Building the Medical Neighborhood
Connecting & Sharing Care

Taming the Referral Process
An Introduction & Invitation

Carol Greenlee MD FACP
TCPi National Faculty
Chair: ACP Council of Subspecialty Societies and the High Value Care workgroup

February 22, 2018

Continuing Education Disclosures

- Commercial support or sponsorship – None
- Speaker or planner relationships with commercial interests – None
- Requirement for CME credit or attendance certificate
  - Full session attendance and completion of online evaluation
- Evaluation link available at the end of the session

Building the Medical Neighborhood
Connecting & Sharing Care

Taming the Referral Process

An Introduction & Invitation

Carol Greenlee MD FACP

TCPi National Faculty

Chair: ACP Council of Subspecialty Societies and the High Value Care workgroup

February 22, 2018

As you listen...

- Think about how things work now in your clinic & how improving the referral process might help
  - Reduce chaos, frustration & burden in the clinic
  - Improve satisfaction & outcomes for your patients
  - Reduce waste & unnecessary resource use

- Why work on this?
- What can be done?
- Does it make a difference?

WIIFM?

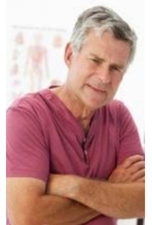
Does any of this sound familiar?

- " Most of the time I don't know what the referring doc wants me to do for the patient"
- *"They had testing done but we don't have the results, since the patient is here now for a consultation, we'll just repeat the testing.*
- *"I don't know if my patient saw the specialist or not"*
- "Why didn't someone let me know they were referring my patient to a surgeon"
- *"I just dug through a 48 page note from the specialist and still have no idea what they think or what they did with my patient"*

…and then there is the Patient Experience

- *"My doctor told me why he sent me to see you but I was so upset about the news he gave me that I don't remember what he said."*
- *"I was supposed to call to schedule with that specialist? I thought her office was supposed to contact me."*
- *"I understood I was here to have the procedure today, not just to talk about my stomach pain!"*

- *"I had that MRI last month.You mean I was supposed to bring the report and the films with me to this visit? I assumed you had that information."*
- *"I waited 3 months for the appointment, took the day off of work & after I was in the exam room learned I needed a different type of specialist"*



IOM 2001 Crossing the Quality Chasm

"A highly fragmented delivery system"

…physician groups, hospitals, and other health care organizations operate as **silos**

a "non-system"

disconnected care

With a few exceptions, most practice in a silo, part of disconnected care

Silo Care / Disconnected Care is:

Not very patient centered

Not very cost effective

Not very satisfying & often burdensome on the back end

The Referral Request

Patient in exam room with cc/o "fatigue" (or "lungs" or "heart" or "anemia" or "pain"…)

Not sure what testing was done or treatments tried before referral

- Try to get her records, keep calling PCP…specialty staff time diverted
- If get through, PCP staff has to stop everything to send records (if using fax, fax machine on either side could be busy)
- Look through records while trying to talk to patient & do exam
- If records come after the appointment, back-end work, missed critical elements, wrong pathway, etc.

Scenarios like these are not uncommon

- **60-70% of specialists** reported receiving **no information**
- **25-50% of primary care providers** received **no information**
  - ~50% did not even know if their patient ever saw the specialist
- 28 % of primary care and 43% of specialists are **dissatisfied with the information they receive**
- **8%** of referrals are **inappropriate** (wrong specialist or are unnecessary) (average 43 referrals /specialist/year)
- >20% of referrals are **never completed** } delayed/missed diagnosis and/or treatment

From Disconnected Care → High Value, Connected Care

Start with the END in mind:

- **Goal of Care Coordination: To Benefit the Patient**
  - Ensure appropriate, continuous connected care
  - Enhance the Quality of Care (6 domains)
    - Patient Centered Care
    - Safety
    - Effectiveness
    - Efficiency
    - Timeliness
    - Equity

