ECHO Diabetes
Improving Your Referral Process

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June 8, 2023

Fragmented Care

- Fragmented care occurs when we practice in silos of care with poor communication between the silos.
- Harms and costs of Fragmented Care
  - missed care
  - duplicative services
  - medication errors
  - poor clinical outcomes & quality of care
  - increased costs
  - patient confusion & dissatisfaction
  - clinician/care team frustration & wasted time

The Solution= Working Together (effectively)

- Silos of care & care fragmentation can occur between practices – but also *within* practices & clinics (*silos within silos*)

- To help improve connected, coordinated & patient-centered care we will focus on
  - Optimizing the Referral Request (today)
  - Optimizing Team-Based Care (future)

As you listen….

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

- Goal = Connected & Coordinated Care vs Disconnected & Fragmented Care

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

The Current State of Referrals

- Up to 50% of referrals are never completed
  - Never scheduled
    - Missing information, process errors, communication failures, patient factors
  - Cancellations
  - No Shows
  - In one system 84% of referrals were not completed

- 60-70% of specialty care clinicians do not have the needed information for the referral at the time of the referral appointment, resulting in:
  - Unable to “do something” at that appointment →"Low value referral appointments” (minimal benefit/cost [time, effort, dollars])
  - Delay in care
  - Increased (unnecessary and/or duplicated) testing, work and workforce needs
  - Additional appointments (backlog access for others)

How this played out in my practice: Case 1 (“Playing Charades”)

70-year-old woman from 2 hours away, doesn’t know why she was referred

- No records
- Only voice mail at referring practice
- What to do?

- Glipizide, metformin, Levothyroxine on med list
- Discussed diabetes and thyroid
- Ordered A1c and TSH

Oops!

- A1c and TSH results done 2 weeks prior were identical to those just done
- Referral was for evaluation of a left a*drenal mass* noted on abdominal CT

The Current State of Referrals

- Inappropriate referrals:
  - ~8% (or more) of referral appointments are *to the wrong specialty.* Of the patients incorrectly referred to the wrong specialty:
    - 63% are re-referred to more clinically suitable physicians
      - Costing unnecessary visit payments, lost wages, unnecessary co-pays annually, delay, etc.
    - 37% are not re-referred, putting quality patient care at risk
  - Many referrals are *not medically necessary*
    - Conditions that do not require further attention (***uncertainty*** – just to be sure)
    - Conditions that can be managed by Primary Care clinicians & care team
- Long Wait Times (up to 6-12months for some specialties)

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

Case 2 (“wasted days & wasted nights”)

- 28-year-old female had routine consultation appt booked with my practice by her PCP front office staff with cc/o *“fatigue”*
- No records sent
- 3 month wait

Oops!

- Referral was for suspected Lupus , she needs a Rheumatology consult, I’m an Endocrinologist….
- Now a 5 month wait….

The Current State of Referrals

- ~50% of primary care clinicians don't know if patient was ever seen by specialty care following referral request
  - 25-50% of primary care have no information back by several weeks after patient's referral appointment
  - Information is often inadequate even when successfully transferred in a timely manner
    - Commonly only ICD codes for impression, no indication of
      - what the SC clinician thinks or is going to do
      - what they recommends the PCP do
      - what they told the patient to do

- 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" (for care PCP could manage)

Patients end up with disconnected care:

- Missed needed care
- Unnecessary care
- Delayed care
- Fragmented care

Can you relate to any of the Current State experiences?

- What are wait times for referrals to specialty care?
- How often does specialty care know the reason for referral & have the supporting data at the time of the referral appointment?
- What are No Show & Cancellation rates for referrals?
- How many referrals are inappropriate or medically unnecessary?
- How often is there “closing-the-loop” on referrals (what %)?
  - Is your clinic tracking referrals?
- Is the referral response information useful or helpful?

"Access to Specialty Health Care for Rural American Indians in Two States"

2008 study by researchers out of U of Washington, funded by HRSA
https://pubmed.ncbi.nlm.nih.gov/18643804/

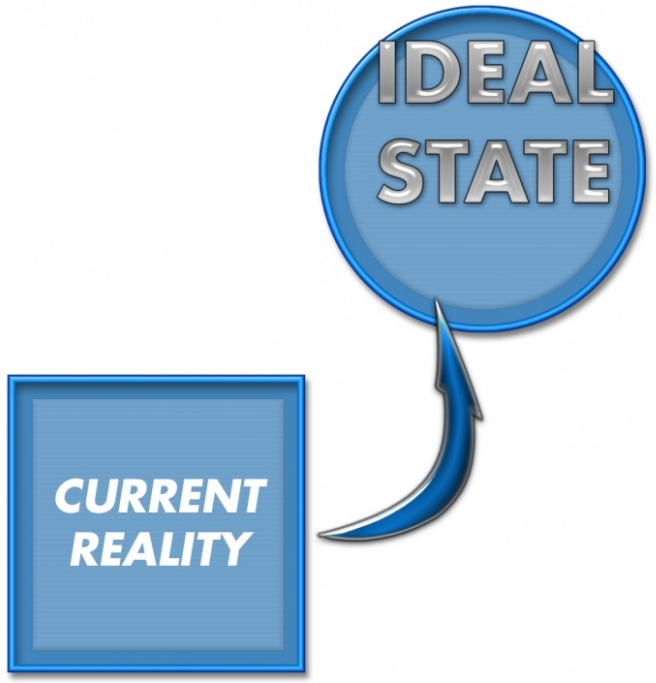
- Top (#1) Barrier = ***Financial* barriers**
  - Over 80% of rural Indian clinic providers in both states reported **insufficient contract services budgets** as a substantial barrier to specialty service access.
  - **Lack of insurance coverage** was frequently reported barrier for Indian patients.
  - In both states, between 20.3% and 31.1% of rural Indian clinic providers reported ***moderate or extreme restriction*** in obtaining non-emergent specialty care for **patients with insurance** (e.g., private, Medicaid).

