Service Agreements

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In flow systems there is delay that is generated not only by the individual clinic both FOR and AT appointments (primary care or specialty care), but also by the step of sending work BETWEEN the providers. Other industries experience the same phenomena. Since other industries instinctively know any delay is waste and cost, they handle these transfers of product between one step and another by specifying which party is responsible for which task. These specifications are reduced to writing in contracts with performance monitoring to govern the work.

In medicine, historically, the way work has been sent from one entity (Primary Care, for example) to another (Specialty Care, for example) has been very different than industry. Consults sent typically have a paucity of information, delays in arrival to the specialist, unclear communication pathways to the specialists, primary care provider, and patient, and unreliable completion expectations. To make matters worse, "if the patient is urgent, the doctors are calling and making appointments." This system is characterized by unreliability, delay, rework, dissatisfaction, and high cost.

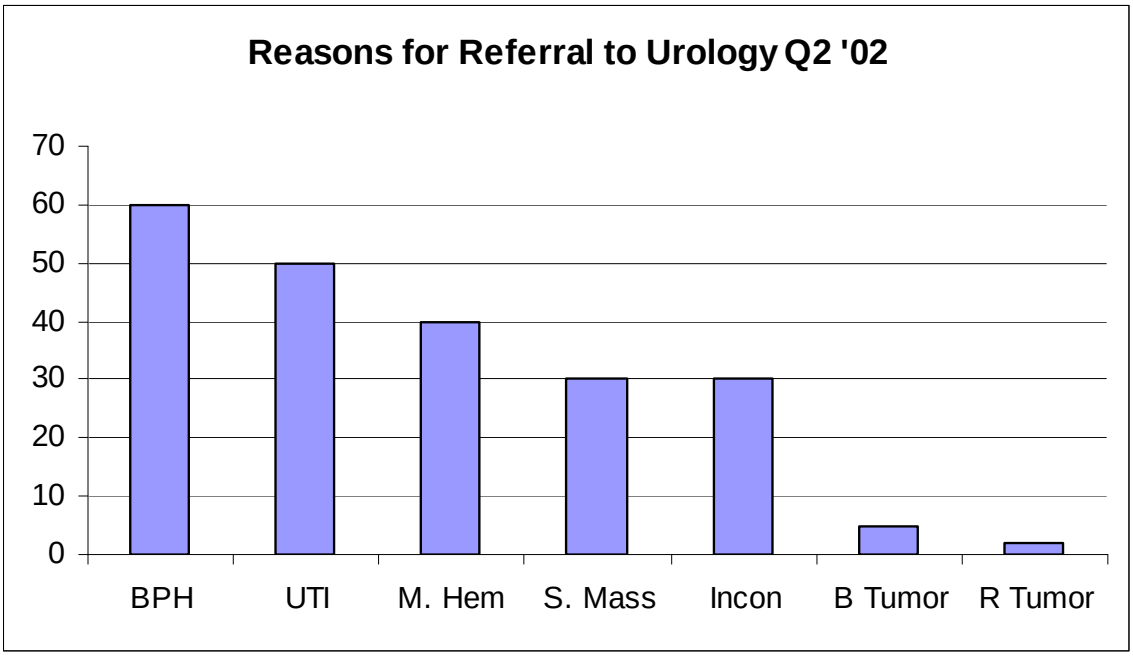
The solution to this is a Service Agreement. A service agreement is defined as an understanding or agreement between any 2 entities, one of which sends work to the other governing the flow process. It is important to understand the "agreement" flavor to this process – it means both parties have to talk to each other. Both parties have to understand the work, the process, and agree on expectations of each other. The work necessary to understand and build a new system is small, however, in relation to the improvements possible in workflow.

