Closing the Loop with Referral Management

**Speaker:** Linda Thomas-Hemak, MD, President and CEO, The Wright Center for Graduate Medical Education

**Moderator:** Ed Wagner, MD, MPH, The MacColl Center for Health Care Innovation
Change Concepts for Practice Transformation

1. Laying the Foundation
   - Engaged Leadership
   - Quality Improvement Strategy

2. Building Relationships
   - Empanelment
   - Continuous, Team-Based Relationships

3. Changing Care Delivery
   - Patient-Centered Interactions
   - Organized, Evidence-Based Care

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination
Care coordination

The goal is to track and support patients when they obtain services outside the practice, and to ensure safe and timely referrals or transitions.
Care coordination

<table>
<thead>
<tr>
<th>Link</th>
<th>patients with community resources to facilitate referrals and respond to social service needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrate</td>
<td>behavioral health and specialty care into care delivery through co-location or referral arrangements.</td>
</tr>
<tr>
<td>Track &amp; support</td>
<td>patients when they obtain services outside the practice.</td>
</tr>
<tr>
<td>Follow up</td>
<td>with patients within a few days of an emergency room visit or hospital discharge.</td>
</tr>
<tr>
<td>Communicate</td>
<td>test results and care plans to patients &amp; families.</td>
</tr>
<tr>
<td>Provide</td>
<td>care management services for high-risk patients.</td>
</tr>
</tbody>
</table>
Care fragmentation

• Provider referral networks have become larger and depersonalized.
• Obtaining specialty support is still a major problem for safety net providers.
• Valuable social/support services are often underutilized.
• Studies demonstrate that critical patient information for referrals and transitions are often missing, which distresses patients and is unhelpful (or worse) for providers.
## Effects of care fragmentation

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care providers (PCPs) reporting that they always get information back after a referral:</td>
<td>37%</td>
</tr>
<tr>
<td>PCPs routinely notified about discharges:</td>
<td>17-20%</td>
</tr>
<tr>
<td>PCP involved in discussion before discharge:</td>
<td>3-23%</td>
</tr>
<tr>
<td>Discharge summaries received by PCP within 2 weeks:</td>
<td>20-40%</td>
</tr>
<tr>
<td>Discharge summaries without info on pending tests:</td>
<td>65%</td>
</tr>
<tr>
<td>Discharge summaries without discharge medications:</td>
<td>21%</td>
</tr>
<tr>
<td>Discharge summaries without follow-up plans:</td>
<td>14%</td>
</tr>
</tbody>
</table>

Care coordination

- Care coordination is “the deliberate integration of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”

- It refers to activities and interventions that attempt to reduce fragmentation and improve the quality of referrals and transitions.

NCQA must-pass element (PCMH 5B): Referral tracking and follow up

The practice coordinates referrals by:
- Providing reason for referral and relevant clinical information.
- Tracking referral status.
- Following up to obtain specialist’s report.
- Documenting agreements with specialists for co-management.
- Providing electronic exchange of patient information.

Use the PCMH-A to help pass the must-pass items. To pass these items your PCMH-A scores should be: at least level B on items 24-26.
Care Coordination Model

- **PATIENT-CENTERED MEDICAL HOME**
  - Accountability
  - Patient Support

- **Relationships & Agreements**
  - Community Agencies
  - Hospitals & ERs
  - Medical Specialists

- **Connectivity**

- High-quality referrals & transitions for providers & patients
  - Involved providers receive the information they need when they need it
  - Practice knows the status of all referrals/transition involving its panel
  - Patients report receiving help in coordinating care

The MacColl Institute for Healthcare Innovation, Group Health Cooperative © 2010
How to improve care coordination

1. Assume accountability

2. Provide patient support

3. Build relationships & agreements

4. Develop connectivity
Academic, Level 3 NCQA, Safety Net Medical Home

All Providers EMR MU Certified

Staffing:
5 Physicians: 4 FTE
  1 FT/1PT Med Peds
  1 FT Internal Medicine
  1 FT Pediatrician
  1 PT Family Medicine
1 NP, 3 PAs
1 RN Care Manager
1 Social Worker
3 LPNs
8 MAs
3 Receptionists
1 Referral/Scheduler
1 EMR Application Specialist

Presented by Dr. Linda Thomas-Hemak, MD
What we changed and why

Care Coordination: “Closing the loop” through referral tracking is one of the greatest benefits we provide as patient advocates.

