



MacColl Center for Health Care Innovation

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



Closing the Loop with Referral Management

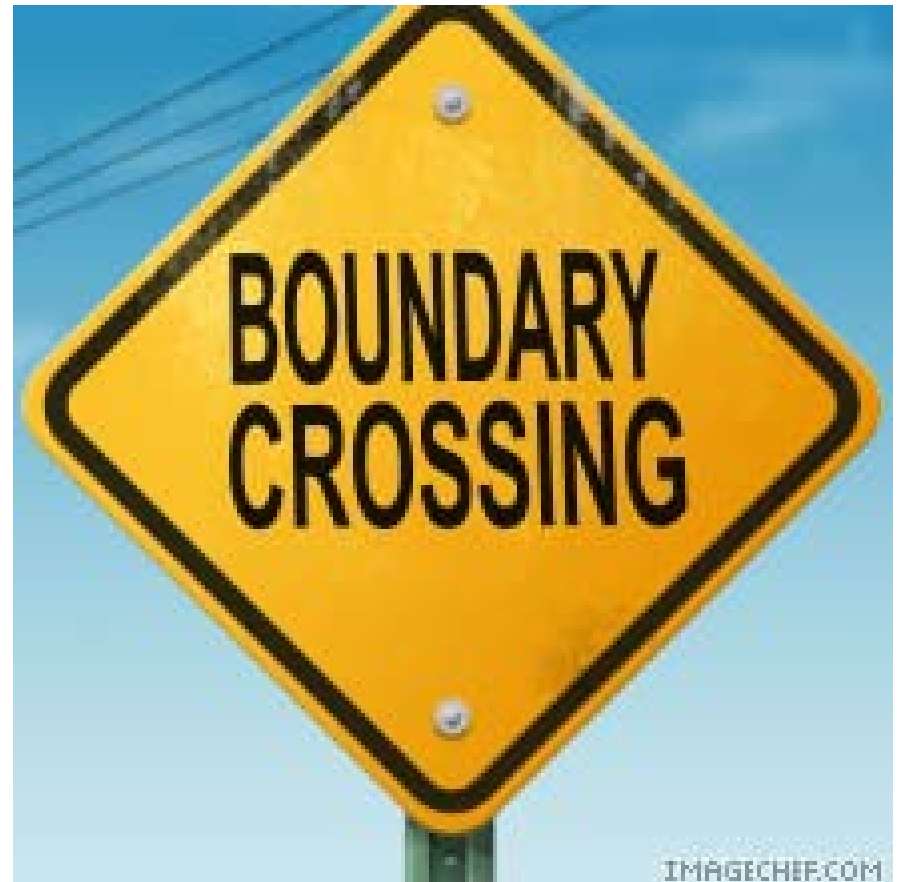
Ed Wagner, MD, MPH, MACP
MacColl Center for Health Care Innovation
Group Health Research Institute

Linda Thomas-Hemak, MD
The Wright Center for Primary Care

February 26, 2013

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

Link

patients with community resources to facilitate referrals and respond to social service needs.

Integrate

behavioral health and specialty care into care delivery through co-location or referral arrangements.

Track & support

patients when they obtain services outside the practice.

Follow up

with patients within a few days of an emergency room visit or hospital discharge.

Communicate

test results and care plans to patients & families.

Provide

care management services for high-risk patients.

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.