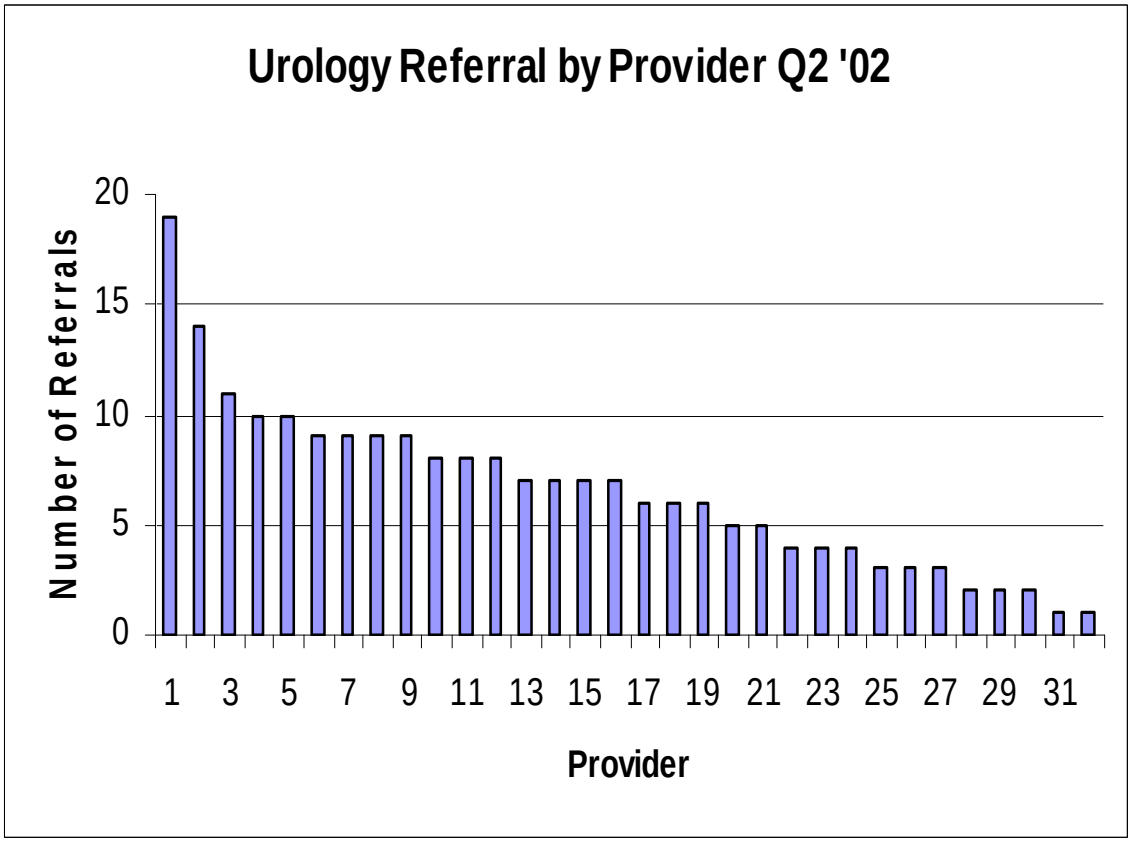
Service agreements, in addition to clarifying communication, processes and expectations have one other explicit function: to decrease demand for specialists. A well-functioning agreement will "sort the work" in the process of requesting it, so the right work gets to the right place at the right time without extra triage or oversight. Remember, "specialists do special things". The last thing desired is for specialists to be doing work that someone else can do – since that work takes them away from the doing the work that only they can do. The "demand" for specialists comes from primary care – and in that way governs the way specialists spend their time.

There are 4 components to a service agreement: 1. Define the work. 2. The sender agrees to send the right work *packaged* the right way. 3. The receiver agrees to do the work right away. 4. The referee monitors the agreement.

1. Define the work

Before any informed discussion about how to change the system can occur, it is prudent, in fact critical, to define the work. Defining WHAT the work is and WHO is sending it brings an element of fact and reference point baseline for any discussion. This step typically involves a chart review of consults and entering of information on a spread sheet so graphs, or pictures of the state of affairs are available. Here is an example of this information:





While such information typically will raise a multitude of questions, the purpose of this step is to arrive at a baseline understanding of "what is". Keep in mind that any strategy to make the specialist more available for primary care patients (decreasing their demand) will involve not only considering a change in behavior about which conditions to refer, but also a change in habits of the most frequent referring provider(s).

2. Sender Sends the Right Work Packed the Right Way

Once the baseline information is collected, the next leg of the agreement is for the sender to consider helpful and appropriate changes. These changes come in two main areas: Sending the "right work" and "packaging" that work in a way that eliminates any sorting by the specialists.

What is the right work?

Defining the "right work" to be sent involves evidence based clinical guidelines and local customs. Once the "current work" being sent is understood, asking the question "if our specialist were the last one standing in this city or state, what is the work (s)he can do that no one else can do?" The Urology example above raised the question if primary care can do some of the "BPH" (Benign Prostatic Hypertrophy) work – or most of it – currently being sent to Urology – or learn how to do it with some tutoring. Having the urologist work with primary care to define which patients they can help (which ones to send) and which ones they cannot help (which ones not to send) is key to establishing a service agreement. Remember -- these decisions about which patients are the right ones to send should be treated as draft decisions that are informed by future chart audits and changed inappropriate ways as time goes on. One more point: decisions about what the right work is cannot be made by only one party. For example, the specialist should not put together a list of criteria for the clinic and implement it without the involvement by the referring providers. This is a recipe for disaster.

Since many times definition of the "right work" may be difficult, creating or clarifying a mechanism for contact between the primary care and specialty care providers -- for example by phone or pager -- along with expected response times is needed. Give specialty providers can respond to phone calls or electronic messages quickly, often a phone discussion can assist the sender in their task of sending the right work packaged the right way. These "sidewalk consults" are thus given structure and standardization.