Uncoordinated, “reactive” care

vs.

Strategic referral tracking

- Causes patient and provider frustration & anxiety
- Diminishes health outcomes
- Redundant & reactive work

- Care utilization & compliance are enhanced
- Barriers to care are identified & mitigated
- Patients appreciate the organized effort!
How we implemented changes

• Leadership: Physician and Management Consensus

• Engaged understanding and intentional MU of EMR Software Functionality

• Building an Accountable and Leaner Medical Home and Medical Village
Intentional MU of EHR software functionality

• One process and language for REAL Meaningful Use
  • Noting preferred provider, indication, and risk stratified, color coded time expectations

• Engaging data management:
  • Close only with attached outcomes
  • For example: a colonoscopy order remains open until procedural notes/biopsies are done

• Specialty specific referral attachments

• Collectively working our open referrals exception report
Creating referrals

- All providers engage the patient and create specific service provider electronic referrals during a point of care, phone or portal based patient encounter
- Special focus of referral is noted by provider in notes section
- All referrals are sent to central, “accountable” referral queen
- Any referrals generated at POC appear in the CVS
- Specialty visits driven by patients drive referral creation
Building a leaner Medical Home & Village

- **Collective Office Accountability**
  - Assigning an accountable “Referral Queen”
  - Open referrals status report and run chart
  - Emphasizing shared accountability for clean up

- **Building our office capacity with work redistribution**
  - Specialty-specific and destination-driven referral attachments
  - Redistributing scheduling work to specialty offices
  - Hunting for missing outcomes and high-volume offenders
  - Preferentially promoting our Good Neighbors

- **Identifying and Mitigating Barriers to Care**
  - Enhancing utilization to avoid acute problems
  - Reducing duplicative work
One language to risk stratify time expectations

Color coded EMR visual management system

- **Red** = Urgent or Emergent
  - **Urgent** = 1 week
  - *Emergent* = 24 hours  Verbal contact made by provider with scheduler
- **Priority** = 2 weeks
- **White** = Routine or Elective
  - **Routine** = 8 weeks
  - *Elective* before next visit

* Turn around time documented in Referral # Space visible in open referral report
Data managing referral outcomes

- Referral requests include our EMR “Inbound Fax” #
- All documents faxed appear directly in EMR holding tank
- Specialty visit notes faxed are attached to open or created referrals
- Procedural results are proactively separated as specific testing orders, not specialty service referrals. Ex: a colonoscopy order is opened so GI referral may be closed. This order remains open until procedural notes/biopsies are secured to close orders
Data managing referral outcomes

Data manager’s role:
- Monitors inbound fax’s holding tank on a daily basis
- Results received are attached to the original referral form which is closed and then results are routed to the provider for review
- Procedural orders may be opened by data management dept if noted in the specialty note
- Procedural results close open orders unless biopsies are noted and then orders remain open until final pathology received
- Providers review all results and close the documents after being addressed
Scheduling referrals & specialty defined information

- Engaging our good neighbor offices to define mutual expectations
- Destination driven data. Proactively sending the information desired/needed:
  - Patient demographics and insurance
  - Focus of requested service
  - Progress notes
  - Medications Lists/Allergies
  - Relevant imaging and lab studies
- Referrals sent via Fax directly from the EMR by the Central Referral Scheduler
Tracking: open referral status and exception report

- Status report checked on a daily basis by our “referral queen” to ensure no open emergent referrals
- Open referral exception report run on a weekly basis
  - The report looks at all open referrals
  - The list is divided into the following two categories:
    - Open for **Less than** 60 days
    - Open for **More than** 60 days
- All referrals open for more than 60 days are considered **overdue** and on the **active daily work list** to obtain results
Results & lessons learned

- Expert-centric, meaningless EHR use is a real nightmare that agitates everybody!
- Referral tracking is daunting and endless, but the power is undeniable for leaner workflow and better care
- Care utilization and “compliance” are enhanced as barriers to care utilization are identified and addressed
- Patients appreciate the organized advocacy effort
- It’s just the beginning: orders, x-rays & labs need the same strategy
## PCMH 2011 Content and Scoring

