Innovations in Working with Specialists: High Value Care Coordination

October 24, 2019

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Conflicts

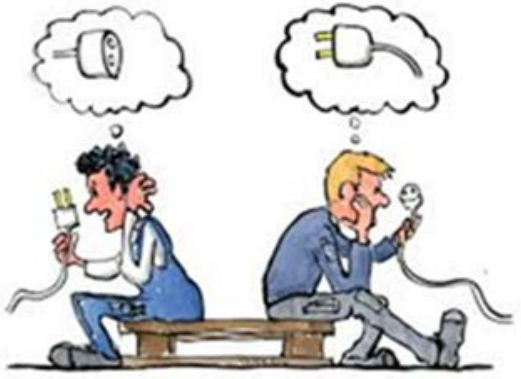
- Paid by ACP to do contract work to develop a High Value Care Coordination curriculum from the ACP policy paper and tool kit

Objectives

- Identify critical elements for a high value referral request, referral response and referral triage and tracking
- Review lessons learned from implementing the Medical Neighbor / HVCC in various healthcare systems, including the RI initiative
- Consider a state-wide effort towards a better referral experience by agreement on a standardized approach and expectations, adaptable to individual practice sites

Working with Specialty Care

- What is it like now?
- What are the issues?
- What innovations might improve the way we all work together?
- How to get started?



In US over 100 Million Referrals per Year

The **ideal referral** involves:

Minimal wait time & efficient use of resources

- **Referral accuracy:** ensures that the referral is:
  - medically necessary
  - directed to the correct specialty
  - complete with relevant history and workup
  - aligned with patient goals
  - defined to appropriately meet the needs of the patient
- **Timely appointment scheduling & completion**
- **Accountable information exchange**
  - Direct communication with relevant information transfer before & after referral visit by specialty care

What is it like now? ...
... the *current* state vs *ideal* state

- Think about what the **current state for referrals** is for your practice and how you could **improve your referral processes** to….
  - Reduce chaos & frustration in the clinic
  - Reduce waste & unnecessary resource use
  - Reduce wait times & improve access
  - Improve satisfaction & outcomes for patients

Consider the **need to optimize the ability to connect & share care** in order to **improve patient outcomes** and be **effective in alternative payment arrangements / APMs**

What is like now? – Getting to Reality

Perception

- 69.3% of PCPs reported they "always" or "most of the time" send notification of a patient's history and reason for the referral to specialists.
- 80.6 % of specialists said they "always" or "most of the time" send consultation results to the referring PCP

Reality

- 34.8% of specialists said they receive it "always" or "most of the time.
- *Colorado Poll indicates 37% of the time specialists receive necessary information*
- 62.2% of PCPs reported getting it "always" or "most of the time."
- *Colorado Poll indicates PCPs receive info 52% of time.*

Referral and Consultation Communication Between Primary Care and Specialist Physicians
O'Malley, AS, Reschovsky, JD. Arch Intern Med. 2011;171(1):56-65

Parallel Universes
Primary Care & Specialty Care

What are the Issues? – Wait Times

- One system had wait times of
  - ***11 months*** for gastroenterology
  - ***10 months*** for nephrology
  - ***7 months*** for endocrinology
- One community had an average wait time for a new specialty care appointment of ***19 weeks (> 4 months)*** –
  - with 30% waiting ***>6 months***
  - 6% waiting ***> 1 year***
- ***RI – wait times***
  - ***15 days to > 6 months***

Effects of Delay

- Worsening of referred condition
  - Use of more medication & ED services
  - Treatable conditions no longer treatable
  - Higher mortality rates
- Need to repeat testing due to delay (outdated results)
  - 38% of all patients; 50% if waited > 6 months
- Patient reported aspects (while waiting):
  - 50% worried about undiagnosed condition
  - 30% had symptoms interfere with activities
  - 24% had to miss work or school

Up to 70% of patients are referred to a specialist in a year ....

- **60-70% of specialists** reported receiving **no information**
- **25-50% of primary care providers** received **no information back**
  - ~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)
- ~50% of referrals are **never completed** } delayed/missed diagnosis and/or treatment

Most referrals are from primary care to specialty care

- PCPs and specialists rarely discuss the **preferred role** for specialty care and ***who will be responsible for what*** aspects of care
  - ~ 50% of specialty care visits are for follow-up specialty care, often "routine check-up" - Limits access for higher acuity new patients & established patients with acute issues
- In up to **26%** of referrals, there is **disagreement** or **misunderstanding of management plans** between referring clinicians and subspecialists/specialists
  - A survey found that **26%** of patients reported receiving ***conflicting information*** from different clinicians
- **Poor referral tracking** leads to missed or inefficient care, inappropriate re-referrals, worse patient satisfaction, and malpractice lawsuits
- 20% of malpractice claims for diagnosis error involve **referral communication deficits**

What innovations might improve the way we all work together?

"Once we get to interoperability…."

Technology is a tool. Care Coordination requires us.

