using the most efficient approach that limits impact on face-to-face clinic time. Section Chiefs and Service Chiefs are responsible for assessing productivity and assigning the appropriate amount of allocated time for all asynchronous care, including E-Consults. Data on individual productivity will continue to guide those individuals in accomplishing their goals. Section productivity can be assessed based on total clinical workload: clinic, ward or inpatient referral coverage, procedures, test interpretation (electrocardiograms (EKGs), pulmonary function tests (PFTs), telephone or tele-video visits and E-Consults. Clinical care in any form should be used to maximize access based upon the need of the Veteran. Clinicians should be reassured that productivity for completing E-Consults is comparable to performing face-to-face visits and is based on the time spent completing the consultation as opposed to care complexity with office-based Evaluation and Management (E&M) codes. Please refer to the Electronic Consult Implementation Guide for additional information and implementation guidance.

12.5 Use of E-Consult Supplemental Materials

- E-Consult Guidebook Version 3

13 TELEHEATH / VIRTUAL CARE

13.1 MISSION Act and Telehealth

The MISSION Act established "Anywhere to Anywhere" telehealth across state lines and from off-site locations to a Veteran's home or community. Through Telehealth, VA has an unprecedented opportunity to grow and to meet Veterans where they are with continuity, convenience, and excellence. Providers should invite Veterans to consider care by Telehealth for several reasons, including its ability to provide overall continuity of care, a Veteran-centric option within VA, and a more convenient option for care, often with reduced travel requirements.

Per the MISSION Act, the below verbiage from the preamble applies when determining community care eligibility when the appointment being offered is considered Telehealth. "The proposed rule stated that if the VA is able to furnish a covered veteran with care or services through telehealth, and the veteran accepts the use of this modality for care, VA would determine that is was able to furnish such care or services in a manner that complies with designated access standards. We received one comment that urged VA to ensure that the option for the Veteran to have face-to-face care would be maintained if the Veteran did not choose the telehealth modality. We do not make changes based on this comment. As stated in the preamble of the proposed rule, VA will not require a veteran to accept the use of telehealth for the purpose of meeting VA's designated access standards." Review specific guidance from the law. Select the Final Rule document and search the word telehealth. Review the Office of Community Care Field Guidebook for additional guidance about eligibility requirements for unique scenarios such as a Veteran who choosing telehealth and then requires an in-person visit.

13.2 What Kinds of Telehealth Appointments Exist at VA?

Synchronous (Clinical Video Telehealth or VA Video Connect into the home/non-VA site), Asynchronous (Store and Forward Telehealth) and Remote Patient Monitoring (Home Telehealth) are telehealth services offered at VA.

VA leads the Nation in telehealth, with options in more than 50 specialties. Service lines consider what care is appropriately delivered by Telehealth by clinical judgement and via guidance from Specialty Telehealth Operational Manuals. Specialty expert consultation by telehealth for select conditions is available through a network of National and VISN based Telehealth Hubs. Inpatient telehealth services include tele-hospitalist, tele-ICU, tele-stroke, and other programs.

Telehealth clinics must be set up in VistA to correctly capture workload. At this time, telehealth services into the home are not associated with a patient co-pay.

Increasingly, VA providers will have the skills to offer Veterans clinical care by telehealth. Video telehealth expansion into the home and non-VA sites of care began in 2018 for Primary Care and Mental Health and expanded to Specialty Care in 2019. All VHA ambulatory healthcare professionals are expected to have completed at least one video visit into the home or non-VA

site, by end of FY2021. Expansion of asynchronous care in eye care, dermatology and sleep is underway. VISN Clinical Resource Hubs offer services in Primary Care, Mental Health and increasingly Specialty Care.

13.3 Advantages of Telehealth

Telehealth, and virtual care in general (mobile applications, secure messaging, remote patient monitoring) should be promoted as an option for Veterans to choose VA, decrease travel time or travel cost, and increase convenience and comfort (for Veterans not wishing to receive care in a medical facility). There is high Veteran satisfaction with Telehealth Services at VA on par with in-person care. To date, the literature on Telehealth suggests equivalence in clinical outcomes, experiences and improved continuity of care.