### PCMH1: Enhance Access and Continuity

| A. Access During Office Hours** | 4 |
| B. After-Hours Access | 2 |
| C. Electronic Access | 2 |
| D. Continuity | 2 |
| E. Medical Home Responsibilities | 2 |
| F. Culturally and Linguistically Appropriate Services | 2 |
| G. Practice Team | 4 |

### PCMH2: Identify and Manage Patient Populations

| A. Patient Information | 3 |
| B. Clinical Data | 4 |
| C. Comprehensive Health Assessment | 5 |
| D. Use Data for Population Management** | 16 |

### PCMH3: Plan and Manage Care

| A. Implement Evidence-Based Guidelines | 4 |
| B. Identify High-Risk Patients | 3 |
| C. Care Management** | 3 |
| D. Manage Medications | 3 |
| E. Use Electronic Prescribing | 3 |

### PCMH4: Provide Self-Care Support and Community Resources

| A. Support Self-Care Process** | 6 |
| B. Provide Referrals to Community Resources | 3 |

### PCMH5: Track and Coordinate Care

| A. Test Tracking and Follow-Up | 6 |
| B. Referral Tracking and Follow-Up** | 6 |
| C. Coordinate with Facilities/Care Transitions | 18 |

### PCMH6: Measure and Improve Performance

| A. Measure Performance | 4 |
| B. Measure Patient/Family Experience | 4 |
| C. Implement Continuously Quality Improvement** | 3 |
| D. Demonstrate Continuous Quality Improvement | 3 |
| E. Report Performance | 2 |
| F. Report Data Externally | 2 |

**Must Pass Elements**
### Stage 2
**Eligible Professional**
**Meaningful Use Core Measures**
**Measure 15 of 17**

*Date issued: November, 2012*

<table>
<thead>
<tr>
<th>Summary of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPs must satisfy both of the following measures in order to meet the objective:</td>
</tr>
<tr>
<td>Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.</td>
</tr>
<tr>
<td>Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.</td>
</tr>
<tr>
<td>Measure 3: An EP must satisfy one of the following criteria:</td>
</tr>
<tr>
<td>• Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in &quot;measure 2&quot; (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender’s EHR technology certified to 45 CFR 170.314(b)(2).</td>
</tr>
<tr>
<td>• Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.</td>
</tr>
</tbody>
</table>
PCMH 5B: Referral tracking and follow-up

1- Giving consultant or specialist the clinical reason for referral and pertinent clinical information
2- Tracking status of referrals including required timing for receiving a specialist report
3- Following up to obtain a specialist report
6- Demonstrating the capability for electronic exchange of key clinical information
7- Providing electronic summary of the care record to another provider for more than 50% of referrals (Meaningful Use Menu item)
What our electronic referral process looks like
Electronic referrals: PCMH and MU standards

PCMH 5B-1: Referral reason

PCMH 5B-2: Tracking Status including timing for receiving report

PCMH 5B-3: Referral reason Depression

PCMH 5B-4: Elective

PCMH 5B-5: Capability to exchange key clinical information between clinicians

PCMH 5B-6: Provide electronic summary of care to another provider

 MU Core Measure 15: Summary care record for each transition of care or referral
Electronic referrals: PCMH and MU standards

PCMH 5B-1: Referral reason
- PCMH 5B-2: Tracking Status including timing for receiving report
- PCMH 5B-3: Follow up to obtain specialists reports
- PCMH 5B-6: Capability to exchange key clinical information between clinicians
- PCMH 5B-7: Provide electronic summary of care to another provider

MU Core Measure 15: Summary care record for each transition of care or referral
### Open Referrals by Rating

#### URGENT
- Yeager, Henry C.,...
- Children's Hospital...
- Batzel, Edward L.
- Yeager, Henry C.,...
- Brutico, Anthony,...
- Thomas, Linda, M.D.

