Closing the Referral Loop: Improving Communication and Referral Management

A joint initiative of PCPI and The Wright Center for Graduate Medical Education
Today’s Speakers

• **Stephen L. Davidow**, MBA-HCM, CPHQ, APR, Director, Quality Improvement, PCPI, Chicago, IL

• **Jignesh Sheth, MD, MPH**, Senior Vice President, Clinical Operations, The Wright Center, Scranton PA

• **Tiffany Jaskulski**, BSBA, EHR and Clinical Innovation Specialist, The Wright Center, Scranton PA
Disclosures

The presenters have no financial disclosures to make.
Agenda

• Introductions and acknowledgements
• Environment and background
• Purpose and goals
• What we did
• What we learned and how you can apply it
• Takeaways and what’s next
• Q&A/Discussion
Acknowledgements

Linda Thomas-Hemak, MD
President and CEO

Connie Sixta, RN, PhD, MBA
Healthcare QI Consultant

Samir B. Pancholy, MD, FACC, FSCAI
Cardiology Fellowship Program Director
General & Interventional Cardiologist

Tiffany Jaskulski, BSBA
EHR and Clinical Innovations Specialist

Courtney Dempsey, BS
Coach

The Wright Center Residents and Cardiology Fellows
12 PCP/Cardiology Dyads from NEPA and Philadelphia
What Is PCPI?

• National, clinician-led, nonprofit organization engaged with the full spectrum of health care delivery system stakeholders
  – More than 70 member organizations
• Focus on improving patient health and safety through innovative approaches to measure, improve and assess performance.
• Leading developer of clinical measures – more than 300 for 47 medical conditions - 90 endorsed by the National Quality Forum.
• Home to the National Quality Registry Network.
• Facilitate QI projects and provide training in healthcare process improvement.
The Wright Center for Graduate Medical Education (TWCGME) is a nonprofit, community-based graduate medical education consortium and safety net provider of primary care that has served Northeastern Pennsylvania for more than 40 years.

Our Mission
The mission of The Wright Center is to continuously improve education and patient care in a collaborative spirit to enhance outcomes, access and affordability.

Our Passionate Purpose
To co-create transformational healthcare teams of leaders who empower people and communities to optimize their health.

Our Niche
Innovative and responsive primary health care through community centric workforce renewal.
Our mission inextricably links patient care and GME aspiring for a learning culture of improvement. ACGME requires reflective practice and system improvement skills (PBLI and SBP).

We leverage learners at all levels of our organization to generate a learning culture.

The Wright Center is educating future physicians in a community immersed THCGME Consortium model and must focus on 21st century skillsets for the new world of high performing healthcare delivery and medical education.

We must develop high impact leaders who can cross organizational boundaries for higher collective purpose.
The Wright Center for Primary Care Mid Valley

- 11,000+ active patients; 34,000+ visits annually
- Integrated Behavioral & Oral Health Services
- Open 83 hrs/week; 365 days/year
- FM/Med-Peds/IM/Peds Faculty PAs and NPs
- Robust Care Management and Data Departments
- Teaching Health Center for IM and FM Residents, PAs and NPs
IHI’s Collaborative Model

• Institute for Healthcare Improvement’s Learning Collaborative Model to test interventions and approaches that improve the referral process within and between health care systems.

• Intervention examples:
  – Defining specific staff roles for tracking referrals.
  – Health information technology functionality, utility and innovations.
  – Shared Care Agreements between primary and specialist physicians.
  – Better illuminating and evolving the role of empowered patients.
TWCGME State/National Experiences

- Pennsylvania Chronic Care Initiative
- Robert Wood Johnson Foundation “The Primary Care Team: Learning From Effective Ambulatory Practices (LEAP)”
- Safety Net Medical Home Initiative, Advanced Primary Care Practice Collaborative (APCP)
- AMA Expert Panel on Closing the Referral Loop
- NCQA Patient Centered Medical Home
- UCSF Center for Excellence in Primary Care
- HIMSS Davies Award

Ed Wagner, MD, MPH, Co-Director PCT-LEAP, “Patients and families just hate that we can’t make care coordination work.”
Care Coordination/“Closing the Loop” through referral tracking is one of the greatest benefits we provide as patient advocates.