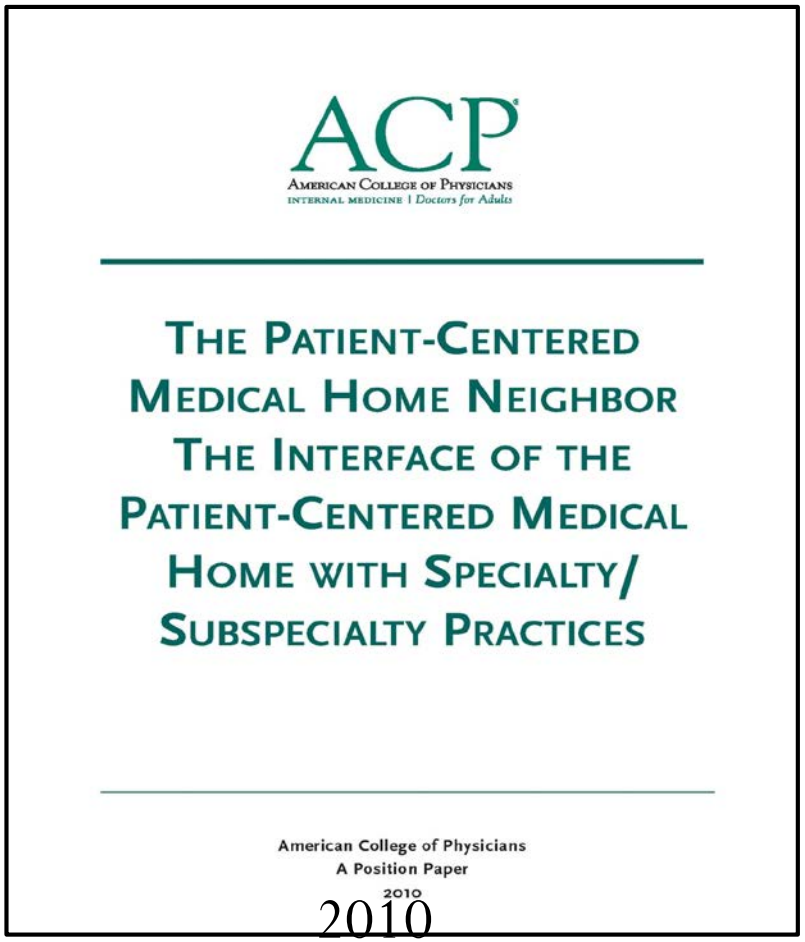
Shared EHR does not solve all the referral/ care coordination problems

Care Coordination requires:

- **Information sharing** ***(can even be done without EMR)***
  - Adequate
  - Pertinent
- **Communication**
  - With patient & family and the medical home team
  - With extended care team (e.g., clinical question)
- **Collaboration/Working Together** ***(mindset – culture)***
  - Standardization & expectations of referral procedures
  - Clarity in roles and responsibilities
- **Patient-centered approach** ***(common goal - meeting patient needs)***
  - Contextual care: considering patient's needs & circumstances
  - Shared goals and decision making

The Medical Neighborhood

October 2010



2010

Medical Neighbor defined:

- Communicates, collaborates & integrates
- Appropriate & timely consultations
- Effective flow of information
- Responsible co-managing
- Patient-centered care
- Support primary care-medical home as hub of care

We need a system for care coordination

The "Medical Neighborhood"

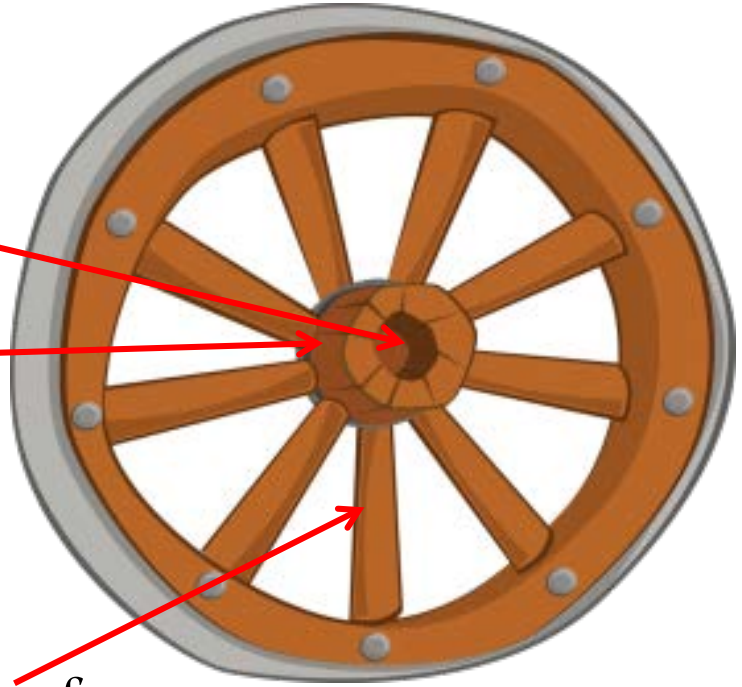
- An ***approach*** to care coordination
  - It's about **working together** better
  - Promotes **connected care** wherever that care may be needed

High Value Care Coordination Tool Kit

- Defining what is **needed & expected** for high value referrals & care coordination (replace **assumptions** with **shared expectations**)

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?