#### PRIORITY
- Yeager, Henry C.,...
- Bushta, John DPM
- Geisinger Healthcare First Priority HLT
- Laporta, Guido, DPM
- Mardini, Malke, M.D.
- Northeastern Eye-
- Bushta, John DPM
- Hershey Medical ...
- Bushta, John DPM
- Pancholy, Samir B.
- Thomas, Linda, M.D.

#### NORMAL
- Geisinger Healthcare First Priority HLT
- MA - Access Plus
- MA
- Highmark Medica...
- Highmark Medica...
- Geisinger Insurance
- United HLT Com...
- MA

**NOTES**
- Elective
- Emergent in 24 HRS

**PCMH 5B -2:** Tracking Status including timing for receiving report
# Referral status (as of 2/19/13)

<table>
<thead>
<tr>
<th>Ref To Dr</th>
<th>Insurance</th>
<th>Referral #</th>
<th>Effective</th>
<th>Expired</th>
<th>Created</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degennaro, Louis</td>
<td>United HLT Community Plan</td>
<td>Imom ? insurance</td>
<td>01/16/13</td>
<td>01/16/13</td>
<td>01/16/13</td>
</tr>
<tr>
<td>Delta Medix, Urology</td>
<td></td>
<td></td>
<td>02/19/13</td>
<td>02/19/13</td>
<td>02/19/13</td>
</tr>
<tr>
<td>Lalos, Alexander</td>
<td>United HLT Community Plan</td>
<td>Geisinger insurance</td>
<td>01/17/13</td>
<td>01/17/13</td>
<td>01/17/13</td>
</tr>
<tr>
<td></td>
<td>Amerihealth Mercy</td>
<td>Out of area</td>
<td>01/25/13</td>
<td>01/25/13</td>
<td>01/25/13</td>
</tr>
<tr>
<td></td>
<td>First Priority Health</td>
<td></td>
<td>02/05/13</td>
<td>02/05/13</td>
<td>02/05/13</td>
</tr>
<tr>
<td></td>
<td>United HLT Community Plan</td>
<td>? which insurance</td>
<td>02/18/13</td>
<td>02/18/13</td>
<td>02/18/13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02/19/13</td>
<td>02/19/13</td>
<td>02/19/13</td>
</tr>
<tr>
<td>Boriosi, Guido, M.D.</td>
<td></td>
<td></td>
<td>02/06/13</td>
<td>02/06/13</td>
<td>02/06/13</td>
</tr>
<tr>
<td>Borowski, Gregory MD</td>
<td>United HLT Community Plan</td>
<td>Imom ? insurance</td>
<td>01/11/13</td>
<td>01/11/13</td>
<td>01/11/13</td>
</tr>
<tr>
<td>Burke, Casey D.O.</td>
<td>United HLT Community Plan</td>
<td>Imom ? insurance</td>
<td>01/03/13</td>
<td>01/03/13</td>
<td>01/03/13</td>
</tr>
<tr>
<td>Bushta, John DPM</td>
<td>United HLT Community Plan</td>
<td>Imom ? insurance</td>
<td>01/22/13</td>
<td>01/22/13</td>
<td>01/22/13</td>
</tr>
<tr>
<td>Cech, Rosanne</td>
<td>United HLT Community Plan</td>
<td>Imom ? insurance</td>
<td>01/29/13</td>
<td>01/29/13</td>
<td>01/29/13</td>
</tr>
<tr>
<td>Drozdick, John, M.D.</td>
<td>Highmark Medicare Service</td>
<td></td>
<td>02/06/13</td>
<td>02/06/14</td>
<td>02/06/13</td>
</tr>
<tr>
<td>Geisinger Urology</td>
<td>United HLT Community Plan</td>
<td>Geisinger</td>
<td>01/21/13</td>
<td>01/21/14</td>
<td>01/21/13</td>
</tr>
<tr>
<td>Hazzouri, Lauren MD</td>
<td></td>
<td></td>
<td>02/13/13</td>
<td>02/13/14</td>
<td>02/13/13</td>
</tr>
<tr>
<td>Hazzouri, Lauren MD</td>
<td></td>
<td></td>
<td>02/13/13</td>
<td>02/13/14</td>
<td>02/13/13</td>
</tr>
<tr>
<td>Hershey Medical Center</td>
<td>United HLT Community Plan</td>
<td>Imom ? insurance</td>
<td>01/30/13</td>
<td>01/30/14</td>
<td>01/30/13</td>
</tr>
</tbody>
</table>
## Open referrals exception report