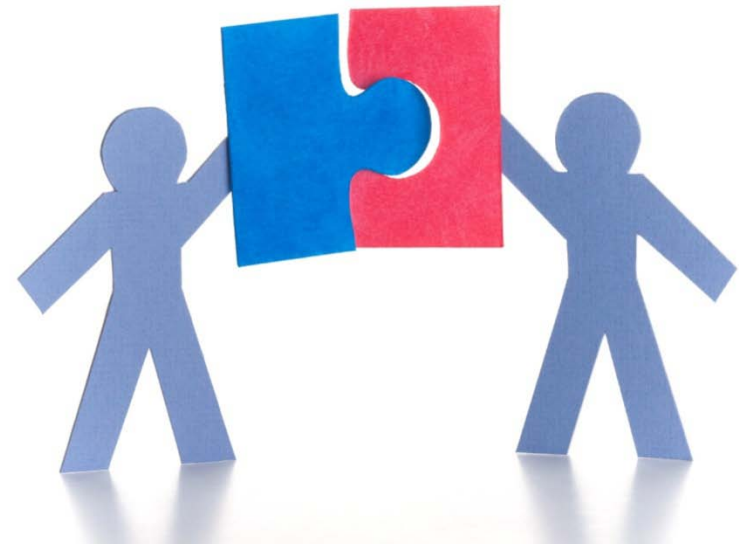


Effects of care fragmentation

Primary care providers (PCPs) reporting that they always get information back after a referral:	37 ⁰ %
PCPs routinely notified about discharges:	17-20 ⁰ %
PCP involved in discussion before discharge:	3-23 ⁰ %
Discharge summaries received by PCP within 2 weeks:	20-40 ⁰ %
Discharge summaries without info on pending tests:	65 ⁰ %
Discharge summaries without discharge medications:	21 ⁰ %
Discharge summaries without follow-up plans:	14 ⁰ %

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.



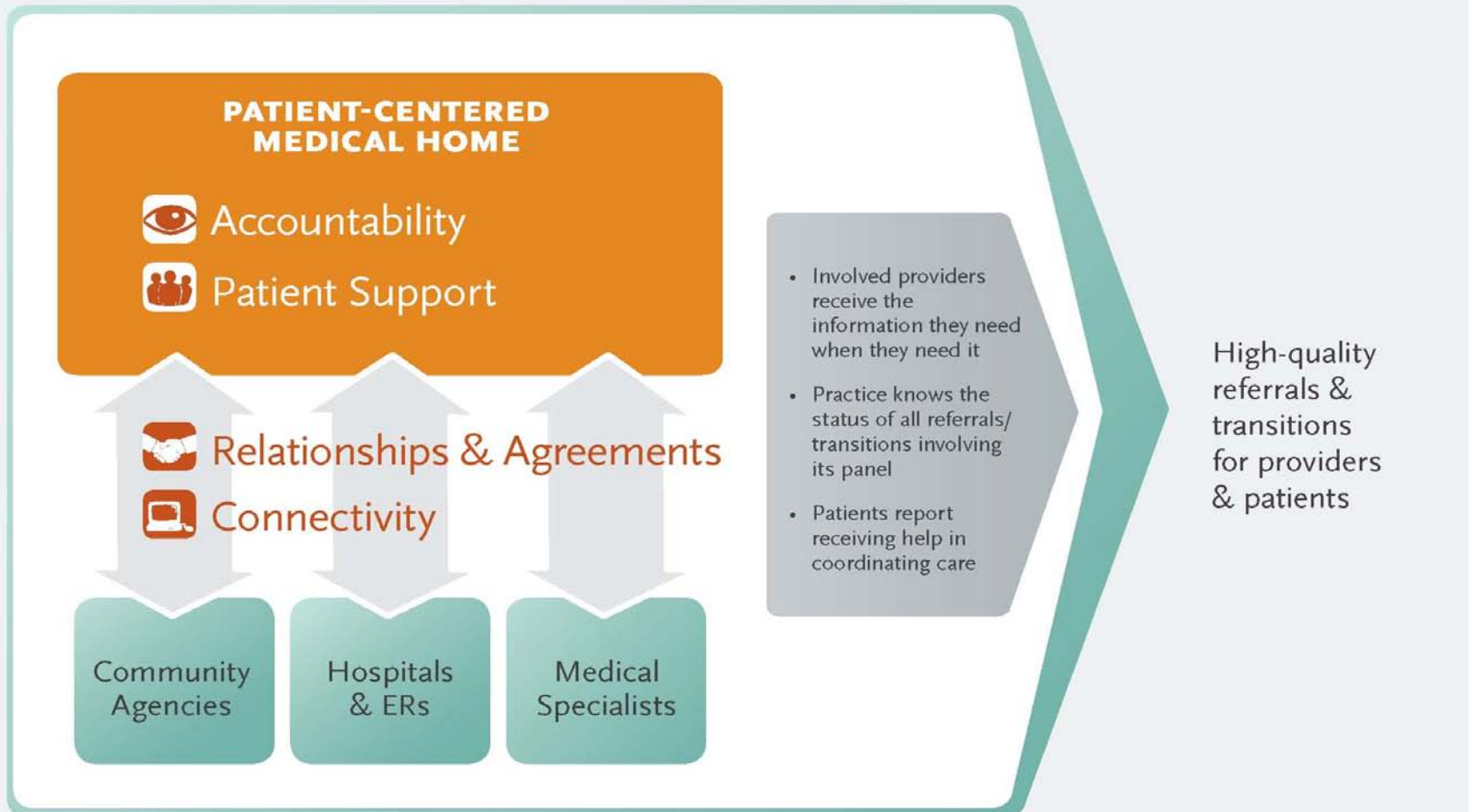
NCQA **must-pass element (PCMH 5B):** Referral tracking and follow up