In the management of rare/specialized clinical conditions, telehealth may be the best option for Veterans who have few (or no) options for care in the community. During disasters or emergencies when facilities experience closures and appointment cancellations resulting in a potential surge of increased eligibility for community care, prioritizing appointment rescheduling to include virtual care supported by facility based, VISN based or national providers can mitigate access challenges during the period of the disaster/emergency.

Since the location of the remote provider is flexible, VA can optimize capacity by recruiting providers in areas where it is relatively easy to do so and match this available capacity to demand elsewhere in the VISN. Clinical capacity for Telehealth may be available through Telehealth providers located in front-line clinics within the healthcare system, or within the VISN Clinical Resource Hub. Facility leadership is encouraged to identify underutilized FTEE for telehealth (Productivity and Staffing Guidance for Specialty Provider Group Practice VHA 1065(1) linked here) Services from providers outside the VISN may be arranged by an MOU and/or cost-transfer.

13.4 Applicable National Data Sources

- VSSC Connected Care Reports
- Appointment Data Cube now includes wait time and encounters for telehealth appointments in addition to in-person appointments. VSSC Appointment Cube
- CVT SFT Data cubes for information on Telehealth Data or historical usage, who/what CBOCs currently use. VSSC CVT SFT Cube
- Provider productivity cubes for evaluation of who may have capacity at your site to start or expand provider side offering of telehealth in your specialty VSSC Provider Productivity Cube
- Community Care data to review what services are being provided in the community. VSSC Community Care Cube
- Virtual Care Scorecards

13.5 How to Increase Awareness with Veterans and Staff

A key to increasing use of virtual care throughout the health care system is to make both Veterans and staff aware of how it works, when it is appropriate to use and that the Veteran will

still be receiving the top quality of care that they receive throughout other modalities. Using tools such as VEText, Secure Messaging, and social media for outreach efforts are recommended.

Promising practices and data to support their process. A summary of these practice may be viewed on the Connected Care Messaging Blog.

13.6 Scheduling with Virtual Care

In VA, there are multiple options for scheduling telehealth. The Telehealth Scheduling Tool Matrix outlines all scheduling platforms and when they are appropriate to use for scheduling. The Office of Connected Care is continuing to work on making the scheduling process streamlined with in person visits. Currently the main platform for scheduling VVC is Virtual Care Manager. Review additional information about Virtual Care Manager and scheduling specific information on VA Video Connect for Schedulers.

13.6.1 Scheduling Training Requirements

All schedulers need to follow OVAC Scheduler Requirements as laid out in VHA Directive 1230 including virtual care scheduling requirements. A Specialty Care Department of Veterans Affairs Video Connect Expansion Memo (VIEWS# 03400841) from August 25, 2020 was sent to the field requiring schedulers mastering the most recent VVC Scheduler training and schedulers are required to have scheduled VVC appointment. The trainings and can be found on TMS, training module #41309.

13.6.2 Understanding Where Virtual Care Is Available in VA Network

To optimally inform the Veteran, the RCT needs to know where virtual care is available across the network. Currently the VHA is in progress of creating an efficient national database however there are ways to gather the applicable information. Below are examples of how sites are sharing this information across their healthcare systems in the interim. Consider using the following practices to understand where virtual care is available across their VISN.

- Create a VISN SharePoint were all information is been posted and shared
- Grant Access to local SharePoint for staff and leadership
- Hold Telehealth Leadership weekly meetings
- Hold a VISN while Telehealth Strategic Planning call
- Hold weekly meetings with Leadership including front office and ACOS
- Connect with the SAIL workgroup, NDPP, Nursing Executive council and Medical Executive Council
- Participate in PACT Huddles and departmental staff meetings
- Distribute local flyer across the facility with all the Telehealth modalities and services offered.
- Work in collaboration with patient advocate team, patient centered care team and Wholehealth team to share Telehealth information across the facility
- Create a spreadsheet by site to show who is offering what about Telehealth at each facility.

