Ensure Quality Referrals

1.5 Coordinated Care Delivery

1.5.4 Ensure Quality Referrals

A referral is part of *taking care* of the patient …*meeting the needs of the patient*

A good referral requires good hand-offs to ensure connected, high value coordinated care

Antithesis of High Value Coordinated Care:

- Common scenario #1:
  - 70 year old woman does not know why she was referred, PCP staff just told her to make appt, no records, only get into voice mail at PCP office
  - Waste:
    - Resources (duplicated testing, visit costs, time)
    - Access “jammed up” (delay of care…downstream effects)

High Value Referral Request

- Prepared Patient
- Type of referral requested (role requested of the specialist)
- Clinical question or reason for referral
  - Ideally a summary
- Core Data Set (reconciled med list, allergies, PMH, etc.)
  - Care plan for the patient
- Pertinent Data set for clinical question
- Referral Status / Urgency: Urgent (recommend direct contact), sub-acute or routine
- Contact info for more information

Content over Format

(as long as information easily found)

- *This information*
  - *should be **included with all referrals***
  - *can be communicated by any of several means including*
    - ***a paper-based referral form**,*
    - ***detailed clinical note from last appointment** or*
    - ***a template within the Electronic Medical Record***

Prepared Patient

- Patient aware of and in agreement with referral with appropriate expectations ***(patient as partner in care)***
  - Consideration of *what matters to the patient*
- Patient understand role of specialist and who to call for what
  - ***Pre-visit patient education regarding the referral condition and/or the type of and role of the specialist***
- Alert specialty practice of any special needs (impaired vision, hearing, cognition, care giver status, etc.)
- Use of Referral Guidelines
  - **Appropriate specialist at appropriate time**
  - **Appropriate testing or therapeutic trials prior to referral**
- Adequate/ Pertinent data ***supplied*** (“handoff” takes place)

Check list for a *High Value* ***Referral Request***

1. Patient Demographics & Scheduling Information
2. Referral Information
3. Patient's Core Data Set
4. Care Coordination/Referral Tracking

1. Patient Demographics & Scheduling Information

- Patient name, demographics, and contact information (including surrogate if appropriate)
- ***Special considerations*** such as
  - vision loss, hearing loss, ambulation limitations, cognitive deficits,
  - language preference, cultural factors,
  - preference regarding who to include in treatment planning
- Insurance company name/type of coverage
- ***Referring clinician's name and contact information*** *(including method for direct contact for urgent issues)*

1. Patient Demographics & Scheduling Information

- Indicate that **patient (or surrogate) understands and agrees** with
  - the *purpose* of the referral,
  - the *type of referral* (e.g. consultation or co-management)
  - possible need for additional testing prior to appointment
  - the expected *protocol for making appointments*
    - the *patient* will call to schedule an appointment
    - the *specialty practice* should contact the patient
      - Allows for Pre-visit assessment/referral disposition
      - Allows for tracking of referrals / accountability

2. Referral Information

a. **What is the specific *clinical question*** (reason for referral)?

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

2. Referral Information

b. **What is the Urgency** : *(Referral status)*

- _____**Urgent** (local definition; often 1-2 days)
  - Recommend ***direct communication*** between referring and referral practice; Minimally provide written justification for urgency
- _____**Sub-acute** *(intermediate, move up)* (local definition; often 1-2 weeks)
- _____**Routine**

2. Referral Information

c. **What type of referral** (*Role of Specialist)* **is requested** (pending specialty evaluation):

- ☐ _____ **Pre-visit Advice** * (Pre-consultation)
- ☐ _____ **Non Face-to-Face** (information-only) **consultation** **
- ☐ _____ **Consultation** (Evaluate and Advise, with the goal of managing the problem remaining with the referring clinician)
- ☐ _____ **Procedural Consultation**
  _____ **Co-Management with Shared Care** (referring clinician (e.g. PCP) maintains first call for the referral disorder)
- ☐ _____ **Co-Management with Principal Care** (specialist assumes first call for the referral disorder)
- ☐ _____ Please assume Full Responsibility for **Complete Transfer** of all Patient Care *(e.g. Pediatric-to-Adult Care)*