Uncoordinated, “reactive” care

- Causes patient and provider frustration & anxiety
- Diminishes health outcomes
- Redundant & reactive work; duplicate tests; unnecessary visits and hospitalizations

Strategic referral tracking

- Care utilization & compliance are enhanced
- Barriers to care are identified & mitigated
- Patients appreciate the organized effort!
A Word About Loops...

Closed – Thrilling!

Open – Not so much...
• **>105 million referrals** of Medicare beneficiaries are made between PCPs and specialists in the U.S. every year.

• **1/3 of MDs** had trouble receiving referral info in a timely manner.

• **68% of specialists** received no info from the PCP prior to referral visits.

• **25% of PCPs** had not received information from specialists weeks after visit.
Background

• Focus group of national improvement experts that identified ambulatory referral as a key area for improvement in 2013.

• In 2014, panel of national experts from organizations that improved the referral process in 4 key areas:
  – Accountability
  – Relationships/agreements between PCPs and specialists
  – EHR connectivity
  – Patient engagement
PCPI partnered with The Wright Center for Graduate Medical Education to complete four goals:

• Identify key interventions.
• Develop the change package.
• Complete a pilot project.
• Disseminate findings and scale and spread lessons.
CRL Funding Statement

- Pilot study partially funded by PCPI through a payment to The Wright Center for Graduate Medical Education.
- The Wright Center provided in-kind staffing, IT resources and funding for the Healthcare QI Consultant.
- Both organizations provided staff expertise and management.
- Dyad sites were not reimbursed.
Key Questions

1. Did the referring primary care physicians get their referral questions answered?

2. Did the specialists get the information they needed to answer the question and complete the referral as requested?

3. Did the patient feel that the care was coordinated and that they got what they needed?
Overall Goals

• Improve process for physician-to-physician referrals in the ambulatory setting.
• Establish accountability.
• Improve information transfer.
• Achieve higher satisfaction and understanding of the referral process among patients and physicians.
CRL Founding Objectives

• Enhance cross-organization leadership by building collaborative relationships with similar minded organizations that have complimentary improvement expertise and infrastructure.

• Test a model for QI pilot testing and spread that includes “intermediate” collaborative organizational support without direct incentives.

• Acknowledge that right minded providers will do the right thing for patients and to honor the lifeline of primary care-specialty relationships.

• Grow the number of “Closing the Referral Loop” experts (referral coordinator, IT, staff) and build a scalable learning community.

• Share lessons learned and feed national discussions about EHR capability, communication, and data standards.

• Enrich the role and experience of patients and families.
Cross-cutting improvement opportunities

• Focus on “Closing the Referral Loop” as a first project in a long-term commitment to improving care coordination nationally.

• Demonstrate meaningful improvements in care coordination through a small scale collaborative with measurable impact promoting the Quadruple Aim.

• Conduct the “Closing the Referral Loop” campaign and collaborative and determine if it should be expanded.

• Engage in evolving conversations about EMR Meaningful Use standards.

• Explore local and national opportunities for greater scale and impact.
• Formalize Shared Care Compacts to enhance communication between a PCP and Specialist “Dyad” with a well established referral relationship.
• Develop and leverage EMR functionality and utility for referral management.
• Complete and evaluate office workflow process map.
• Evaluate staff roles and responsibilities to achieve lean workflow.
• Empowering ability to generate reports for data and exception reports.
• Achieve timeliness and effectiveness of referrals and satisfaction of patients/providers.
• Better understand the “no show” phenomenon.
• Stimulate PDSA based QI and innovations.
Conducted pilot study:

- Recruited PCPs and specialists to be part of “dyad” teams.
- Used IHI Breakthrough Series Collaborative Model:
  - In-person Learning sessions
  - Virtual Action Periods
- Conducted pre-work with storyboards and baseline performance data.
- Trained cardiology fellows to be improvement coaches.
- Created change package.
- Facilitated and completed Care Compacts between dyad participants.
- Collected performance data.
- Focused on improving information-related workflows between practices.
Aim of the Pilot

The aim of the pilot project was to improve the efficiency and effectiveness of the referral processes between PCP and specialist so:

1. The PCP’s reason for the referral is clearly stated.
2. The PCP referral is sent in a timely manner with clear and consistent supporting information.
3. The specialist response clearly addresses the reason for the referral.
4. Timely completion and receipt of referral report improves.
5. Satisfaction of the PCP, the specialist and the patient with the referral process improves.
6. Use of the EHR in supporting the referral processes is maximized to increase reliability and consistency.
Definition of Referral

- A new patient is referred by the PCP to a Specialist to answer a PCP’s clinical question.