More active feedback about what is the "right work" may be appropriate for some "senders" perceived as sending "too much". The baseline studies will show which providers refer the most and the least. While it may be impossible to know what is the "right" rate of referral, if the data matches perceptions, it may be an opportunity for

individual private discussions with targeted individuals aimed at improving the quality of referrals. This is often called “focused education”.

How do we package of the work correctly?

Packaging the work correctly speaks to the process of referring patients from the sender to the receiver. Just as a chart audits informs decisions about a service agreement, flow mapping the process of referral informs the decision about packaging. They few minutes spent sketching out a flow mapped of the referral process from the first to the last step is time well invested in understanding the current process. Typically, showing a draft will raise many issues about what the process really is, how many areas there are for failure, and while a simpler process might be. In VA, the embodiment of “packaging the work” correctly for providers ultimately is the consult template. Remember: consult templates are not service agreements.

It is important to remember that once criteria are drafted that propose the "right work" and consult templates are drafted these should be circulated widely for comment feedback and improvements before they are implemented. Many practices also trial implementation with one or two providers to work out any bugs before they are implemented widely.

In addition to physician and process factors, there are many patient and staff factors involved in packaging consults correctly. One of the key patient factors under the control of the primary care provider and primary care staff is closing the visit. If the physician orders a consult without informing the patient, the specialist will suffer the consequences of this poorly package referral. Not only will there be a high chance of the patient failing to show up to the specialists appointment, but there will also likely the poor understanding about the reason for referral on the part of both the patient and the specialist. Primary care should discuss with the patient at some length the reason for referral, obtain agreement from the patient that referral is necessary and desired, and then write the consult. As the patient leaves the primary care office and goes to the clerk to check out, it is strongly recommended that the date and time or the specialty appointment the established at that moment. Naturally, not all appointments will be able to be made on the spot, however contacting the patient later to establish the specialty appointment increases the amount of work needed to make the referral. Then, when the patient arrives at the specialty office, they should be warmly greeted. The staff should acknowledge the referring provider, the reason for referral, and reinforce the name of the specialist the patient will see. These words can be scripted for staff to use consistently. This sort of process not only improves confidence on the part of the patient, but also timeliness and reliability of communication between providers.

3. Receiver does the work right away

This principle is easy and yet hard. This emphasizes that in return for the sender doing more work to sort out though "right" work and to package it correctly, the sender and the patient get something in return. What they get from the receiver (the specialist) is

speed. Often specialists who see the same type of problem frequently do not value speed as much as the patient or the primary care provider. The primary care provider and patient are typically anxious about the issue. Any delay in care by the specialists only make life worse for the patients and primary care providers. Therefore, what the specialists, or receiver has two "give" to this negotiated agreement is a change in behavior in the direction of improving access to their clinic -- or "speed". In other words in exchange for the sender sending the right work the right way, the receiver agrees to do the work without delay.

Complying with this principle means the receiver needs to understand and implement the appropriate changes in their clinic as outlined in the section of this document discussing improving access for appointments. A measurement of access that is objective should be established and agreed upon in the final service agreement.

4. Referee Audits the Agreement

Finally, the fourth principle is related to audits. In order for the agreement compliance to be objectively visible, continually improved upon, and transparent, regular audits with clear criteria should be established. This is really relatively simple since there are only three things that need to be audited: First, is the right patient being sent? This item is the responsibility of the sender. Second, is the patient package the right way? This item is also the responsibility of the sender. Third, is the patient being seen in the agreed upon timeframe? This item is the responsibility of the receiver.

Implementation of service agreements

These are the recommended process steps to consider as service agreements are implemented. Past experience suggests that each of the steps is important to the final product.

1. The volume reason and source of existing referrals are objectively audited.
2. The consultation process is flow mapped.
3. Face-to-face discussion occurs between the sender and receiver with the above two pieces of information available for the meeting. Improvements are discussed.
4. One or two specific topics for a service agreement are chosen.
5. A simple service agreement is drafted specifying the expectations of both parties in measurable fashion. This draft is widely circulated and discussed.
6. Consensus is reached among the sender and receiver group about the details of the written service agreement. Process improvements are also agreed upon and implemented.
7. The agreement is formally adopted by the medical executive committee and contains signatures from at least the primary care leader, the specialty care leader (or sender and receiver Representative), and the Chief of Staff or other appropriate system leader.

8. Service agreement implementation tools such as structured consults and patient education materials are identified, distributed, and implemented.
9. A person responsible for performing periodic (quarterly?) audits along with the expected timeframe is established
10. Results of the audit are regularly discussed at face-to-face meetings with the appropriate parties.