13.7 Specialty Specific Guidance on How to Start and Expand

Through virtual care Telehealth is well suited to provide care for the majority of outpatient clinic visits through Synchronous Telehealth/Clinical Video telehealth (CVT), CVT to home (VVC), and other Virtual Care options including Asynchronous Store and Forward Telehealth (SFT) or E-Referrals. Expansion of Virtual Care offerings is the appropriate step for many services and for patients to bring the right care to the right place at the right time. This following seven specialty sprint focus areas gives recommendations on evaluation and expansion of Virtual Care offerings to be implemented in conjunction with the Referral Coordination Teams (RCT). Each specialty focus area includes the following sections specific to that specialty

- Services to consider for E-Consults
- Services to consider for telehealth
- What the Veteran & Provider can expect when using telehealth
- Recommended care pathways
- Staffing recommendations for telehealth
- FY2020 Usage facts
- Current promising practices
- Resources & innovative approaches needed to continue to expand virtual care

In the Field Guides, you will also find a Telehealth Supplement if one exists. The supplement includes use cases and set up for telehealth. Select and view guidance specific to your specialty on the Telehealth website.

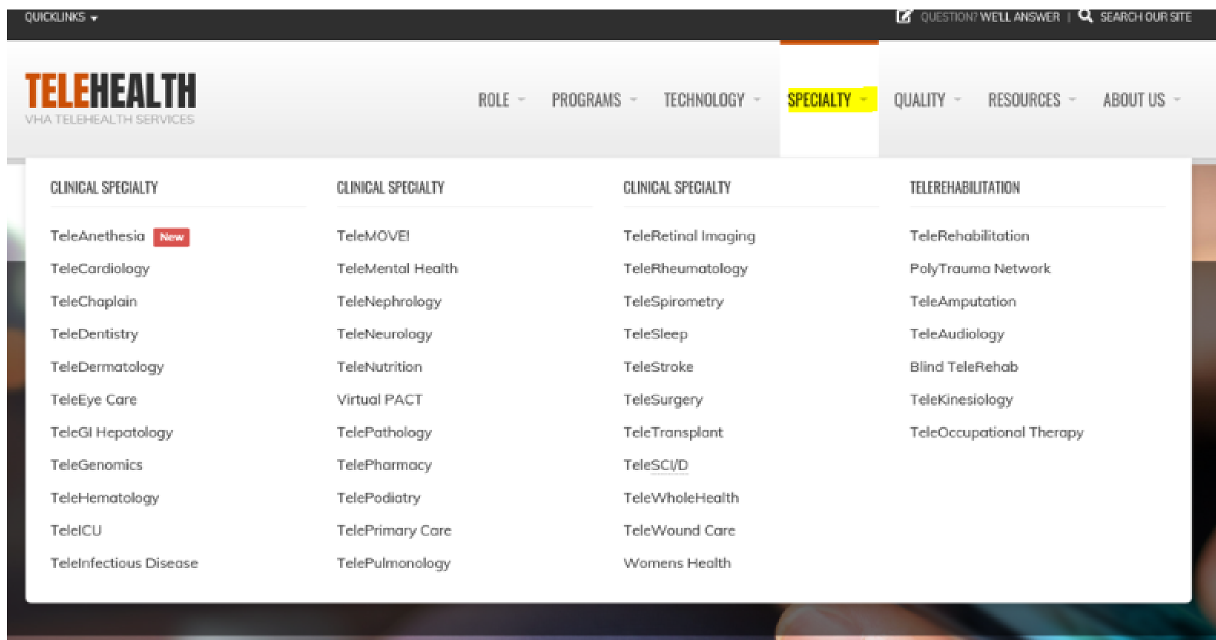


Figure 16: Telehealth Specialty Menu

13.7.1 Steps to Start Expansion

1. Review telehealth utilization, wait time and Community Care data to determine best specialty in which to expand.
2. Contact your Facility Telehealth Coordinator (FTC) and RCT review telehealth data and community care cost data, see where telehealth is offered at CBOCs see where you can expand, consider VISN CRH level approach.
3. See what the highest community care utilization is for your service(s) and plan how to include virtual health offering, prioritize where to start and with what service based on data.
4. Include RCI team at local facilities to make aware of current telehealth options for service(s) and expansion of service(s)/offering let it be known *which* CBOCs offer Telehealth currently.
5. Discuss pathway with RCI team for offering patients telehealth, (e.g., what does that look), use of telehealth admin scheduling referrals, how does RCT involve telehealth option up front and aware to offer this first to patients.
   a. Examples:
      i. Identify CBOCs in your VISN that do not offer TeleDermatology or face to face Dermatology care.
      ii. Evaluate the staffing at the CBOCs and if there is a TCT trained in TeleDermatology, if not have the FTC take steps to have the TCT at the CBOC trained in TeleDermatology.
      iii. Assess that the CBOC has the equipment for TeleDermatology, a hand-held point and shoot camera with dermascopy attachment is recommended, cost is around $2000.00 per unit.
      iv. Follow telehealth specialty supplement for referral and clinic set up for go live of new TeleDermatology service offering.
6. Market to patients and providers.