From Disconnected Care → High Value, Connected Care

Start with the END in mind:

- **Goal of Care Coordination: To Benefit the Physician and Clinical Team**
  - Working together/Cooperation/Cohesion
    - Increase effectiveness and safety
    - Increase satisfaction
    - Reduce stress, chaos and burden
    - Increase connectedness and part in the bigger picture
    - More enjoyment (JOY) in the work

…Connecting the Care, Sharing the Care

We need a *system* for care coordination

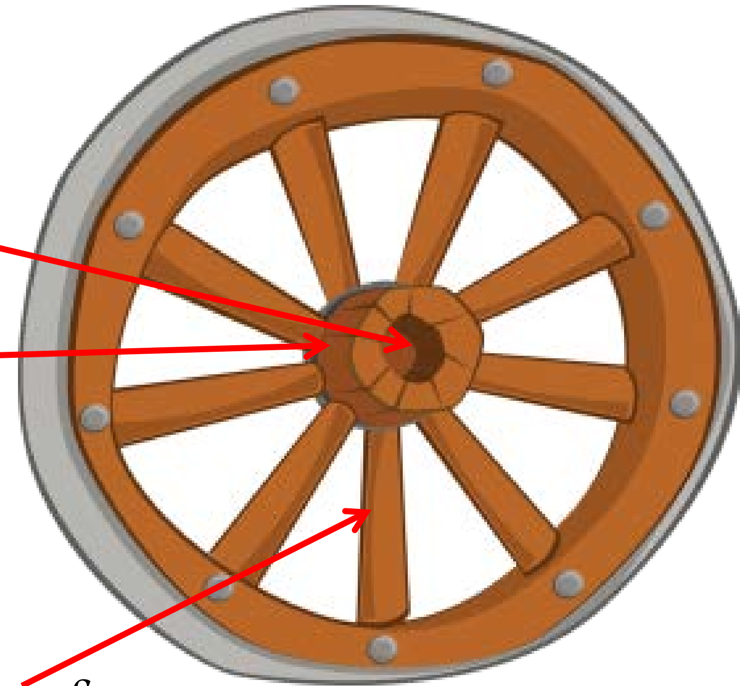
The "Medical Neighborhood"

- An ***approach*** to care coordination
  - It's about **working together** better
  - Promotes **connected care** wherever that care may be needed

High Value Care Coordination

- Defining what is **needed & expected** for high value referrals and care coordination

Patient-Centered Connected Care- *the patient's medical neighborhood*



- The Patient is the **center** of care
- Primary Care is the necessary **hub** of care
- Specialty/ancillary care is an **extension** of care
  - Helping with care to meet patient needs

What do you need to connect the care?

High Value Care Coordination

- Information Sharing
- Communication
- Collaboration

Start with Check Lists for:

High Value Referral Request

High Value Referral Response

Expectations for High Value Referrals

Referral Request

- *Prepared Patient*
- Type of referral
- Clinical question
- Urgency
- Core Data Set
- Pertinent Data set

Referral Response

- Answer the clinical question
- What the specialist is going to do
- What the patient is instructed to do
- What does the referring physician need to do & when
- What **follow up** is needed & with whom

Prepared Patient

- **Patient as partner in care**
  - Patient included in the process
  - The patient's needs & goals considered
- Patient understand **role of specialist** and who to call for what
  - **Pre-visit patient education** regarding
    - The referral condition and/or
    - The type of and role of the specialist
    - Info on the specialty practice (parking, contact info, other logistics)*
- Appropriate (patient-centered) "handoff"
  - Specialty practice alerted of any **special needs** of the patient
  - **Appropriate specialist at appropriate time to meet the patient's needs**
  - **Appropriate preparation with testing or therapeutic trials prior to referral**