Antithesis of High Value Coordinated Care:

- Common scenario #2:
  - 60 yo woman was referred to surgeon Dr. Z by another specialist for a procedure. After a 3 month wait for the appointment, Surgeon Z. read her records as he walked in the room saying “I don’t do that procedure. You will need to go to XXX Clinic to get that done”.
  - Waste:
    - Delay: Progression of condition, harm
    - Non-value-added appointment for all in involved

Pre-visit Advice / Pre-consultation

Intended to expedite/prioritize care

- ***Previsit Advice***
  - Does the patient need a referral
  - Which specialty is most appropriate
  - Recommendations for what *preparation* and/or “pertinent” data will best facilitate the referral evaluation and /or management (what to send with the referral) or help with *when* to refer
- ***Previsit Review***
  - Is the clinical question clear
  - Is the necessary data attached
  - Triage urgency
- ***Urgent Cases***
  - Expedite care
  - Improved hand-offs with less delay and improved safety

2. Referral Information

d. A brief ***summary*** of case details pertinent to the referral, include related co-morbidities *(alarm signs or symptoms)*

e. ***Pertinent data*** set**:** Clinical information ***directly relevant to the specific referral question***. May include:

- Office notes
- Care summaries
- Lab and imaging results (and other test results)
- Clinical information requested by the referred to specialty/subspecialty practice prior to a consultation regarding the specific condition(e.g. specific lab tests)

Parameters for Pertinent Data Sets

- provide information so the referred to physician can
  - determine if the referral is to the appropriate specialty
  - effectively triage urgency
    - Need Clinical Information (“alarm signs or symptoms”)
    - Need Referral Guidelines (when to refer not just what to send when refer) (“pre-visit advice”)
  - effectively address the referral (enough info to do something)
    - may include providing a non face-to-face consultation(e.g. advice to the referrer / address simple issue) or
    - engage in the requested care during a typical face-to-face visit.
    - effective use of appointment time; need-to-know information
- The PDS should not represent a significant burden to the referring physician *(“minimal data set”-can ask for more based on the case)*
    - Can be *iterative*, ask for more information

ACP High Value Care

Pertinent Data Sets

Anaphylaxis (including idiopathic anaphylaxis, possible reaction to drug, insect sting, food, exercise, etc.)

Developed by	The American Academy of Allergy, Asthma & Immunology (AAAAI) and the American College of Allergy, Asthma and Immunology (ACAAI)
How developed	Prepared by task force of the AAAAI and the ACAAI with approval by both organizations
Additional essential patient information	History is essential and patients are more likely to remember preceding events more clearly closer to the event. Therefore the following history should be obtained: • List of all foods consumed and drugs taken within the 4 to 6 hours preceding the event • Circumstances of a preceding bite or sting • Preceding activities (exercise, sexual)
Additional patient information, if available	Tryptase levels (be sure to note when the tryptase was drawn in relation to the time of the event)
Alarm symptoms/conditions	Prescribe intramuscular epinephrine for possible future episode. Antihistamines often inadequate
Tests/procedures to avoid prior to consult	See Choosing Wisely section
Common rule-outs to consider prior to consults	None provided
Relevant "Choosing Wisely" elements	• Do not order specific IgE testing for foods • Do not be concerned about allergy reaction to egg protein in influenza and other egg based vaccines
Healthcare professional and/or patient resources	Healthcare Professional Information: Lieberman et al. The Diagnosis and Management of Anaphylaxis Practice Parameter: 2010 Update. J Allergy Clin Immunol. 2010; 126: 477-80 Update on influenza vaccination of egg allergic patients: Ann Allergy Asthma Immunol 2013; 111: 301-302 Healthcare Professional and Patient Information: http://www.aaaai.org http://www.acaai.org