Expectations for High Value Care Coordination

- Information Sharing
- Communication
- Collaboration
- Patient-centered approach

Start with a

High Value Referral Process

What is the Goal of the Referral Process ?

- To help patients receive the care they need in a timely manner (access to care) with the least fragmentation possible

Necessary components:

- The patient shows up for the referral appointment
  - The appointment is scheduled appropriate to the need for care (urgency)
- The specialty care practice has the information they need to determine what care is needed and to be able to provide it
  - The specialty care role in care is appropriate for the need
  - Patients that do not need an appointment are identified and reassurance provided
- The requesting practice & other relevant clinicians and patient/caregiver are informed of the specialty care clinician's assessment, recommendations and/or actions

Steps toward the Ideal State

Referral critical elements & processes:

- High value referral request
  - Prepared patient – participating partner in their care
  - Clinical question / detailed reason for referral
  - Pertinent supporting data
- "Pre-consultation" requests & reviews
  - Referral Triage – Pre-appointment collaboration
- Defined scheduling protocol
- Referral Tracking – closing the loop
- Defined roles for specialty care
  - Graduation/Hand-back to primary care
- High value referral response

A Prepared Patient helps reduce Incomplete & Inappropriate Referrals

- **Patient as partner in care**
  - Patient included in the process - & feedback on the process
  - The patient's needs & goals considered – include patient's goals in the referral request
- Patient understands **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" as part of the care of the patient
  - Specialty practice alerted of any **special needs** of the patient
    - Language, impaired vision, hearing or cognition, caregiver involvement, etc.
  - **Appropriate specialist at appropriate time to meet the patient's needs**
  - **Appropriate preparation with testing or therapeutic trials prior to referral**
  - **Appropriate timeliness** – receive the care they need when they need it

A Clinical Question is core to Referral Accuracy & Information Exchange

“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

Appropriate (pertinent) Supporting Data for Referral Accuracy & Information Exchange

- **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 at the initial visit)

The requesting practice needs to know - what is pertinent…

Establish referral guidelines *(Pertinent Data Sets)*

- Define:
  - Information needed
  - 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

Elements from the Patient's Core (general) Data Set

- Active problem list
- Past medical and surgical history
- Medication list
- Medical allergies
- Preventive care (e.g. immunizations and screening tests)
- Family history
- Habits/social history
- List of providers (care team) (other specialty care clinicians caring for patient).
- Advance directive;
- Overall current care plan and goals of care

- Pain Contracts
- Care Management
- Behavior Health

A Key Element for Referral Accuracy: "Pre-consultation"/ Pre-visit Request & Review

(referral triage - intended to expedite/prioritize care)

- **Pre-visit *Request* for Advice**
  - Does the patient need a referral (medical necessity)
  - Which specialty is most appropriate
  - Recommendations for what preparation or when to refer
  - Wait times and approach to take in the interim
- **Pre-visit *Review* of all Referrals**
  - Is the clinical question clear
  - Is the necessary data attached
  - Triage urgency (risk stratify/prioritize the patient's scheduling needs)

- **Urgent Cases**
  - Expedite care
  - Improved access to care with less delay and improved safety

Case example: (You're kidding, Right?)
This could be your patient…

- 60 yo woman was referred to surgeon Dr. Z by her PCP for a needed 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

Recommendations for "Neighborly" Response to Pre-consultation/ Pre-visit Request or Review

- Avoid "deferred", "not appropriate", "reject"
- *"It appears this patient was referred for Lupus and would benefit more from referral to Rheumatology rather than Endocrinology. However, if there are endocrine issues that I failed to recognize and that need to be addressed, please let me know and we will schedule …otherwise we will defer scheduling at this time…"*
- *"It appears that this referral is regarding a 4 mm thyroid nodule noted on thyroid ultrasound. Current ATA thyroid nodule guidelines indicate that no further evaluation is needed. If there are additional concerns that I missed, please let me know…otherwise, we will defer scheduling at this time"(can include:"here is what the current guideline states [copy &paste]")*
- Consider a call to clarify (and build the relationship & the process)
  - Can be clinician-to-clinician or team member-to-team member

Pre-consultation/ Pre-visit Review/Referral Triage

very high "value-add" & ROI

- Avoids inappropriate (unnecessary) appointments
- Improves value of appointment for patients
- Creates more time for interaction with the patient around the reason for referral or the clinical question
- Improves resource utilization by both requesting & responding practices (reduced disruptions to staff and clinician time)
- Reduces stress and increases cooperation around caring for the patient
- Improves access
- Improves safety
- Reduces waste

Define the Protocol for Making Appointments to improve Referral Scheduling & Completion

- What is the expected protocol?:
  - The **patient** will call to schedule an appointment
    - Need parameters & process for handling if patient does not call
      - Does SC practice call the requesting practice or the patient?
      - Urgent vs routine referral request, etc.
  - The **specialty practice will** contact the patient
    - Allows for Pre-visit assessment/referral disposition
    - Allows for tracking of referrals / accountability