Define the **specialty role** to most appropriately meet patient needs

- ___**Pre-consultation**/ pre-visit assistance/preparation
- ___**Medical Consultation**: Evaluate and advise with recommendations for management and send back to me
- ___**Procedural Consultation**: Specialist to confirm need for and perform requested procedure if deemed appropriate.
- ___**Shared Care Co-management**: I prefer to *share the care* for the referred condition (PCP lead, first call)
- ___**Principal Care Co-management:** Please assume principal care for the referred condition: (Specialist assumes care, first call)
- ___Please assume full responsibility for the care of this patient (**Complete transfer of care**)(e.g. Pediatric to Adult Care transition)

Pre-consultation Request & Review

Intended to expedite/prioritize care

- **Pre-visit Request for Advice**
  - Does the patient need a referral
  - Which specialty is most appropriate
  - Recommendations for what preparation or when to refer
- **Pre-visit Review of all Referrals**
  - Is the clinical question clear
  - Is the necessary data attached
  - Triage urgency (risk stratify the patient's referral needs)
- **Urgent Cases**
  - Expedite care
  - Improved hand-offs with less delay and improved safety

Antithesis of High Value Coordinated Care:

- 60 yo woman was referred to surgeon Dr. Z by another specialist for a procedure. After a 3 month wait for the appointment, Surgeon Z. read her records as he walked in the room saying "I don't do that procedure. You will need to go to XXX Clinic to get that done".

This patient (and clinician) would have benefited from a
Pre-consultation Request "Do you do this procedure?"
Or at least a **Pre-consultation review** to catch the inappropriate referral

Provide a Clinical Question
(or summary of reason for referral)

- "eyes"   "gallbladder"   "diabetes"
- 68 year old female with intermittent double vision. Is ophthalmopathy assessment the correct starting point?
- 39 year old female with severe RUQ pain, abnormal US and known diabetes, does she need surgery?
- 20 yo female with T1DM since age 8 on insulin pump therapy, transferring from pediatric to adult care

Provide **Supporting Data (pertinent data set)** for the referred conditions

- **Pertinent** (*not data dump*)
- **Adequate** (*reduce duplication*)

- To allow the specialty practice to
  - **determine if the referral is to the appropriate specialty**
  - **effectively triage urgency**
  - **effectively address the referral (enough info to do something)**

Establish *referral guidelines (Pertinent Data Sets)* for a High Value specialty consultation

- Define:
  - Testing needed
  - Therapeutic trials
  - What not to do
  - Alarm signs & symptoms
  - Urgency

Cognitive/Memory Difficulties

Developed by	American Academy of Neurology
How developed	A survey identified the most common reasons for referral. The templates were developed after review of the literature. In addition to a dedicated work group, multiple committees where asked to review and comment.
Additional essential patient information	• A brief summary of the case details pertinent to the referral, including family history. Please indicate in the summary if the patient has any of the following: • Rapidly progressive cognitive difficulties • Focal findings on examination • Associated abnormal movements • Use of psychotropic medications • Provide: • TSH • Vitamin B12 • Folic acid • CBC with differential • CMP
Additional patient information, if available	• Images • Neuropsychological testing • Drug screen • Urinalysis
Alarm symptoms/conditions	Rapidly evolving cogitative disorder
Tests/procedures to avoid prior to consult	Imaging, EEG, neuropsych testing
Common rule-outs to consider prior to consults	Depression
Relevant "Choosing Wisely" elements	None provided
Healthcare professional and/or patient resources	Healthcare Professional Information: Rosenbloom MH. *The Neurologist* 2011;17:67-74 Brodaty, Am J Geriatr Pshchiatry, 2006 Patient Information: http://www.alz.org/dementia/mild-cognitive-impairment-mci.asp

- Create:
  - Capability to schedule based on needs

Antithesis of High Value Coordinated Care:

- 54 yo male with thyroid nodule evaluated by endocrinologist with report to PCP indicating "FNA shows Papillary Thyroid Cancer. Needs surgery."
  - F/u appt with PCP a year later shows thyroid intact and nodule still palpable…
- Risk:
  - Delayed care: potential harm to patient
  - Liability concerns

