Referral Management through the Eyes of the Patient

Case Study

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Introduction and Background

Referral management serves an important role in the delivery of patient care. When done well, care is delivered in a timely, accurate, efficient, and well-coordinated manner. When not done well, there may be waste in the system in the form of unnecessary delays, fragmented care, duplication of services, or insurance denials.

Following the conversion to an electronic medical record, a multi-specialty medical group took a long hard look at the referral processes then embarked on a journey of continual process improvement. This effort was seen as a proactive tactic to mitigate opportunities for process failures and the potential negative impact on patient experience.

A multi-disciplinary workgroup was formed in the spring of 2014 to examine the current workflows for outbound primary care referrals. Workgroup members included representatives from practice leadership, application support, clerical staff, medical assistants, and a performance improvement coach. The workgroup met on a weekly basis for two months with individuals rotating assignments of meeting leader, scribe, and timekeeper.

The first step in the process was to create a flow chart of the current referral process. Members of the workgroup were assigned as many as four primary care locations to spend a day job shadowing staff with responsibility for any component of outbound referrals. Following the day of job shadowing, flow charts were created based on observations. After all members completed the assignment, the workgroup convened for an extended session to compare flow charts and to assess variation across all sites.
Although some variation was expected, members of the workgroup were shocked by the extent of variation found across the primary care locations. In addition to uncovering variation among sites in overall process, workgroup members also reported finding variation in staff knowledge of payer plans and competency with navigating payer websites, variation in workflows when referring within the medical group versus outside of the group, variation in documentation and information required by specialists prior to accepting the referral request, and finding a significant number of occurrences of incomplete information in the referral order.

The workgroup suspected that this degree of variation was likely resulting in unnecessary delays in scheduling and errors. Assistance from the business intelligence team and the central billing office staff was solicited to collect and analyze data. Data obtained and reviewed included:

1. Lag time from the referral order to the date the specialty appointment was booked
2. Number of open and closed referral orders each day
3. Number of denied claims per month due to missing insurance referral authorizations

Analysis of the data led the workgroup to conclude that the process of outgoing referral management is a highly complex task requiring attention to detail, an in-depth knowledge of payer plans, and a high degree of competency with the practice management, electronic medical record, and payer plan systems. The current system was broken and in need of repair.

**Alternatives Considered:**

The workgroup identified three different approaches to correcting the issues identified and gave consideration to the pros and cons of each approach. They were:

**Option 1:** Maintain the status quo of a decentralized model for primary care with a focused effort on staff training and standardization. The advantages of this option were that staff and work would remain in close proximity to the care team and the point of care delivery. The
disadvantages were that staff would continue to be pulled to perform other duties, there would be a lack of in-depth expertise in referral management on site, quality assurance systems would remain inefficient and inconsistent across locations, and this option would fail to address the receiving end of the referral management process (specialty intake).

**Option 2:** Transition primary care referrals management to a centralized model. Many of the variation issues identified during job shadowing would be mitigated by co-locating staff that are dedicated experts in referrals management. In addition, the workgroup predicted an increase in efficiency, staff productivity, staff satisfaction, timely referral processing, and timely identification of care not received. The disadvantages to this model were that staff would no longer be embedded in the care team and, similar to the first option, would fail to address the receiving end of the referral management process (specialty intake).

**Option 3:** Transition to a centralized model for primary care and expand the work to include the inbound referral management process in the specialty clinics. In addition to all of the advantages previously outlined in option 2, this model would address the full continuum of the patient referral experience from primary care, to specialty care and back to primary care. Thinking more broadly, this option would serve to advance the medical group’s pursuit of the NCQA Patient Centered Specialty Practice recognition. (National Committee of Quality Assurance, 2013) The disadvantage to this model was that it represented a significant medical group wide initiative during a time of low employee and physician engagement.

**Chosen Solution:**

Recognizing that one of the three proposed solutions was taking the form of a medical group wide transformation effort, the workgroup prepared a presentation for the senior leadership team and for the Patient Advisory Committee.
The presentations took place in early spring 2014. The first presentation was to the medical group’s senior leadership team in the form of a SBAR: Situation, Background, Assessment and Recommendation (Institute for Healthcare Improvement, 2014). The team was impressed with the initial efforts by this workgroup and encouraged members to proceed with plans to engage the Patient Advisory Committee.

The presentation to the Patient Advisory Committee took the form of a formal PowerPoint presentation. Content was adjusted to the audience while maintaining the integrity of the data and findings. Two members of the workgroup, a practice manager and the performance improvement coach, volunteered to meet with the Patient Advisory Committee and deliver the presentation.

The patient advisors listened attentively for a short time before interrupting the presentation to share their personal experiences with the medical group’s management of referrals. This was a turning point for the project. Patient advisors were clear and firm in their expectation, “My care team will manage my fears through timely communication and access to care.” From the patients’ perspectives, a referral to a specialist generates fear and anxiety. It is the care team’s responsibility to ease the patients’ fears as best possible. It is the medical group’s responsibility to create systems to support this.

As of this meeting, the Patient Advisory Committee became the compass. The patient advisors challenged the medical group leaders to look at the work from the patient perspective. Through this lens, the solution was clear. The medical group must focus on the full continuum of the referral process, addressing deficiencies and variation in both primary and specialty care.

Shortly after the Patient Advisory Committee meeting, a presentation was delivered to the medical group’s Board of Directors by the Senior Vice President of Operations. The presentation generated a lively discussion and concluded with a unanimous vote to pursue option 3, transformation of the referral process across the entire medical group.
Methodology:

The Board of Directors assigned the medical group’s Operations Committee with responsibility for oversight of the transformation project. The Operations Committee, composed of medical and administrative leaders representing primary care, medical specialties, surgical specialties and cardiovascular services, was well positioned to accept this challenge and proceeded to dedicate the following two years to this effort.