Referral Tracking to "Close the Loop" helps Reduce Incomplete Referrals & Improve Outcomes

- **Referral request sent, logged & tracked**
- **Referral request received and reviewed**
  - Referral **accepted** with **confirmation** of appointment date **sent back to referring practice**
  - Referral **declined due to inappropriate referral** (wrong specialist, etc) and **referring practice notified (redirect or reassure)**
  - ***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)
    - Have a **No-Show policy & process** – seek first to understand vs "punish"
- Referrals made from one specialty to another (e.g. **secondary referrals**) include **notification of the patient's primary care clinician**

Define the *specialty role (referral type)* to most appropriately meet patient needs

- ___**Medical (Cognitive) Consultation**: Evaluate and advise with recommendations for management and send back to me*
- ___**Procedural Consultation**: Specialty care 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: (Specialty care assumes care, first call)
  - **I prefer return to me for management of the condition once stable**
  - **Please assume ongoing care for this condition**
- ___ **Complete transfer of care**(e.g. Pediatric to Adult Care transition, new clinician/practice) Please assume full responsibility for the care of this patient

*** Potential for virtual clinician-to-clinician assistance**

Formal Consultation

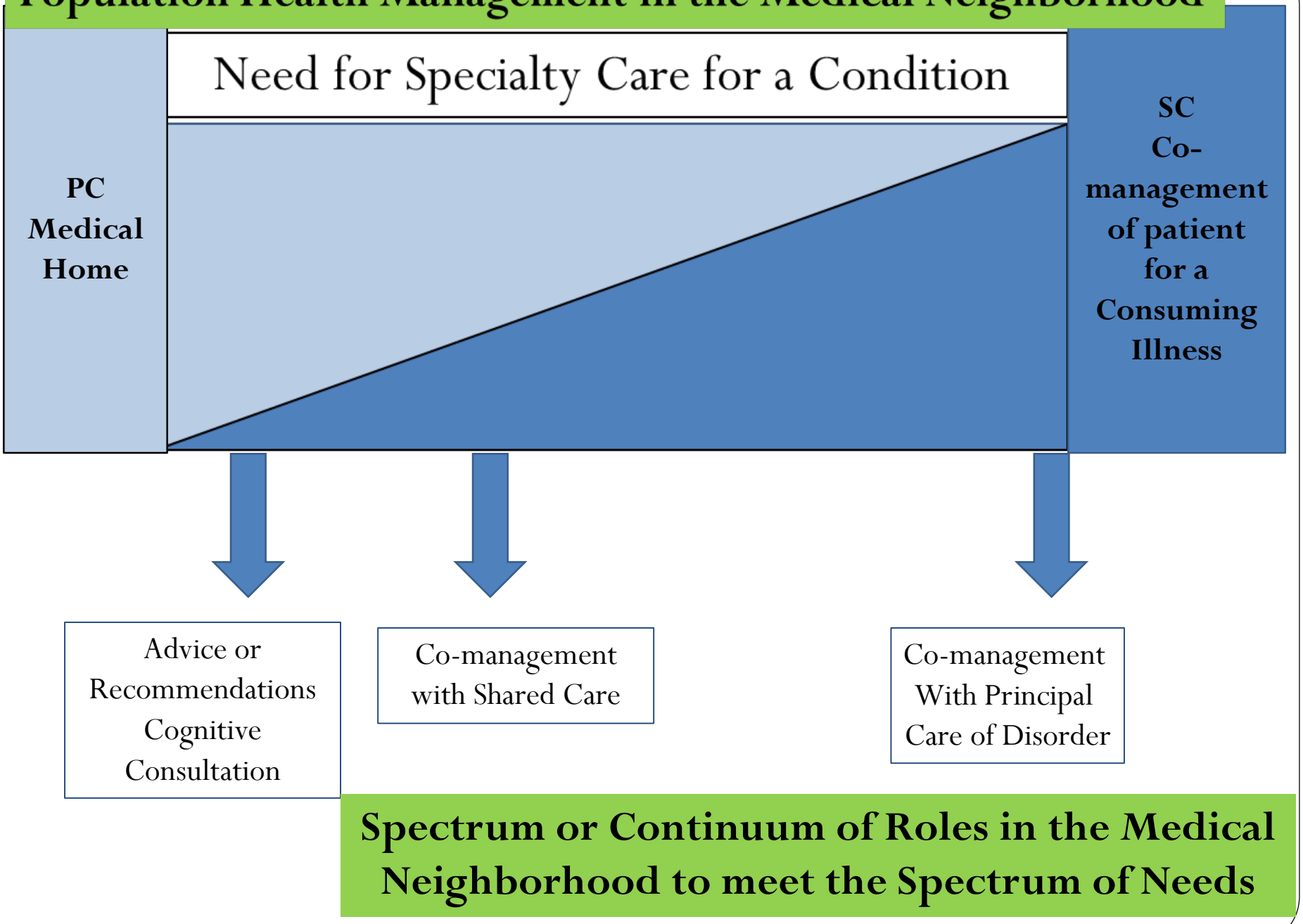
- **Cognitive consultation (advice)**
  - To obtain specialty care clinician's opinion on a patient's diagnosis, abnormal lab or imaging study result(s), treatment or prognosis
  - Limited to one or a few visits that focus on **answering a discrete question**
    - **e-Consultation**: provide advice/recommendations without an office visit by patient *(virtual clinician to clinician)* – usually asynchronous
- **Procedural consultation**
  - To obtain a technical procedure for diagnostic, therapeutic or palliative purposes
- Short term (episode) of involvement by specialty care clinician
- Should include detailed report back to referring physician
- *Examples*: MRSA infection with recurrent carbuncles; Colonoscopy, Bone Marrow Biopsy, Ocular exam; Surgery