Provide a High Value Referral Response

- **Answer the clinical question/address the reason for referral-**Summary (include some thought process)
- Agree with or Recommend type of referral / **role of specialist**
- Confirm existing, new or changed **diagnoses**; include "ruled out"
- **Medication /Equipment changes**
- **Testing** results, testing pending, scheduled or recommended (including how/who to order)
- **Procedures** completed, scheduled or recommend
- **Education** completed, scheduled or recommended
- Any **"secondary" referrals** made (confer with and/or copy PCP on all)
- Any **recommended services or actions to be done by the PCMH**
- **Follow up** scheduled or recommended

- Clear indication of
- **What the specialist is going to do**
- **What the patient is instructed to do**
- **What the referring physician needs to do & when**

- Easy to find & refer to in the response note

How do we make this happen? Make an Agreement….

Care Coordination Agreement

(Collaborative Care Agreement/Care Compacts)

- *Platform that everyone agrees to work from:*
  - *Standardized Definitions*
  - *Agreed upon expectations regarding communication and clinical responsibilities.*
- *Can be formal or informal*
- *Your policies and procedures should be aligned to support the agreement*

What's in the Care Compact ?

(start with the basics)

- **Critical elements of the referral request**
- **Critical elements of the referral response**
- Protocol for **scheduling appointments**
- **Closing the Loop-**referral tracking protocol

Template Care Coordination Agreement

PCP/ Requesting

- Prepare patient
  - Use of referral guidelines where available
  - Patient/family aware of and in agreement with reason for referral, type of referral, and selection of specialist
  - Expectations for events and outcomes of referral
- Provide appropriate and adequate information. *(Optimally adopt mutually agreed upon referral form with neighbor*)*
  - Demographic and insurance information
  - Reason for referral, details
  - Core Medical Data on patient
  - Clinical data pertinent to reason for referral
  - Any special needs of patient.
- Indicate type of referral requested:
  - Pre-visit Preparation/Assistance
  - Consultation (Evaluate and Advise)
  - Procedure
  - Co-management with Shared Care
  - Co-management with Principal Care
  - Full responsibility for all patient care

* See provided model check list of suggested areas to address.

Neighbor/ Responding

- Review Referral Requests and Triage According to Urgency
  - Reserve spaces in schedule to allow for urgent care
  - Notify referring provider of recognized referral guidelines and inappropriate referrals
  - Work with referring provider to expedite care in urgent cases
  - Verify insurance status
  - Anticipate special needs of patient/family
  - Agree to engage in pre-referral consult if requested.
  - Provide PCP with number for direct contact for urgent/immediate matters.
- Provide appropriate and adequate information in a timely manner. *(Optimally adopt mutually agreed upon referral response form with PCP*)*
  - To include specific response to referral question and any provision of or changes in type of recommended interaction; diagnosis; medication; equipment; testing; procedures; education; referrals; follow up recommendations or needed actions

* See provided model check list of suggested areas to address.

12

Define the protocol for scheduling appointments

- What is the expected protocol:
  - the **patient** will call to schedule an appointment
  - the **specialty practice** should contact the patient
    - Allows for Pre-visit assessment/referral disposition
    - Allows for tracking of referrals / accountability

Open loop – Open ended

53 year old man had skin lesion resected by PCP

- Pathology showed melanoma
- Referred to Dermatology for the needed further management
- Patient was No Show for Dermatology appointment

…and neither clinician was aware…

Referral Tracking **"Closing the Loop"** protocol

- **Referral request sent, logged and tracked**
- **Referral request received and reviewed**
  - Referral ***accepted*** with ***confirmation*** *of appointment date* **sent back to referring practitioner**
  - Referral ***declined due to inappropriate referral*** (wrong specialist, etc) and **referring practice notified**
  - ***Patient defers*** making appt or cannot be reached and **referring practice notified**
- **Referral response sent** (must address clinical question/reason for referral)
  - ***Referral Note*** sent to referring clinician and PCP in timely manner
  - ***Notification of No Show or Cancellation*** (with reason, if known)
- Referrals made from one specialty to another (e.g. **secondary referrals**) include **notification of the patient's primary care clinician**