3. **Patient's Core (general) data set:**

a. Active problem list

b. Past medical and surgical history

c. Medication list

d. Allergies

e. Preventive care (e.g., vaccines and diagnostic tests)

f. Family history

g. Habits/social history

h. List of providers (care team) (other specialists caring for patient)

i. Advance directive;

j. Overall current care plan and goals of care

4. **Care Coordination**

a. Referring practice notification from the specialty practice of the following: ("close the loop"-referral tracking)

- Receipt of the referral
- Date of scheduled appointment
- Decision to defer appointment and reason why
- Patient cancellation or no-show for the appointment
- Referral response note

b. Referrals made from one <u>non-primary care</u> specialty to another (e.g. *secondary referrals*) are advised to include the ***notification of the patient's primary care clinician***.

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Referral Processing and Tracking Sheet: date_____
Referring Practitioner: _____
Patient: _____DOB_____

We have received your referral_____: Patient has called for appointment_____
_____We have scheduled new patient appointment for_____
_____placed on move up list
_____Appointment NOT schedule due to_____
_____Patient deferred appointment at this time due to_____
_____Patient was NO SHOW: _____Patient cancelled appt due to _____

We need additional information:
___Clinical Question or Reason for Referral with brief summary of issues
___Type of Interaction Requested
- _____Consultation only with Recommendations for management sent back to me
- _____Co-Management: I prefer to Share the Care for the Referred Disorder (s)
- _____Co-Management: Please assume Principal Care for the Referred Disorder(s)
- _____Please have Dr Greenlee recommend type of interaction best suites this case

_____Additional DATA
- Core Data_____
- Lab_____
- Imaging_____
- Office Notes _____
- Other_____

Thank you,
Care Coordinator for Western Slope Endocrinology

Antithesis of High Value Coordinated Care:

- Common scenario #3:
  - 59 yo man with T2DM, HTN, Hyperlipidemia & obesity
    - referred to cardiology with unexplained DOE.
    - 18 page note from the cardiologist
      - only ICD codes for impression
      - no indication of what the cardiologist thinks or is going to do or what s/he recommends the PCP do
  - Disconnected Care
    - More questions than answers
    - Safety concerns

High Value Referral Response

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

Referral Response: *Audit for Critical Points*

- **Answer the clinical question/ address the reason for referral**
  - Summary or Synopsis (include some thought process)
- Clear indication of diagnosis/evaluation &/or the treatment plan
  - **What is the specialist going to do**
  - **What is the patient instructed to do**
  - **What does the referring physician need to do & when**
- What **follow up** is needed and with whom

Apply to All Referral Situations

- *Primary Care to Specialty Care (Radiology & Pathology)*
- *Specialty to Specialty*
- *Specialty to Primary Care*
- *Other services (Diabetes Ed, Physical Therapy, Nutrition, etc.)*

The referring clinician and the responding clinician agree to provide the appropriate information & communication needed for a high value referrals and agree to work together in the care of mutual patients

Ensuring that Quality Referrals Happen

- *Ideally*:
  - high quality referrals
    - become *what is expected* with *any and all referrals*
    - become part of usual care, no matter where that referral may be to or from.

- *To help us get there*:
  - Care Coordination Agreements or Care Compacts
    - help establish the platform of expectations to make it happen

Elements to Consider in a Care Coordination Agreement / Compact

1. **The PCP defines the type of referral relationship being requested**
2. **The PCP agrees to provides a clinical question with all referrals**
3. **The PCP and Specialty practice establish a core data set to accompany all referral.**
4. **The PCP and Specialty practice establish a pertinent data set for specific clinical conditions.**
5. **The PCP and Specialty practice establish a communication protocol**
6. **The Specialty practice agrees to respond to a referral request that includes the agreed upon critical elements**
7. **The PCP and Specialty practice agree on a protocol for making appointments**
8. **The PCP and Specialty practice agree on a “Closing the Loop” protocol**

end

Questions:

- Do you have a process now to provide previsit review or pre-consultation advice for referral requests?
- What common referral condition(s) could you use or create Pertinent Data Sets for to help ensure more appropriate referrals ?
- Do your referral response notes pass the audit checklist ?