Co-Management

(ONGOING management of a patient's medical condition)

- **Shared Care for the disease**
  - (PCP responsible for Elements of Care, takes 'first call')
  - "Collaborative Care Model" – APA – virtual clinician to clinician assistance
- **Principal care for the *disease*.**
  - (Specialty care responsible for Elements of Care for that disorder or set of disorders, takes 'first call' for the disorder)
- **Principal care of the *patient*** for a consuming illness for a limited period of time
  - (Specialty care serves as first-contact but patient maintains PCP as medical home/ hub of care)

Population Health Management in the Medical Neighborhood

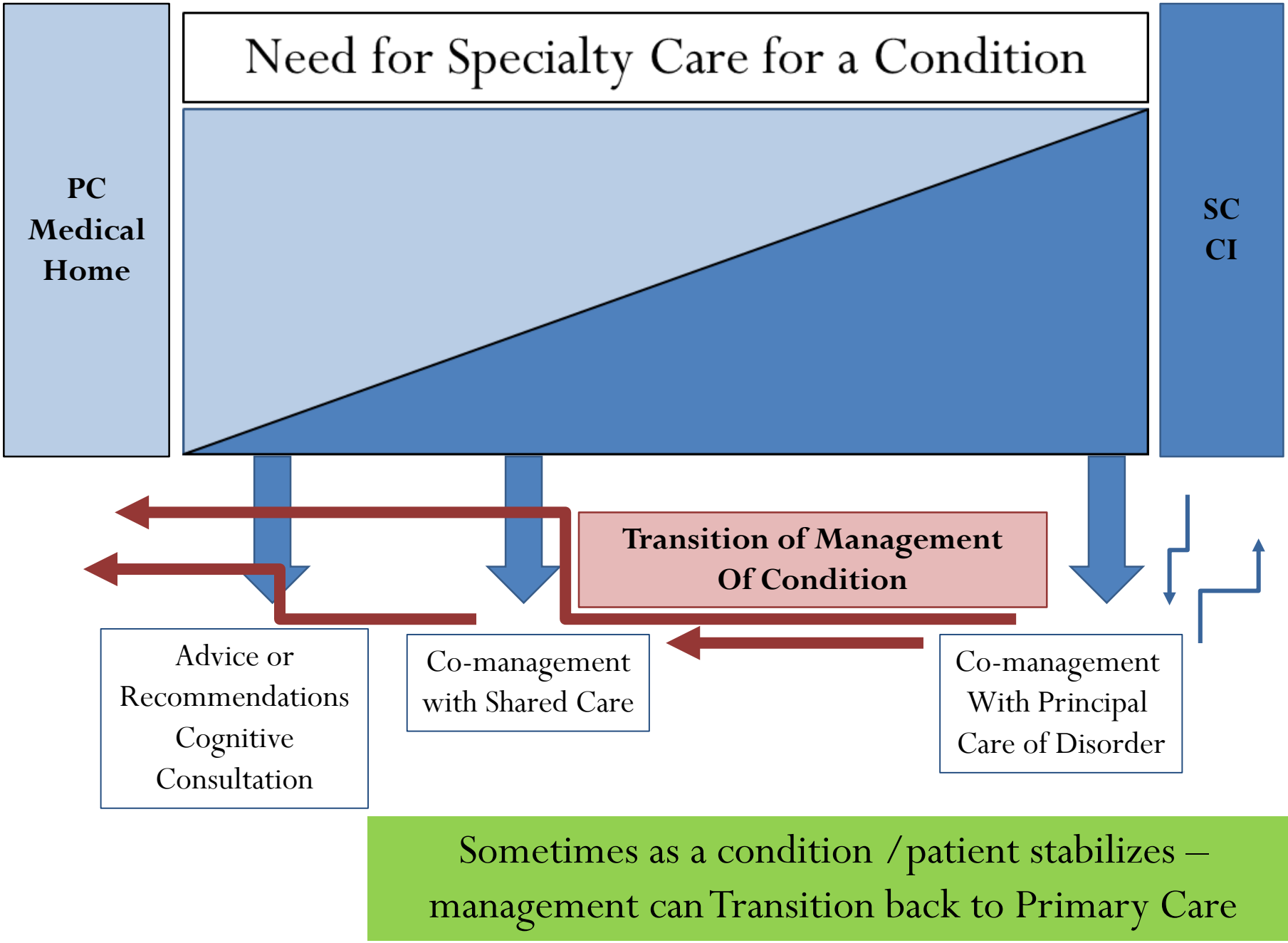


Spectrum or Continuum of Roles in the Medical Neighborhood to meet the Spectrum of Needs