To have connected care *between* practices, need to have connected care *within* practices

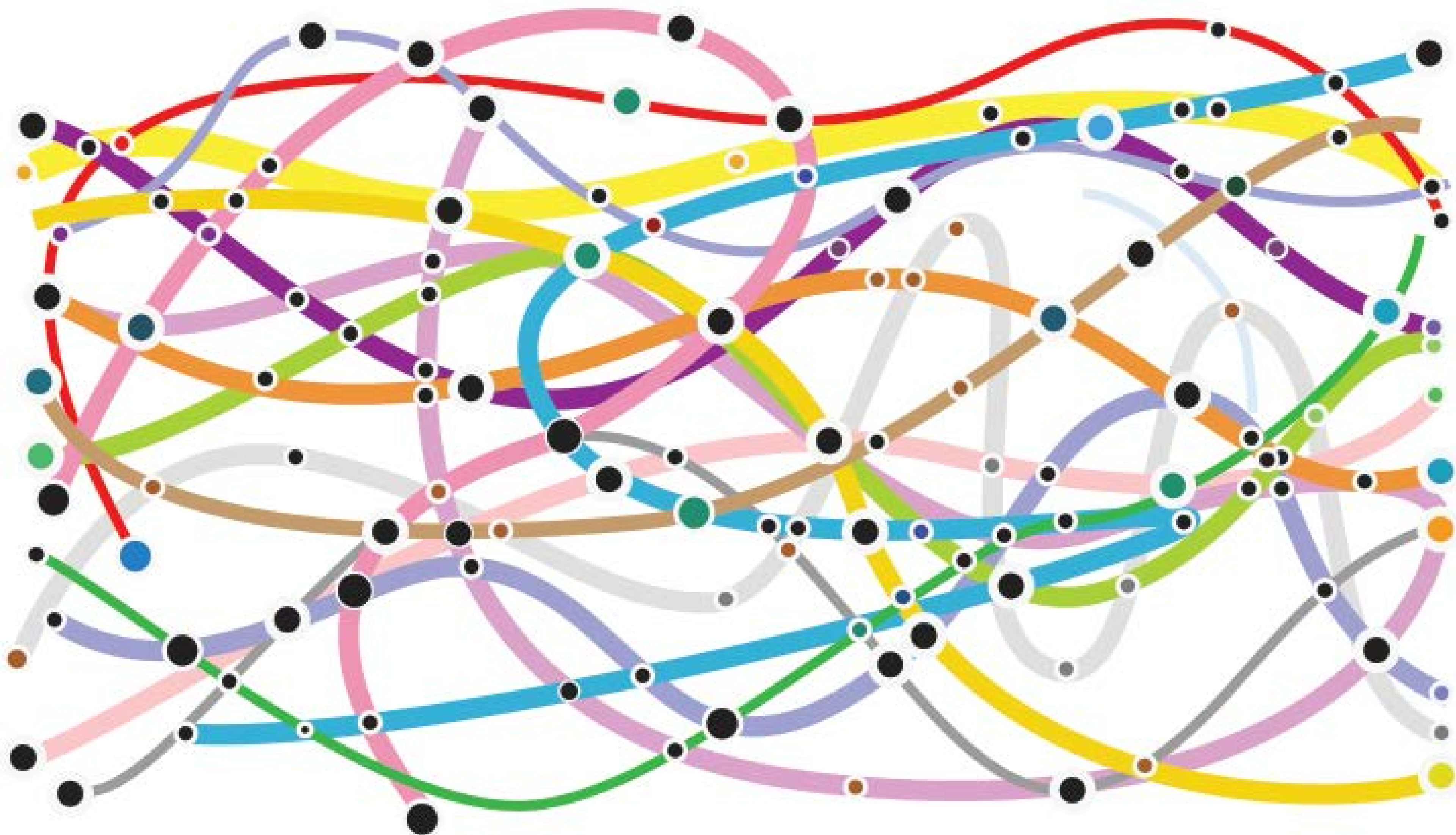
We often have silos within our silos

- Need to develop **Patient-centered team care** (entire staff) around the **referral process**
  - Make the referral part of taking care of the patient
  - Work as a team to design improvements, test and implement
- **Intentional** internal processes (Policy & Procedures)
- **Track** the referrals and the process

Start with One Step at a time….

- **Get your own "house" in order**
  - Start with a Process Map
    - Make it a team approach
    - Look for gaps ("opportunities")in the internal referral process

Process Map (Mess)



Tips to Help you Process Map

Requesting a Referral

- **Process Start and End**
  - Start = Decision to refer
  - End = Referral reconciled
- **Referral reconciled means:**
  - Referral response received and recommendations are incorporated into the patient's care in partnership with patient OR
  - Referral incomplete and next steps have been made in partnership with patient

Responding to a Referral

- **Process Start and End**
  - Start = Receipt of referral request
  - End = Referral Response sent
- **Referral Response can be :**
  - Redirection to more appropriate specialist
  - Referral not needed or Answer to simple question without appointment
  - Notice of No Show or Cancel
  - Completed Referral with note

Tips to Help you Process Map

- Map your process "as is"
  - resist the tendency to "fix" as you map
- Include those who actually "do" this process
  - Different people may vary in how they do the job
- With complex processes such as this one, consider multiple passes, allow time to revisit & tweak
  - Include:
    - Who? Include handoff details, Patient involvement
    - What? Time parameters? Documentation and notification parameters?

Develop a P&P (Policy & Procedures)

- Set a practice policy for referrals