The practice coordinates referrals by:

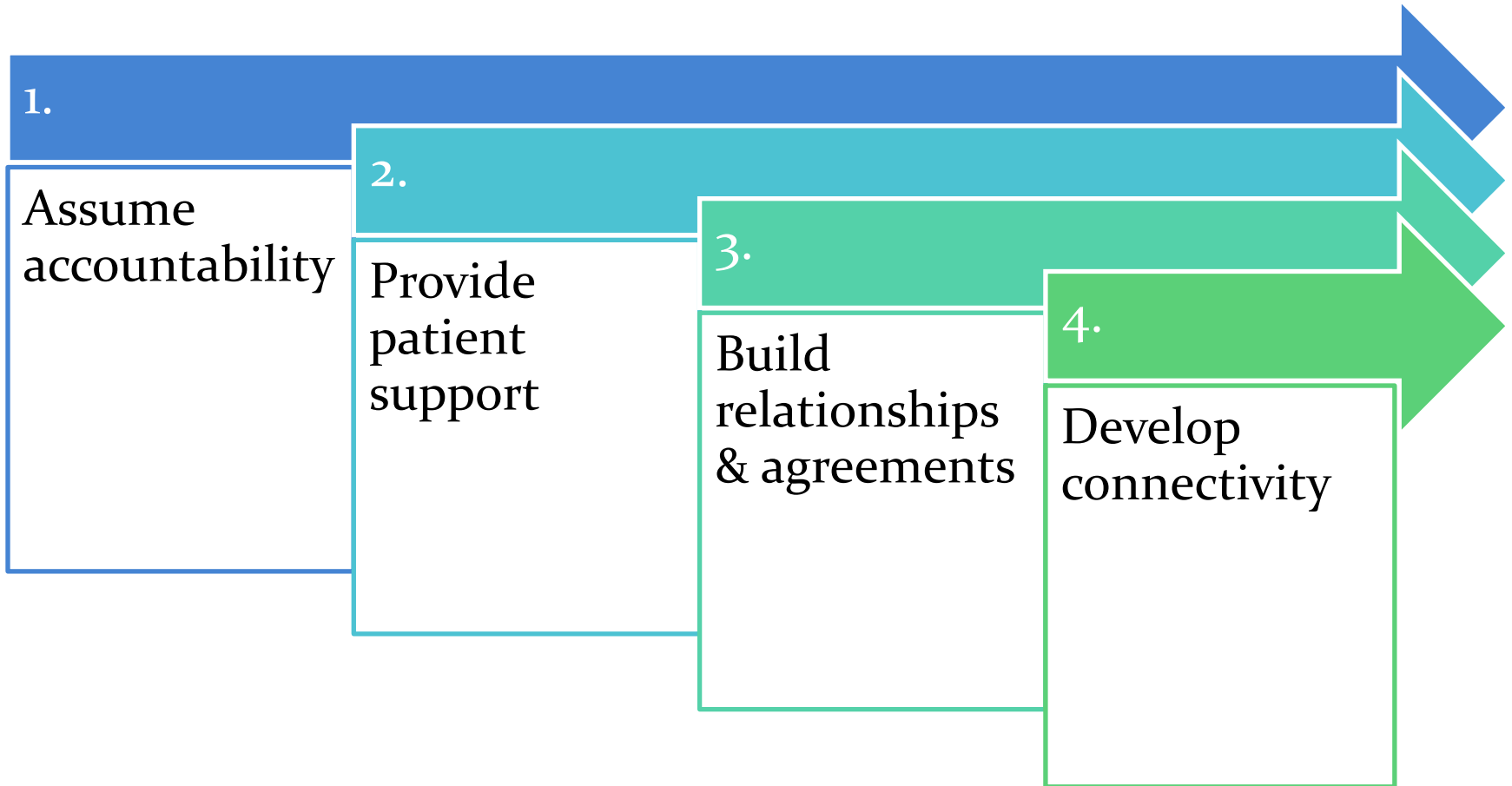
- Providing reason for referral and relevant clinical information.
- Tracking referral status.
- Following up to obtain specialist's report.
- Documenting agreements with specialists for co-management.
- Providing electronic exchange of patient information.