Open up Access through "Graduation" Transition of Management back to Primary Care

- Patients with minor or resolved issues
  - Especially if based on new approach, those issues could have been handled by pre-consultation or virtual (e-) consultation
- Patients who were referred with an unstable condition that are now stable and are appropriate for management by their primary care team

Roles are *fluid* based on changes in the patient or the condition


Need for Specialty Care for a Condition
PC Medical Home
SC CI
Transition of Management Of Condition
Advice or Recommendations Cognitive Consultation
Co-management with Shared Care
Co-management With Principal Care of Disorder
Sometimes as a condition /patient stabilizes – management can Transition back to Primary Care

A High Value Referral Response is Critical for Information Exchange & Continuity

- **Answer the clinical question/address the reason for referral-**Summary (include some thought process)
- Agree with or Recommend type of referral / **role of specialty care**
- 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 PCP/PCMH**
- **Follow up** scheduled or recommended

- Clear indication of
- **What specialty care 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 you get started?
Make an Agreement….

Care Coordination Agreement

(Collaborative Care Agreement/Care Compacts)

*An **invitation** to work together better*

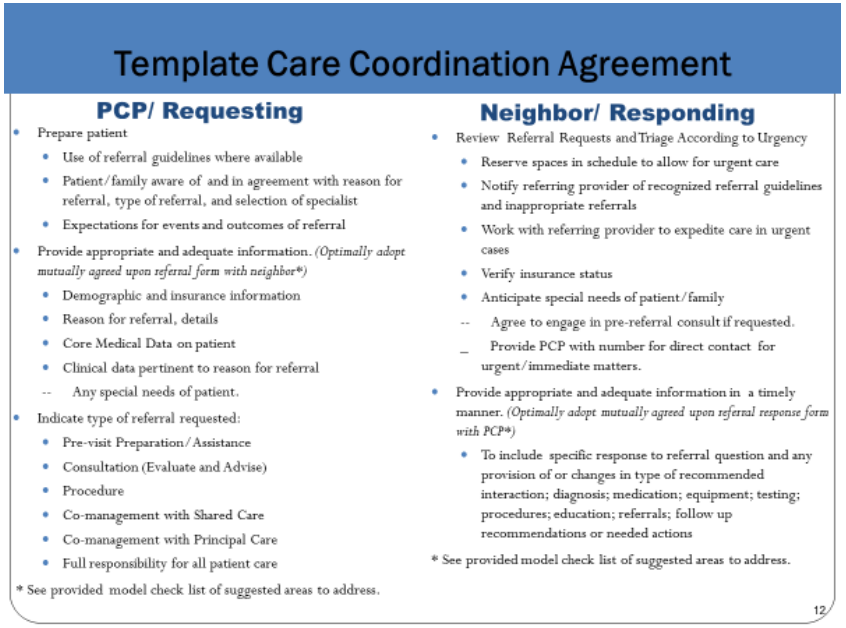
- Provides a platform that everyone agrees to work from:
  - Standardized Definitions
  - Agreed upon expectations regarding communication and clinical responsibilities.
- Can be formal or informal
- *Internal practice policies and procedures* should be aligned to support the agreement ("practice operations")

Can be ***system-wide agreement*** for "how we do it"

- with individualized specialty specific/condition specific referral guidelines

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.

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Expectations for High Value Referrals

Referral Request

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

Referral Response

- **Answer the clinical question**
- **What specialty care 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

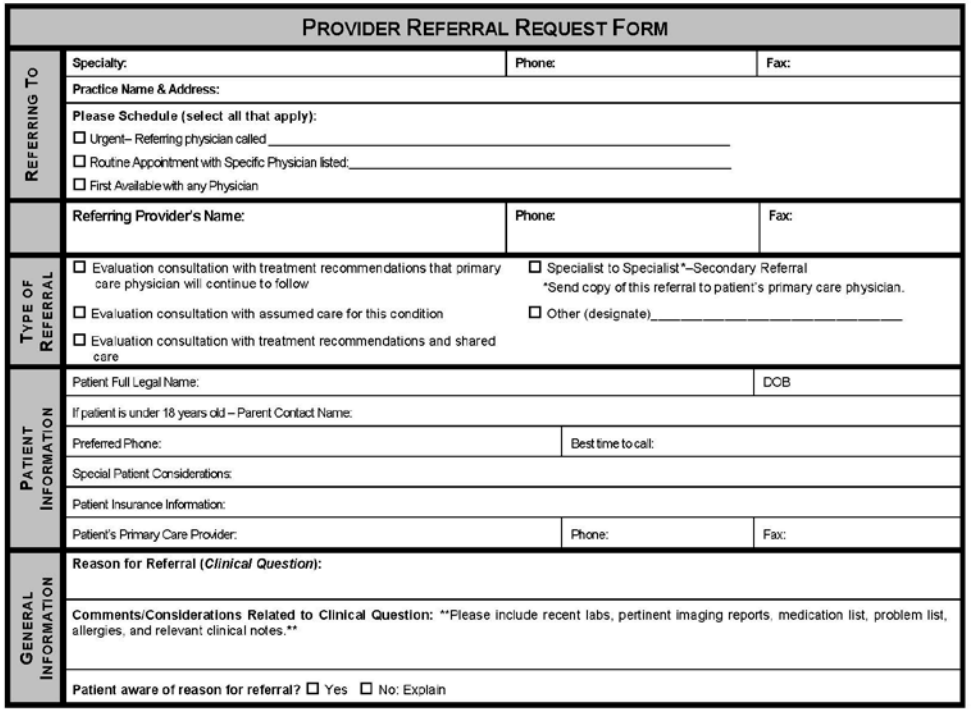
Example of System-wide CCA for IPA
(Independent Physicians Association)