13.8 Virtual Care Supplemental Materials

- Telehealth Website
- Telehealth Expansion - VHA Telehealth Services Intranet (va.gov)
- Specialty VA Video Connect Expansion VSSC Report
- Inclusion for Specialty Care Service Lines
- Facility Executive Leadership VA Video Connect Checklist
- Example of VISN Menu of Services
- Example of VISN Telehealth Service Agreement

14 CHANGE MANAGEMENT

This section of the guidebook will reference Prosci® tools and techniques to support RCI. Prosci® Change Management focuses on managing the people side of change with research-based processes, tools and techniques to achieve the required business results. Every organizational change ultimately has individual impacts—the tens, hundreds or thousands of employees who have to do their jobs differently when they adopt the solution. This is the role of change management.

On October 22nd, 2019, VHA approved an Executive Decision Memo that recognized Prosci® as VHA's current methodology for Change Management. Organizations that integrate Change Management into their project management delivery are six times more likely to successfully reach their program/project objectives. Change management is the use of an organized framework that helps to guide individuals through the change process. According to Prosci research, "the results and outcomes of changes are tied to individual employees doing their jobs differently. A perfectly designed process cannot improve performance until employees follow it. A perfectly designed technology adds no value to the organization until employees use it. Perfectly defined job roles won't deliver results until employees fulfill them. Employee adoption and usage are the bridge between a great solution and ultimate results" (Top Contributors to Change Management Success, Prosci®, 2016).

14.1 Three States of Change

Change is about moving to a future state while change management is about supporting individual employees impacted by the change during their transitions—from their current state to their future state.

There are three states of change: current state, transition state, and future state. The current state is how things are done today. The transition state is how to move from current to future. The future state is how things will be done tomorrow.

14.1.1 Why is Change Management Important?

It is important to understand VHA's future state is actually the collection of many individual future states.

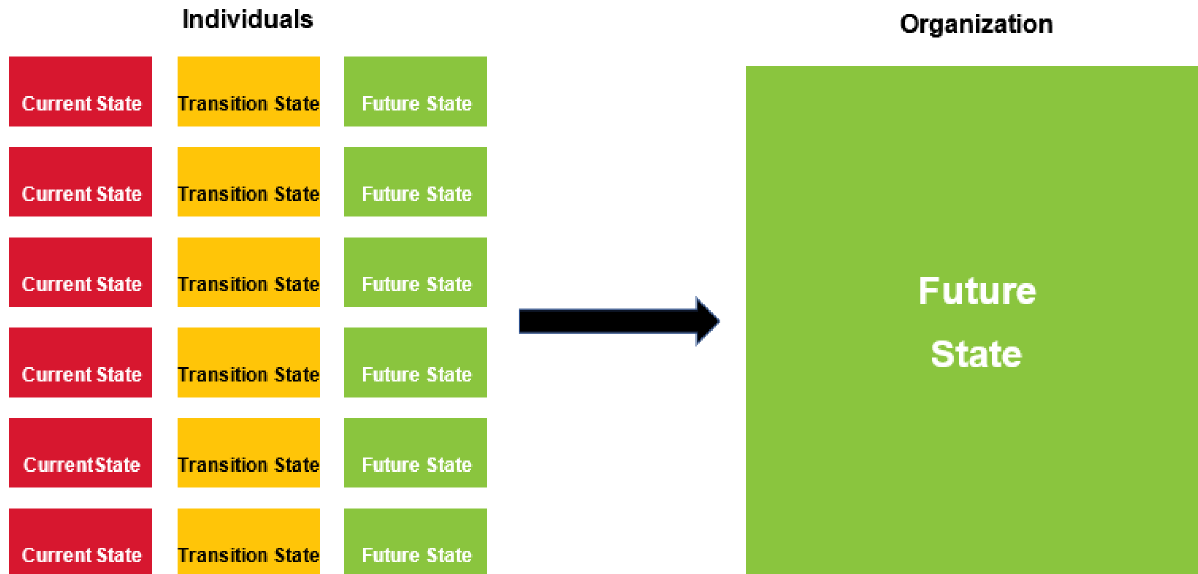


Figure 17: Change Management States of Change

Change management increases organizational outcomes to achieve desired results by driving individual adoption and usage. In order to drive individual adoption and usage, facilities must enable success by supporting each individual through his/her personal change journey. With excellent change management, employees:

- Adopt changes faster, more completely and more proficiently.
- Stay engaged in the organization during disruptive change.
- Understand why the change is happening.
- Have the time and tools to get on board and feel heard and supported.

14.2 Change Management Framework

ADKAR is a change management framework for understanding change at an individual level (Hiatt, Jeffrey. ADKAR. A Model for Change in Business, Government and our Community, 2006). Every change that occurs in a system is dependent on individuals making individual changes. Applying ADKAR framework can assist organizations in successful change by understanding the elements necessary for change results to be recognized. ADKAR presents in five stages that individuals go through when making a change.

- A in ADKAR stands for Awareness. For change to occur, the individual needs to have awareness of the need for change and the nature of the change.
- D stands for Desire. The individual must have the desire to support the change, participate, and engage in the change.
- K stands for Knowledge. The individual should have knowledge on how to change and on how to implement the new skills and behaviors.
- A stands for Ability. The individual should have the ability to implement the change and demonstrate performance.

- R stands for Reinforcement. The individual needs reinforcement to sustain the change and build a culture and competence around change.

For sustainable change to occur in a system or organization, individuals must reach the level of Ability. The elements of ADKAR are sequential, requiring individuals to move through each stage successfully.

14.3 SmartChange Toolkit

VHA's National Center for Organizational Development SmartChange Toolkit provides simple, powerful tools to make change easier at all levels of the organization. This toolkit consists of 6 steps to help organizations think through and support the 'people side' of change. You can access the SmartChange Toolkit to gain a better understanding and best practices for each step. This guidebook provides a summary of all six steps with an intended focus on Step 1.

14.3.1 Step 1 – Define Success

In any change scenario, organizations should be able to answer the basics – starting with what's changing, why a change is needed, and what happens if we don't change. When you start with the Six Essential Questions, you'll get clear on what's changing, why, and what success looks like. The process of answering the Six Essential Questions gets people on the same page. Once the answers are in place, you have the cornerstone for key change messages.

Beyond informing communications, Six Essential Questions can:

- Help a leader decide if it is the right change to implement.
- Help a leader understand the change more fully so they can better lead others.
- Help a leadership coalition or project group come to consensus on the key reasons for the change and facilitate buy-in.
- Identify when you need to seek out more information to better understand the change.
- Initiate discussions with key leaders to discuss alternatives to the change and/or fully understand implementation options.

The Six Essential Questions for RCI is included in Appendix A – RCT Six Essential Questions.

14.3.2 Step 2 – Strengthen Your Foundation

Once the reasons for change and expected benefits are clear, it's time to examine and strengthen your foundation. Change success depends on a balance of technical decisions and actions that help people adopt and use the solution as intended. By measuring the Foundations for Change, you'll get a snapshot of your project's health, and a good sense of which elements need the most attention.

14.3.3 Step 3 – Prepare Sponsors

Benchmarking studies repeatedly show the number one predictor of change success is active and visible sponsorship. Using the Preparing Sponsors tool, you'll identify the coalition needed to support your change, and discover how best to facilitate their success in these critical roles.

14.3.4 Step 4 – Understand Individual Change

When you understand individual change, you can decode the mystery (and relieve the frustration) of organizational change. By applying Prosci's ADKAR® model, you can easily see where to focus your efforts, avoiding the common change management error of scheduling the "right" tactic at the wrong time.

14.3.5 Step 5 – Engage Impacted Groups

You know how change happens at an individual level (that's ADKAR!) – now it's time to shift your focus to engage groups affected by change. Resistance to change is normal and should be expected. Managing that resistance, however, depends on knowing several things: how the change impacts different groups, their readiness for change and their context for change. By using the Engaging Groups tool, you'll gain insight into what support is needed by whom and when.