<table>
<thead>
<tr>
<th>Specialty</th>
<th>under 60 days</th>
<th>over 60 days</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy &amp; Immunology</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Audiologist</td>
<td>7</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>Cardiology/Phys/Osteo</td>
<td>7</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Case worker</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>22</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Clinical/Social Worker</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Counseling/Psych</td>
<td>22</td>
<td>85</td>
<td>107</td>
</tr>
<tr>
<td>Dentist</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dermatology</td>
<td>33</td>
<td>26</td>
<td>59</td>
</tr>
<tr>
<td>Endocrin, Diabetes, Metabo</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>25</td>
<td>26</td>
<td>51</td>
</tr>
<tr>
<td>Gynecology</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Hematology &amp; Oncology</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nephrology</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Neurodevmntl Dis/Peds</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Neurology</td>
<td>10</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Neurology, Child</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>OB/Gyn/Phys/Osteo</td>
<td>14</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>40</td>
<td>128</td>
<td>168</td>
</tr>
<tr>
<td>Optometrist</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surg</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>26</td>
<td>30</td>
<td>56</td>
</tr>
<tr>
<td>Pediatric Cardiology</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Physical Medicine/Rehab</td>
<td>20</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>10</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Psychologist</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
Closing the Loop

Goal: To ensure that the desired consultation note is in the patient’s record following a referral.

- Collect key information about each referral.
- Save it in a tickler file.
- Monitor for completion of key steps.
- Remedy identified problems.
Steps for improving care coordination

1. Assume accountability
   - Initiate conversations with key consultants, EDs, hospitals, and community service agencies.
   - Set up an infrastructure to track and support patients going outside the PCMH for care—referral coordinator and tracking system.
2. Provide patient support

- Help patients identify sources of service—especially community resources.
- Help patients make appointments.
- Track referrals & help resolve problems.
- Ensure transfer of information.
- Monitor hospital and ED utilization reports.
- Manage e-referral system.
Steps for improving care coordination (cont.)

3. Build relationships & agreements

- Primary care leaders initiate conversations with key specialists, hospitals, and community services around mutual expectations.
- Specialists have legitimate concerns about inappropriate or unclear reasons for referral, inadequate prior testing, etc.
- Agreements are sometimes put in writing or incorporated into e-referral systems.
4. Develop connectivity

- Most of the complaints from both PCPs and specialists focus on communication problems: too little or no information, etc.
- Evidence indicates that standardized formats increase provider satisfaction.
- Consider three options for more effective flow of standardized information: shared EHR, e-referral, & structured referral forms.
**Why make care coordination a priority?**

<table>
<thead>
<tr>
<th>Happier patients</th>
<th>Patients and families hate it that we can’t make this work.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer problems</td>
<td>Poor hand-offs lead to delays, lapses in care, adverse drug effects, and other problems that may be dangerous to health.</td>
</tr>
<tr>
<td>Less waste</td>
<td>Enormous waste is associated with duplicate testing, unnecessary referrals, unwanted specialist-to-specialist referrals, and failed transitions from hospitals, EDs, &amp; nursing homes.</td>
</tr>
<tr>
<td>Happier physicians &amp; staff</td>
<td>Clinical practice will be more rewarding.</td>
</tr>
</tbody>
</table>
Safety Net Medical Home Initiative Resources

To help practices understand and implement the Patient-centered Medical Home (PCMH), we have created a library of resources and tools, all of which are publicly available on the web site.

http://www.safetynetmedicalhome.org/

A good way to find resources is to look at the Change Concepts tab (e.g., care coordination) on the web site.
Closing the Loop with Referral Management

Q & A
Project Funders

We would like to thank the following for the generous support:

The Commonwealth Fund (Project Sponsor)

Co-Funders:
Colorado Health Foundation
Jewish Healthcare Foundation
Northwest Health Foundation
Partners HealthCare
The Boston Foundation
Blue Cross Blue Shield of Massachusetts Foundation
Blue Cross of Idaho Foundation For Health
Beth Israel Deaconess Medical Center