Focus on **Referral Process :**

- ***Referral Request***
  - Clinical question
  - Supporting data
- ***Prepared Patient***
- ***Referral Response***
  - Address clinical question

Referral Tracking

- **Confirmation of appointment or decline (redirect) referral**
- **Notification of *No Show* or *Cancellation***



PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Specialty: | Phone: | Fax:

Practice Name & Address:

Please Schedule (select all that apply):

☐ Urgent– Referring physician called _____

☐ Routine Appointment with Specifc Physician listed: _____

☐ First Available with any Physician

Referring Provider's Name: | Phone: | Fax:

TYPE OF REFERRAL

☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow

☐ Specialist to Specialist*–Secondary Referral
*Send copy of this referral to patient's primary care physician.

☐ Evaluation consultation with assumed care for this condition

☐ Other (designate)_____

☐ Evaluation consultation with treatment recommendations and shared care

PATIENT INFORMATION

Patient Full Legal Name: | DOB

If patient is under 18 years old – Parent Contact Name:

Preferred Phone: | Best time to call:

Special Patient Considerations:

Patient Insurance Information:

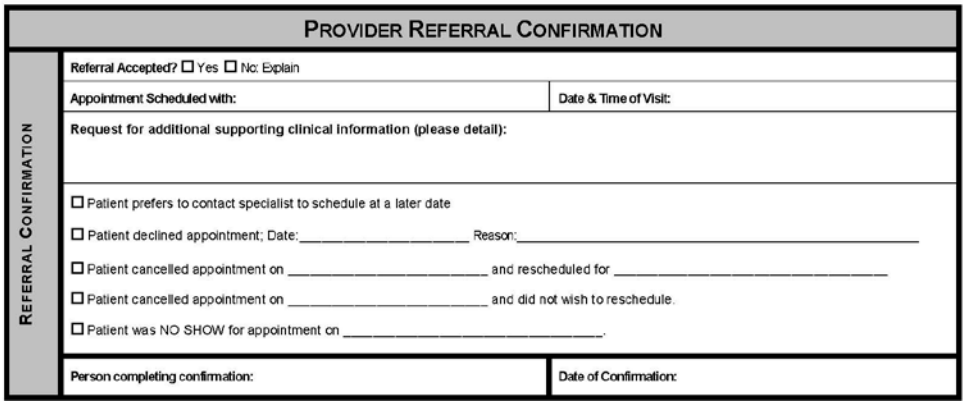
Patient's Primary Care Provider: | Phone: | Fax:

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):

Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.**

Patient aware of reason for referral? ☐ Yes ☐ No: Explain



PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain

Appointment Scheduled with: | Date & Time of Visit:

Request for additional supporting clinical information (please detail):

☐ Patient prefers to contact specialist to schedule at a later date

☐ Patient declined appointment; Date: _____ Reason: _____

☐ Patient cancelled appointment on _____ and rescheduled for _____

☐ Patient cancelled appointment on _____ and did not wish to reschedule.

☐ Patient was NO SHOW for appointment on _____.

Person completing confirmation: | Date of Confirmation:

Lessons Learned - What did we find in RI?
High Value Care Coordination Pilot
Some Issues with Perception vs Reality —

- Primary Care *reported (perceived)* utilizing referral guidelines to ensure appropriate information sent with the referral request for 70 - 90% of referrals
  - But also reported that Specialty Care asked for additional info for up to 70% of referral requests (fewer requests for additional info if PC had shared EMR with SC)
  - SC indicated often did not receive needed info
  - The information sent with referral request was most often determined by the PC staff person who "knew what was needed" –
    - kept "in her head", not written down
    - Often not established by what SC considered pertinent or necessary

RI High Value Care Coordination Pilot

- One SC practice *perceived* ~100% close-the-loop (~ 85% of **referral response notes sent** immediately, remaining 15% sent late) – actual data from PC showed only 13 -17% close-the-loop on referrals
  - Wrong contact info – PC did not receive referral response note
  - Patients never scheduled or no show or cancelled – PC not notified
  - Reports closed by SC but not sent to PC
- Some SC practices only sent referral response notes back if referral was urgent
- PC staff spent **hours** tracking down what happened with their referral requests & to get referral response report if completed (and each call is disruption to SC)
  - PC burden/ time requirement for tracking down referrals → limited time to get new referrals out timely or efficiently or effectively
  - PC often opted to only track "urgent" referrals