14.3.6 Step 6 – Pull it Together: Your Change Strategy

You've assessed your change from several key perspectives, and now it's time to put it all together to make sense of the bigger picture. Whether you are a team of one leading a change in your workgroup, or responsible for a much larger change in your organization, this SmartChange Snapshot is a great way to capture the next actions to best drive the people side of change for the results you want and need.

14.4 Change Management Resources

There are many VHA change management resources available to assist with change success. We encourage all levels of the organization to become familiar with the following resources:

- VHA NCOD SmartChange Toolkit
- Best Practice Tip Sheet for Communications
- Best Practice Tip Sheet for Engaging Managers
- Sponsorship Roles
- Actions that drive ADKAR – Senior Leaders, Mid Managers/Supervisors, Individual level
- Plan for Sustainment: 3 Key Sustainment Elements
- Prosci Portal – VHA employees can create a Prosci account by using their VA email to register.

15 ACRONYMS AND GLOSSARY

Table 5: Acronym List

Abbreviations	Meaning
ADPCS	Associate Director for Patient Care Services
AMSA	Advanced Medical Support Assistant
APRN	Advanced Practice Registered Nurse
BDOC	Bed Days of Care
BIM	Business Implementation Manager
BMI	Best Medical Interest
BPDF	Behavioral Patient Disruptive Flag
BT	Beneficiary Travel
CAC	Clinical Applications Coordinator
CC	Community Care
CITC	Care in the Community
CMO	Chief Medical Officer
COO	Community Opt-Out
COR	Contracting Officer's Representative
COS	Chief of Staff
CPL	Community Provider Locator
CPM	Clinic Practice Management
CPRS	Computerized Patient Record System
CRH	Clinical Resource Hub
CTB	Consult Toolbox
CTM	Consult Tracking Manager
CVT	Clinical VA Telehealth
DAV	Disabled American Veterans
DBC	Disruptive Behavior Committee
DO	Doctor of Osteopathy
DoD	Department of Defense
DSS	Decision Support System
DST	Decision Support Tool
E-Consult	E-Consult Electronic Consultation
ECHO	Echocardiogram
EHR	Electronic Health Record
EKG	Electrocardiogram
ELT	Executive Leadership Team
FBG	Field Guidebook
FTC	Facility Telehealth Coordinator
FTE	Full Time Equivalent Employee

F2F	Face to face
GEC	Geriatrics and Extended Care
GI	Gastroenterology
GPM	Group Practice Manager
HAS	Health Administrative Services
HCS	Health Care System
HOC	Health care Operations Center
HRTG	Highly Rural Transportation Grants
HT	Health care Technicians
ICC	Integrated Clinical Community
IFC	Inter-Facility Consult
IRMAC	Integrated Referral Management and Appointing Center
JOC	Joint Operations Center
JLV	Joint Longitudinal Viewer
LIP	Licensed Independent Practitioner
LOS	Length of Stay
LPN	Licensed Practicing Nurses
MD	Doctor of Medicine
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
MSA	Medical Support Assistant
NP	Nurse Practitioner
OCC	Office of Community Care
OCC	Office of Connected Care
OVAC	Office of Veterans Access to Care
PA	Physician Assistant
PACT	Patient Aligned Care Team
PAO	Public Affairs Officer
PFTs	Pulmonary Function Tests
PPMS	Provider Profile Management System
PSDS	Patient Self-Referral Direct Scheduling
RCI	Referral Coordination Initiative
RCT	Referral Coordination Team
RN	Registered Nurse
SFT	Asynchronous Store and Forward Telehealth
SMT	Special Mode Transportation
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SW	Social Worker
SWS	Social Work Service

TH	Telehealth
TPA	Third Party Administrator
VA	Department of Veterans Affairs
VAMC	Veteran Affairs Medical Center
VCCPE	Veterans Community Care Program Eligibility
VHA	Veterans Health Administration
VISN	Veteran Integrated Service Network
VEO	Veteran Experience Office
VSO	Veteran Service Organization
VSS	Veteran Self-Scheduling
VSSC	Veterans Health Administration Support Service Center
VTP	Veterans Transportation Program
VTS	Veterans Transportation Service
VVC	VA Video Connect
WT	Wait time
WVPP	Workplace Violence Prevention Program

16 APPENDIX A – RCT SIX ESSENTIAL QUESTIONS

16.1 What is changing?

The Veterans Health Administration (VHA) is changing its existing referral process by implementing the Referral Coordination Initiative (RCI). RCI shifts the referral responsibility from providers to Referral Coordination Teams (RCTs) that include dedicated clinical and administrative staff.