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



How to improve care coordination



The Wright Center for Primary Care Mid-Valley Practice

Archbald, PA

**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		Pts
A.	Access During Office Hours**	4
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20
PCMH2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	Use Data for Population Management**	5
		16
PCMH3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	Care Management**	4
D.	Manage Medications	3
E.	Use Electronic Prescribing	3
		17

PCMH4: Provide Self-Care Support and Community Resources		Pts
A.	Support Self-Care Process**	6
B.	Provide Referrals to Community Resources	3
		9
PCMH5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	Referral Tracking and Follow-Up**	6
C.	Coordinate with Facilities/Care Transitions	6
		18
PCMH6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	Implement Continuously Quality Improvement**	4
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
		20

**** Must Pass Elements**



Stage 2 Eligible Professional Meaningful Use Core Measures Measure 15 of 17

Date issued: November, 2012

Summary of Care	
Objective	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.
Measures	<p>EPs must satisfy both of the following measures in order to meet the objective:</p> <p>Measure 1:</p> <ul style="list-style-type: none">• 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. <p>Measure 2:</p> <ul style="list-style-type: none">• 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. <p>Measure 3:</p> <p>An EP must satisfy one of the following criteria:</p> <ul style="list-style-type: none">• Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (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).• Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Exclusion	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.

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 -2: Tracking Status including timing for receiving report

PCMH 5B -1: Referral reason

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

Rating	1 Normal		
Created	11/29/12	RcvdCp	00/00/00
Sched	00/00/00	RwvdCp	00/00/00
Sent	00/00/00	Notified	00/00/00
RcvdPt	00/00/00	Closed	00/00/00
RwvdPt	00/00/00	Declined	00/00/00

Result Letter	11/29/2012	Referral To Garrett Lee Smith
Document	11/26/12	.Progress Note, Bee Allergy, P
Lab	01/16/12	CKD Panel+

Electronic referrals: PCMH and MU standards

>> New eRx, Fax, Thpy, Imm, Fax... THE WRIGHT CENTER MEDICAL GRO JS, Thr, 11/29/12

Send Print Fax PDF Re-Order Log Ins Switch View EMR

****Alert**** Outgoing Referral Babies test Age 9 yrs, 11 mos DOB 11/30/02 Acct#30248

User Rating Home (570)-000-0000

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

Ref To Dr Bannon, Charles-Wo (570)-340-5844 Sent Notified AV Surgery, General RcvdPt Closed **PCMH 5B-3: Follow up to obtain specialists reports**

PCP Dr Thomas, Linda, M.D. (570) 81 Internal Medicine

Location THE WRIGHT CENTER, ABI CPT

Dr Note

Reason for Re **PCMH 5B -1: Referral reason**

Ins Member Id

Referral # **PCMH 5B-6: Capability to exchange key clinical information between clinicians**

Visits Left

Effective Exp Service Type Service Location

RDr Signed

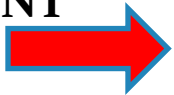
	Ref Notes	Triage	Letter	Report	Links
	Document	01/02/13	DR Bannon Note		
	Document	10/30/12	.Progress Note, AB Pain Female		
	Document	10/10/12	Medical Clearance		