  - Example primary care policy: *"Our policy is to provide standardized referrals with a clear reason or question stated and attach the appropriate information so that our patients get the care they need efficiently, effectively and safely"*
  - Example specialty policy:*"Our policy is to provide high value, patient-centered referrals appropriate to the needs of the patient"*
- Design the Procedures the way you want it to work
  - See if it works
  - Make improvements/changes as needed to get it working well

Leave in action….

- Where is the waste & chaos in your referral process?
  - Do a **Process Map** of your internal referral processes
    - Identify needed team members, roles & responsibilities for your practice referral process
    - Identify gaps in "**Critical Elements**" (key items for improvement)

Request Process

- **Prepared Patient**
- **Scheduling Protocol**
- ***Clinical Question***
- **Referral Tracking**
- **Team Approach**

Response Process

- **Patient-centered**
- **Scheduling Protocol**
- ***Pre-Consultation***
- **Referral Tracking**
- **Team Approach**

    - Develop a **Policy & Procedures** document for how you want it to work
  - Develop a **Care Coordination Agreement/ Compact** with another practice or practices

www.acponline.org/hvcc-training

- Primary care checklist for referral process assessment and critical elements
- Specialty care checklist for referral process assessment and critical elements
- Sample policy & procedures for referral content
- Sample Care Coordination Agreements/Compacts
- Pertinent Data Sets (Referral Guidelines) for 35 conditions
- Referral Request and Referral Response checklists

cgreenlee@westslopeendo.com

Idea Sharing

- Anyone already working on their referral process?
- Has anyone done a process map of your practice referral process?
  - What did you learn?
- Does anyone have a care coordination agreement (compact) in place?

Continuing Education Certificate

For CME credit or attendance certificate,
complete the online evaluation:

https://www.surveygizmo.com/s3/4142546/February-22-2018-Taming-the-Referral-Process

or

http://bit.ly/2Dxzefb

Thank you!