OR

- A **new** clinical question is posed by the PCP for a patient currently being co-managed by the PCP and the Specialist (does not include questions asked in normal course of treatment for previous clinical questions being co-managed over a 12 month period).
Change Package

- Referral types
- Care compact
- Clinical question
- Patient engagement
- Electronic communication
- Process mapping
- Referral tracking system
### Original Measures

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Total number of referrals by type:</td>
</tr>
<tr>
<td></td>
<td>- Urgent (less than 7 days)</td>
</tr>
<tr>
<td></td>
<td>- Priority (7-14 days)</td>
</tr>
<tr>
<td></td>
<td>- Routine (14-28 days)</td>
</tr>
<tr>
<td>2.</td>
<td>Number of Referrals closed in a timely manner</td>
</tr>
<tr>
<td>3.</td>
<td>Referrals with an answer to the clinical question posed by the primary care provider</td>
</tr>
<tr>
<td>4.</td>
<td>Patient satisfaction with the referral process</td>
</tr>
<tr>
<td>5.</td>
<td>Primary care provider satisfaction with the referral process</td>
</tr>
<tr>
<td>6.</td>
<td>Specialist satisfaction with the referral process</td>
</tr>
</tbody>
</table>
IHI Breakthrough Series Collaborative Learning Model

- Leadership Team and Project Team
- QI Project Director and Clinical Innovations Specialist
- Pre-work
  - Recruitment of the Dyads and team members
  - Integration of the residents and fellows
  - Process mapping
  - Referral definitions
  - Defining data collection and reporting responsibilities
- Learning Sessions (2/year, 4 hours in length)
- Coaching – site visits
Collaborative Expectations

- Participation by Dyad team members in monthly conference calls
- Monthly data collection and reporting
- Learning Sessions (2 per year) with PCP and Cardiologist participation
- Dyad “Storyboard” deliverable
  - Dyad Aim Statement, PDSAs, measure run charts
  - Challenges, solutions and lessons learned
Typical Referral Process in Collaborative

- **PCP Visit**
  - Create referral
  - Add clinical question

- **Specialist Review**
  - Answer clinical question
  - Create a note

- **Data Dept.**
  - Create referral
  - eFax the referral

- **Data Dept.**
  - Receive referral and make appointment
  - Inform PCP office of appointment date

- **Data Dept.**
  - Send the note to PCP

- **Data Dept.**
  - Attach note
  - Close referral

© 2015 PCPI Foundation. All rights reserved.
Requirements for PCP Office

• Data Tracking in EHR:
  – Create an Electronic Referral Request
  – Risk Stratify Referrals:
    • Urgent vs. Priority vs. Routine
  – Attach the “Clinical Question”
  – Track “Date of Appointment”
  – Trackable referral closure by attaching specialist note

• Data Extraction from EHR:
  ▫ List of open referrals by specialist
  ▫ Time from referral created to sent
  ▫ Time from referral sent to appointment date
    • Organized as Urgent vs. Priority vs. Routine
  ▫ Time from appointment date to referral closed
Requirements for Specialist Office

• Data Tracking in EHR:
  – Risk Stratify incoming referrals
    • Urgent vs. Priority vs. Routine
  – Identify the “Clinical Question”
  – Electronically communicate date of appointment
  – Electronically send the note with answer to the “Clinical Question”

• Data Extraction from EHR:
  ▫ Time from referral received to appointment date
  ▫ Time from appointment to note sent
Out-Going Referral Document

• Identifies the following key Information:
  – Dyad physicians (PCP and Specialist)
  – Linked Clinical Question document
  – Create/sent date
• Appointment date and time (made by specialist’s office)
  – To be updated and entered at a later date into the same referral document.
Clinical Question Process

• PCP creates clinical question document (CQD) and identifies the question that needs to be addressed by the specialist.
• Scheduler attaches and sends CQD along with the outgoing referral.
• Specialist report comes back to PCP office and scheduler routes CQD back to the PCP to select if their question was answered or not.
Current PQRS Measure 374 Closing the Referral Loop:

“Receipt of Specialist Report” - Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
Patient Survey

• All patients who we received specialist’s report back received a call from project management department at The Wright Center to complete the patient satisfaction survey.