MU Core Measure 15: Summary care record for each transition of care or referral

PCMH 5B-7: Provide electronic summary of care to another provider

Open referrals by rating

URGENT



PRIORITY



NORMAL



Scheduled - Outgoing Referral View for Laretta Zantowsky					
Ref To Dr	Insurance	Referral #	Effective	Expired	Created
Yeager, Henry C.,...	MA		10/17/12	10/17/13	10/17/12
Childrens Hospita...	United HLT Com...		11/06/12	11/06/13	11/06/12
Batzel, Edward L.	Highmark Medica...		11/15/12	11/15/13	11/15/12
Yeager, Henry C.,...	Geisinger Gold		11/20/12	11/20/13	11/20/12
Brutico, Anthony,...	MA - Access Plus		11/28/12	11/28/13	11/28/12
Thomas, Linda, M.D.	NOTES	Emergent in 24 HRS	12/02/12	12/02/13	12/02/12
Yeager, Henry C.,...	Highmark Medica...		04/14/12	04/14/13	04/14/12
Bushta, John DPM	MA		04/30/12	04/30/13	04/30/12
Geisinger Urologus...	First Priority HLT...		06/22/12	06/22/13	06/22/12
Laporta, Guido DPM	MA		08/14/12	08/14/13	08/14/12
Young, Paul M., M.D.	Bluebird Optio...		09/24/12	09/24/13	09/24/12
Northeastern Eye-...			11/27/12	11/27/13	11/27/12
Bushta, John DPM	Geisinger Insurance		11/28/12	11/28/13	11/28/12
Hershey Medical ...	United HLT Com...		11/28/12	11/28/13	11/28/12
Bushta, John DPM	MA		11/28/12	11/28/13	11/28/12
Pancholy, Samir B...	Highmark Medica...		11/30/12	11/29/13	11/30/12
Thomas, Linda, M.D.	NOTES	Elective	12/02/12	12/02/13	12/02/12

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

Referral status (as of 2/19/13)

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

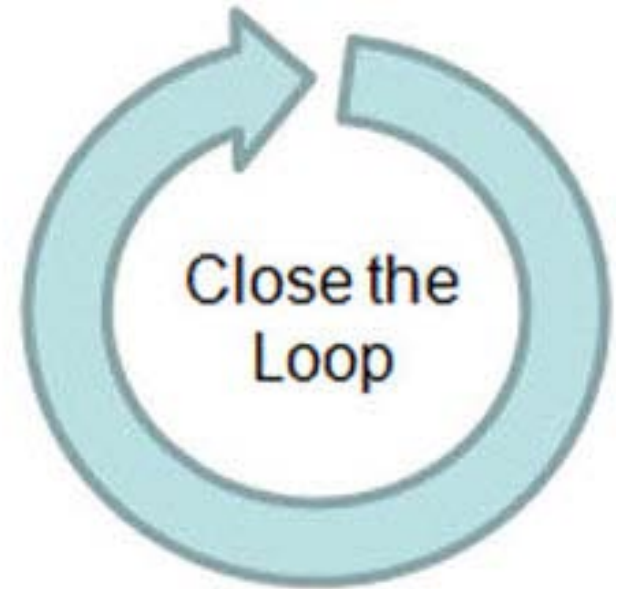
Open referrals exception report

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

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.

Steps for improving care coordination (cont.)



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.

Steps for improving care coordination (cont.)

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?

Happier patients

Patients and families hate it that we can't make this work.

Fewer problems

Poor hand-offs lead to delays, lapses in care, adverse drug effects, and other problems that may be dangerous to health.

Less waste

Enormous waste is associated with duplicate testing, unnecessary referrals, unwanted specialist-to-specialist referrals, and failed transitions from hospitals, EDs, & nursing homes.

Happier physicians & staff

Clinical practice will be more rewarding.

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.

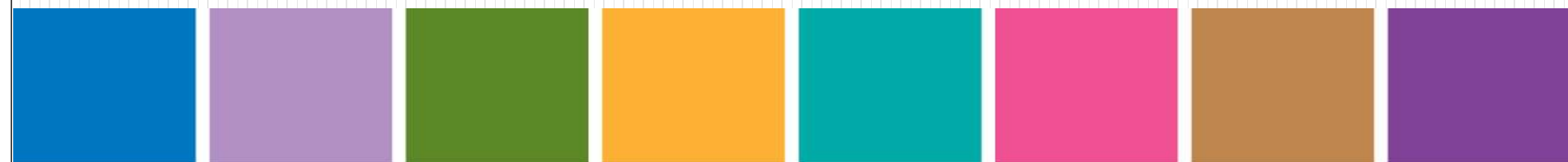
<http://www.safetynetmedicalhome.org/>

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



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