RI High Value Care Coordination Pilot

- Specialty Care practices reported receiving referral requests
  - **In multiple different ways** (fax, direct messaging, EMR, etc.) for the same referral request – often going to different people (for the same referral request) – often duplicate/triplicate entry (wasted time & effort)
  - **In multiple pieces** – 3 faxes for same referral request, each with different components of referral information – confusion, missing parts
  - **Without clear clinical question** / detailed reason for referral
    - PC reports providing clinical question / summary of reason for referral 70-90%
    - Reality: Primary Care clinician enters ICD code & occasionally ICD verbiage
  - **Without indication of special considerations** (language, impairments, need to contact caregiver, etc.) – often prevents patient being scheduled
  - Most SC provided no Pre-visit review for appropriateness, urgency, visit prep
    - Some SC clinicians individually have opted to do pre-visit review – most don't review until walking into the room
    - "Need to see every referral for liability & business reasons" – what's the risk of delay?

RI has Some Opportunities

Next Steps

- How to get started – one possible option:
  - Among CTC RI participants / PCMH practices **agree to common referral request & referral tracking components**
  - Do a **reality check** on your processes – get your own house in order
    - Do a process map and/or audit of your referral processes & referral requests
      - How is the patient/caregiver engaged in the referral process?
      - Are you letting the SC practice know if special accommodations are needed for language, vision, hearing or cognitive impairment, etc.
      - Do you share the patient's goals in the referral request when relevant?
      - Are you providing a clinical question/ detailed summary for reason for referral?
      - Do you know what the specialty care clinician needs with any given condition?
      - Are you indicating what role you want from the specialty care clinician?
      - How is all of this sent to the SC practice and by who?
      - Are you tracking all referrals? Who and How? Is it effective? Do you have a process for patients who 'no show' or cancel without rescheduling?

Start by "getting your own house in order"

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 it part of taking care of the patient
  - Work as a team to design improvements, test and implement
- **Intentional** internal processes (Policy & Procedures)
- **Track** for process improvement – utilize available facilitation
- Prepare your "offers" … and "requests"

RI has Some Opportunities

Next Steps

- How to get started – continued:
  - **Go to Specialty Care practices with your "requests & offers"**
  - **Have a conversation**: "we so appreciate your help with our patients…" - "It would help us if…"
  - **Provide your requests** – "we could get the referral response note back without having to call to ask for it"
  - **Having data helps** - "Since January, we have referred 33 patients to your practice and have received a response note on only 7 of those."
  - **Provide your offers** - "We want to be sure you are getting what you need…"
    - "we realize we need to let you know when the patients we refer are non-English speaking & we need to provide a more specific reason for referral …"
    - "we have worked out a checklist for what to include when we request a referral to be sure you get what is needed & would like your input on …"
    - "we have an updated contact list for our clinicians…"

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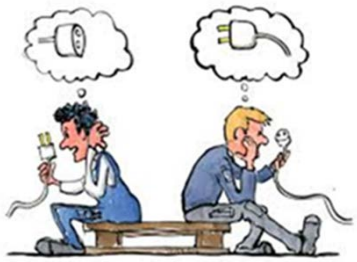
Next Steps

- How to get started – one possible option:
  - Among CTC RI participants / PCMH practices agree to common referral request & referral tracking components
  - Do a reality check on your processes – get your own house in order
  - Go to Specialty Care practices with your "requests & offers"
    - Start with key practices and add on
  - ***Have a conversation – mutual requests & offers***
  - **Encourage common shared agreement on the general referral process elements** (everyone on the same page)
    - Specialty/condition specific referral guidelines



What really matters …

- Relationships – working together / cooperation
  - Cultural mindset of "in it together" vs separate silos/ parallel universes
    - Truly *connecting* care for the ***patient***
- Willingness to improve the processes needed to improve the referral experience
  - Coming to agreement
- Doing what is needed to enact/implement the necessary processes

Idea Sharing

- Do you think improving the referral process would benefit your patients or your practice?
- Are you comfortable agreeing to shared expectations across practices?
- What do you need to get started?
- Who can help guide/coach/facilitate?
- Are there specialty care practices you are comfortable reaching out to?
  - What would help this process?

Other ideas on approach to getting to an improved referral process/working with specialty care

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http://www.acponline.org/hvcc-training

Lessons Learned from HVCC – Referral Process

- It's about working together – a new mental model
- Technology is a tool
  - Interoperability doesn't fix all the problems
  - Formatting EHR doesn't create better referral process (EHR is a tool and an effective tool is better than an ineffective tool)
- Care coordination (a *better referral process*) requires *us*
- "Pushing"(providing) is more effective than "digging"
- Expectations are more effective than assumptions
- Data can help clarify and drive the process *(perception vs reality)*