The first step for the Operations Committee was to gain a thorough understanding of the work to date by the workgroup. Following a series of educational sessions, the Operations Committee elected to formally establish the Referral Redesign Workgroup as a subcommittee. Together, they worked in unison on this effort.

The Operations Committee adopted the Clinical Microsystems Model for Improvement. (Eugene C. Nelson, 2007) A formal project management plan was developed which included:

1. Statement of vision, premise and purpose
2. Statement of value proposition
3. Statement of goals and objectives
4. Project communication plan
5. Statement of resistance mitigation
6. Identification of key stakeholders
7. Action plan
8. Financial proforma

Execution:

The first action was to develop, seek endorsement, and communicate the following statement of vision and goals:
Vision: The medical group will consistently deliver exceptional patient centered care through the management of referrals in a timely, efficient, and accurate manner.

Goals:

1. Patients will be *contacted within 24 hours* to be offered appointment options that accommodate and respect patient preferences

2. The general guidelines for appointment access will be:
   a. **Urgent** – same day
   b. **Acute** – within 24 hours
   c. **Routine** – within 2 weeks

3. Clinicians and staff will *actively collaborate and communicate* with each other and with the patient to ensure appropriate exchange of information and coordination of care

4. Appropriate *insurance referrals and pre-authorizations* will be obtained:
   a. **Urgent** – same day
   b. **Acute** – within 24 hours
   c. **Routine** – within 2 weeks

These goals were met with trepidation by many of the specialists who were currently reporting appointment wait times significantly beyond the stated goals.

The Operations Committee remained confident and committed to success. Meeting frequency was increased from once per month to twice per month and was extended from one hour to one and 1/2 hours to expedite efforts. Prior to the end of each meeting, assignments were delegated to the Referral Redesign Workgroup and individual members as appropriate. The performance improvement coach maintained highly detailed project and action plans to track progress against
timelines and deliverables. Regular communication occurred with key stakeholders to share progress, obtain feedback, and build engagement.

**Outcomes:**

In April 2015, a key milestone was met with the opening of the primary care centralized referral department. A team of highly trained referral specialists came together in one facility to process all outbound referrals for 118 primary care physicians and advanced practice professionals in the medical group. Key performance indicators (KPIs) included:

1. Adherence to standard policies, procedures, and workflows
2. Lag time from the referral order to the date the specialty appointment was booked
3. Number of open and closed referral orders each day
4. Number of denied claims per month due to missing insurance referral authorizations
5. Staff satisfaction
6. Provider satisfaction
7. Patient experience

With measurable and sustainable improvements in place within primary care, a higher level of focus and attention was placed on specialty care. Similar to early efforts in primary care, committee members job shadowed in the specialty clinics to observe workflows and identify areas of variation and barriers to achieving the established goals.

A project plan specific to specialty efforts was developed and rolled out to the specialty medical directors and administrative directors. The local dyad leadership team was held accountable for the local efforts and for reporting progress to the Operations Committee on a quarterly basis. Performance improvement coaches were available as needed.

Action items and milestones were as follows:
1. Develop an “acuity grid” for the top reasons for referrals – Due 07/31/2015

2. Finalize flow chart of current referral process – Due 08/31/2015

3. Develop a dashboard to track trends in 3rd next available new patient and established patient visits – Due 08/31/2015

4. Measure lag time from receipt of referral request to the date appointment was booked - Due 09/30/2015

5. Develop and implement performance improvement plans with the aim of achieving established goals – Due 12/31/2015

6. Develop standard clinical guidelines for the top reasons for referrals – Due 03/31/2016

Referring back to the Patient Advisory Committee’s expectation of “manage my fears through timely communication and access to care,” key performance indicators for the specialty clinics were tracked at the clinic level:

1. Adherence to the acuity grid
2. Adherence to established goals for appointment access
3. Lag time from receipt of referral request to the date appointment was booked
4. Reductions in variations in care through the adherence to clinical guidelines

Approaching the one year mark for the focused work with the various specialty clinics, all process measures have been achieved.

Medical group wide, the focus is shifting to outcome based measures. Many of the disciplines selected “referral process redesign” as a quality improvement metric for the 2016 physician compensation program. Early review of key performance indicators reveal improvements in lag time from the referral order to the date the specialty appointment was booked, access as measured by 3rd next available appointment, and patient satisfaction. By the end of calendar year 2016, selected outcome based key performance indicators will be reported and published across the
medical group. The Operations Committee will remain responsible for oversight of the continual improvement efforts and will review the newly developed stop light dashboard on a monthly basis to ensure sustainability of efforts.

Lessons Learned:

Engaging the Patient Advisory Committee early in the assessment and planning processes and continually throughout execution was critical to success. The patient advisors’ personal stories created the burning platform for change, created a vision for referral management “through the eyes of the patient,” and heightened the level of accountability for improvement felt by all members of the medical group.

Reflecting back on the past two years of work, the referral process transformation initiative was and continues to be a strong example of the medical group’s value of “patient centered” in action. In retrospect, though, the Operations Committee missed an opportunity to invite patient advisors to fully participate in the efforts by way of membership on the Operations Committee. Many believe this would have demonstrated an exceptional commitment to the value of “patient centered.”

Recommendation:

Trust the voice of the patients to serve as a compass for large and small improvement initiatives. It is through their eyes that medical group leaders gain the greatest insight into care delivery.
Bibliography