16.2 Why is it changing?

VA is streamlining the referral experience to improve timely access to care, empower Veterans to make informed care decisions, and ensure only eligible Veterans who want to receive care in the community are being referred and scheduled into the community.

16.3 Why is it changing now?

Assessment of MISSION Act implementation and the ongoing COVID-19 pandemic response to health care delivery resulted in more Veterans being referred to the community than expected. Veteran feedback suggests many Veterans prefer to receive internal/direct VA care.

16.4 What is not changing?

VA will continue providing an exceptional Veteran experience and delivering the highest quality care and services aligned to each Veteran’s needs and life goals – whether that is in-house VA care or care in the community. Eligibility standards for community care are not changing.

16.5 What are the benefits of this change?

RCTs align with VHA’s modernization efforts to enhance referral timeliness and consistency, empower Veterans to make more informed choices about their care, and maintain high levels of Veteran satisfaction.

16.6 What are the risks of not changing?

Without a streamlined and consistent referral process, the scheduling of referrals will be longer than necessary; Veterans will have an inconsistent experience and lower satisfaction; Veterans may not receive all the information needed to make decisions about their health care needs; and Veterans who prefer to receive in-house VA care may instead be referred to care in the community.

17 APPENDIX B – COMMUNICATION MATERIALS

Table 6: Communication Materials

Communication Material	SharePoint Link
Veteran Fact Sheet	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/RCI%20External%20Communications%20Documents/External%20Veteran%20Fact%20Sheet%20Final%20022321.pdf
Internal Staff Fact Sheet	Coming soon

18 APPENDIX C – POLICY MATERIALS

Table 7: Policy Materials

Policy Material	Link	Issue Date	End Date
Community Care Scheduling Enhancements Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Community%20Care/Scheduling/Community%20Care%20Scheduling%20Enhancements%20VIEWS%20%2303771730.pdf?csf=1&web=1&e=tcWdTA	10/28/2020	10/31/2022
National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065 – COVID-19 Upgrades Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Announcements/National%20Deployment%20of%20Consult%20Toolbox%201.9.0063%20and%201.9.0065%E2%80%93%20COVID-19%20Upgrades%20(VIEWS%23%2002748457)%20signed.pdf?csf=1&web=1&e=MF6jcA	05/18/2020	
Changes to Consult/Referral Management during COVID-19 Memo	https://dvagov.sharepoint.com/:b:/r/sites/vacovha/DUSHCC/DC/DO/CI/CI_Artifacts/CI_10N%20Memo/Conditions%20-%20Flu%20%20etc/COVID19/Changes%20to%20Consult%20Referral%20Management%20during%20COVID-19%20.pdf?csf=1&web=1&e=PNHS3P	09/13/2020	
RCI Memo			
Prioritization for Consultations Procedures and Appointments	https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NA/ACAO/ConsultManagement/SitePages/Consult%20Toolbox.aspx	N/A	N/A
Consult Processes and Procedures Directive 1232 (2)	https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3230	06/28/2019	N/A
CPRS Technical Guide	https://dvagov.sharepoint.com/sites/ReferralCoordinationInit/Shared%20Documents/Guidebook%20Supporting%20Documents/RCI%20Technical%20Guide%202%202%202021%20RW%20%202%205%202021%20cp%20v1.pdf	N/A	N/A
E-Consult Guidebook Version 3	https://dvagov.sharepoint.com/:b:/r/sites/vhaovac/cpm/Shared%20Documents/Guidebooks/E-Consult%20Guide%20Book%20V%203.0.pdf?csf=1&web=1&e=WbAagT	N/A	N/A
Office of Community Care Field Guidebook (FGB)	https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx	N/A	N/A
Service Agreement SOP	Coming Soon	N/A	N/A

Unable to Schedule SOP	Coming Soon	N/A	N/A
Minimal Scheduling Effort SOP	Coming Soon	N/A	N/A