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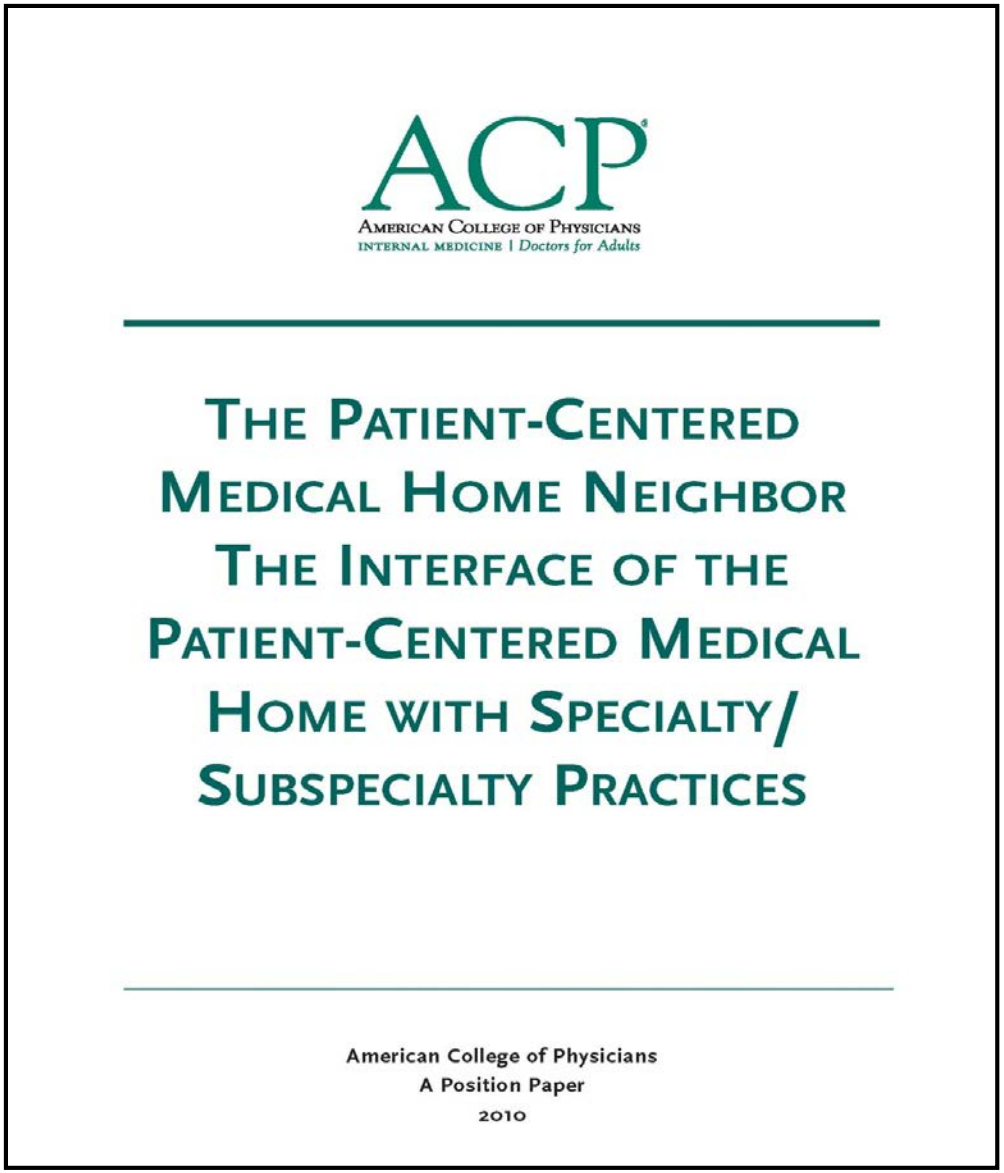
High Value Care Coordination Project

http://hvc.acponline.org/physres_hvcc_project.html



http://**www.acponline.org/advocacy/where_we_stand/policy/**