• Survey results for all dyads were entered directly through The Wright Center website for uniform data collection, storage and analysis.
## Results: Summary of Referral Characteristics

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>Pre (n=110)</th>
<th>Post (n=240)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent (3-7 days)</td>
<td>24%</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Priority (7-14 days)</td>
<td>10%</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Routine (14-28 days)</td>
<td>65%</td>
<td>95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral Status</th>
<th>Pre (n=110)</th>
<th>Post (n=240)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>60%</td>
<td>30%</td>
</tr>
<tr>
<td>Closed</td>
<td>40%</td>
<td>70%</td>
</tr>
</tbody>
</table>

- Referrals closed in a timely manner (Specialist visit summary received by PCP within 7 days of appointment)
  - Pre: 40%
  - Post: 70%

- Referrals with clinical question answered by specialist
  - Pre: 50%
  - Post: 75%
• PCP satisfaction was high throughout the collaborative with some improvement in every area post intervention.

• Specialist satisfaction improved in every area with significant improvement in:
  – PCP clinical question information received prior to referral visit
  – PCP knows specific information needed prior to the referral visit
  – All needed information prior to referral visit was typically received
## Recommended Measures

1. Total number of referrals by type:
   - Priority (7-14 days)
   - Routine (14-28 days)

2. Number of Referrals closed in a timely manner

3. Referrals with an answer to the question posed by the primary care provider

4. Patient satisfaction with the referral process

5. Primary care provider satisfaction with the referral process

6. Specialist satisfaction with the referral process
Challenges and Barriers

• Intense catchup work in outstanding referrals

• Lack of Meaningful EHR functionality
  – Lack of trackable field to document clinical question and occasionally type of referral – Requires workarounds
  – Clinical question cannot be a required field with a hard stop for all outgoing referrals – Requires workarounds
  – Lack of electronic linkages between EHRs

• Time and capacity commitment to generate EHR functionality and PCP-Specialist shared care compacts
Key Lessons Learned

• Assure full engagement of dyad physicians (PCP-Specialist), management, and referral staff.
• Formal Co-created PCP-Specialist Shared Care Compact must be completed in writing prior to the start of the collaborative to gain agreement regarding referral types and definitions, role expectations, and communication expectations.
• Reports should be structured, simple but meaningful for both sides
• Clarify measure definitions and share individual/aggregate data early and spread quickly.
Key Lessons Learned

• **The clinical question is the key driver** for improving provider satisfaction and preventing duplication of tests and services.

• Conduct Process Mapping and offer Quality Improvement Training for staff to sustain outcomes.

• Patients’ activated engagement in communicating the clinical question and answer may reduce “no shows” and improve both patient and provider satisfaction.

• Patients can make meaningful contributions.
• Most PCP EHRs identified possible ways to send referrals electronically and evolved traditional faxes.

• PCP practice quickly identified their super-users.

• Clinical question was included in the referral request; not always in a structured field.

• Cardiologist’s EHR sent the report to the PCP; not always automatic function.

• EHRs are unable to track referral process steps.

• Communication between the PCP and cardiologist were enhanced by the use of direct messaging.
What Do You Need to Make Improvement Happen?

• Physician champion and Project lead with knowledge of your current referral management process.

• Referral coordinator and EHR specialist.

• System that facilitates bi-directional communication between primary care and specialist physician offices, which could be an eFax or direct messaging systems such as a Health Information Service Provider (HISP).

• Data collection system to track status of referrals and when they are closed.

• A learning culture of improvement helps!
EHR Functionality Future Goals

• Ability to automatically update in the PCP referral screen the status of the patient’s specialist appointment in the EHR.

• Ability to contact the specialist’s office for updates on outstanding referrals via Health Information Exchange (HIE) or Health Information Service Provider (HISP).

• Automatically update the PCP EHR of patient “no-shows” and patient declines.

• Separate field for the “status of referral” (e.g., Priority or Routine), which allows closure and the ability for PCP to track for follow-up with patient.
CRL Tool Kit

Practical, implementable lessons from the Closing the Referral Loop pilot project:

www.thepcpi.org
What’s Covered in the Tool Kit?

• Referral Process Flow Maps
• Measures
• Sample Implementation Time Line and Project Plan
• Lessons Learned
• Sample Shared Care Compact
• Key Change Ideas
• Health Information Technology Improvements
• Readiness Assessment and Satisfaction Surveys
Takeaways

• The lessons and knowledge can be implemented easily at the local level.

• Using the tool kit can help close more referrals in a timely manner.

• Extensive technology or IT projects are not necessary.

• Motivation to close more referrals to improve care coordination is a pre-requisite.

Let us know if we can help!
What’s Next?

• **Journal of Ambulatory Care Management**
  
  – Care Coordination Patient Safety Tool Kit: AAAHC
  
  – Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR era: IHI/NPSF

• Sharing lessons and experience.

• Exploring scale and spread opportunities
  
  – Impact on ambulatory patient safety: No shows, Redundant testing

• Working with you?
# Participating Specialist-PCP Dyads

<table>
<thead>
<tr>
<th>Specialists</th>
<th>Primary Care</th>
<th>Cardiology Fellow</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Samir Pancholy</td>
<td>Dr. Jignesh Sheth</td>
<td>Dr. Gangadhara Kabbli</td>
<td>Drs. Knorek, Kaushik</td>
</tr>
<tr>
<td>Dr. Stafford Smith</td>
<td>Dr. Wasique Mirza</td>
<td>Dr. Nishith Vayada</td>
<td>Drs. Dhillon, Munjal, Cortes</td>
</tr>
<tr>
<td>Dr. David L. Smith</td>
<td>Dr. Paul Spiro</td>
<td>Dr. Nimesh Patel</td>
<td>Drs. Reddy, Devota</td>
</tr>
<tr>
<td>Dr. Joseph Kenney</td>
<td>Stephanie Wroten, RN</td>
<td>Dr. Toral Patel</td>
<td>Drs. Lee and Rothman</td>
</tr>
<tr>
<td>Dr. William Petrucci</td>
<td>Dr. Cynthia Salinas</td>
<td>Dr. Nimesh Patel</td>
<td>Dr. Mariano Giordano</td>
</tr>
<tr>
<td>Dr. Stephen Voyce</td>
<td>Dr. William Dempsey</td>
<td>Dr. Keyur Mavani</td>
<td>Drs. Pai, Das, Denise</td>
</tr>
<tr>
<td>Dr. Michael C. Kayal</td>
<td>Dr. Michael L. Kondash</td>
<td>Dr. Nick Ierovante</td>
<td>Drs. Nguyen, Chang</td>
</tr>
<tr>
<td>Dr. Haitham Abughnia</td>
<td>Dr. Richard Weinberger</td>
<td>Dr. Gangadhara Kabbli</td>
<td>Drs. Nanavaty, Patel</td>
</tr>
<tr>
<td>Dr. Haitham Abughnia</td>
<td>Dr. Susan Baroody</td>
<td>Dr. Monodeep Biswas</td>
<td>Drs. Supogu, Chandran</td>
</tr>
<tr>
<td>Dr. David Lohin</td>
<td>Dr. Randall Brundage</td>
<td>Dr. Nick Ierovante</td>
<td>Drs. Minello, Punch</td>
</tr>
<tr>
<td>Dr. Rupen Parikh</td>
<td>Dr. Richard English</td>
<td>Dr. Monodeep Biswas</td>
<td>Drs. Platt, Naing</td>
</tr>
<tr>
<td>Dr. Andrew Litwack</td>
<td>Dr. Eric Palecek</td>
<td>Dr. Keyur Mavani</td>
<td>Drs. Pai, Das, Denise</td>
</tr>
<tr>
<td>Dr. Jeremiah Eagen</td>
<td>Dr. Archana Chaudhari</td>
<td>N/A</td>
<td>Dr. Manoj Das</td>
</tr>
</tbody>
</table>
References


Thank You!

Questions?