- Barrier #2 = ***Patient lack of referral follow-through***

	Montana – AI clinics	Montana – non-AI clinics	New Mexico – AI clinics	NM – non-AI clinics
Patient sense of futility about health	**40%**	13%	**62.3%**	24.8%
Patient lack of follow-through (with referral to specialty care clinic)	86.4%	65%	78.4%	65%

Defined Steps to move from Fragmented to Connected, Coordinated Care

Moving from **Current State** toward **Ideal State-**



ACP Medical Neighbor & High-Value Care Coordination

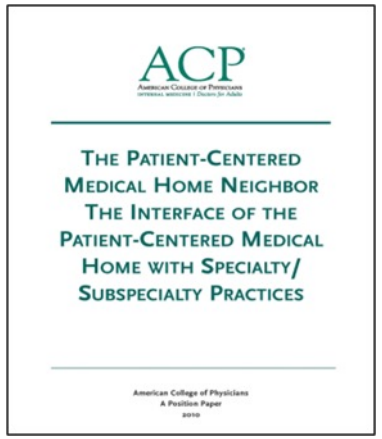
The **Medical Neighborhood** –

defines an ***approach*** to connecting care & working together

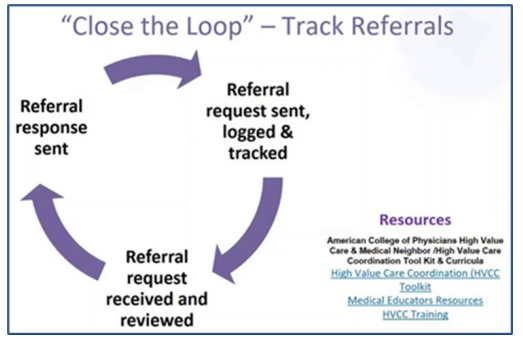
Fosters a mindset of cooperation, collaboration & cohesion

ACP **High Value Care Coordination** (HVCC) ***tool kit*** –

defines *expectations & critical elements* for a high value *referral process*



- High Value Referral Request & Referral Response
- Critical Processes for a High Value Referral Process
  - Pre-visit Advice ("enhanced referrals")
    - Pre-visit Review (referral triage)
    - Close-the Loop & Referral Tracking



The Critical Elements of the Referral Request

- <u>Check list for a high value **Referral Request**</u>
  - *Patient Demographics & Scheduling Information*
  - *Referral Information*
  - *Patient's Core Data Set*
  - *Care Coordination/Referral Tracking*

  - *First ensure a prepared patient…..*

Prepared Patient

- Ensure that patient/caregiver understands and agrees with the purpose of (and type of) referral
  - Include patient-specific goals (if appropriate)
    - What the patient hopes to gain medically (e.g., avoid surgery vs undergo surgery; ensure diagnosis or Rx is correct/optimal, etc.)
    - Goals for life (be able to care for grandkids, travel, etc.)
  - Educational material for patient (on disorder and/or specialty)
  - Information about the specialty practice
    - logistics, contact info, what to bring, etc.
    - consider providing patient with referral "one pager"
      - At Denver Health - reduced "no show" rate for referrals
  - Does patient have concerns about the referral or the specialty practice?
  - Consider the "burden" for patient
    - Location/ hours/transportation/appropriate wait time

Referral Info for Patient

Patient name_____ Referred on_____

Reason for Referral:_____ Patient Goal_____

Type of referral(role requested of specialty care)*: (recommend have options to be circled)

To: Practice name/ physician name(s) - Practice address & phone

Info about practice: including link to website for additional info

Role Requested of you -the Patient/Caregiver: Wait to be contacted, what to do if... ..

Appointment scheduling: will SC practice call, time frame to expect, etc.

Visit preparation: Previsit forms, who /what to bring, fasting for test, etc.

What to expect: what care team members involved, time allotment, etc.

Directions: (bus & train routes & stops; parking & costs; door entrance, elevator bank, floor, etc.)

Patient Demographics and Scheduling Information

- Name, demographics, contact info, surrogates/caregivers
- Special considerations (language, impaired hearing, vision, cognition, etc.)
  - Need to be aware for scheduling, forms, rooming needs
- Insurance information
- Referring clinician/practice name, contact info (including *direct contact for urgent matters*)
- Indicate (determine with SC practice) whether
  - Patient should call to schedule (challenges to referral tracking)
  - Specialty practice should contact the patient (usually preferred)

Referral Information

- What is the specific **clinical question** (reason for referral)
  - Or a brief Summary of case details pertinent to the referral, include relevant co-morbidities and any alarm signs or symptoms
- **Urgency** (referral status or referral priority)
  - Recommend *call* specialty care to notify/explain any urgent needs
- **Referral Type** (role in care requested of the specialist)
  - What role do you want specialty care to play – advice or management
- **Supporting data for the referral** ("pertinent data set"):
  - Clinical information directly relevant to the specific referral question (office notes, test results, therapeutic trials, etc.)

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?
- 55-year-old male with difficult to control T2D, how should insulin be adjusted?

Referral Type
(What is the suggested role of the specialist)

- _____ Consultation (Evaluate and Advise, with the goal of management of the problem remaining with the referring clinician)
- _____ Procedural Consultation
- _____Co-Management with Shared Care (Referring clinician (e.g., PCP) maintains first call & management of elements of care for the referral disorder with SC input)
- _____ Co-Management with Principal Care (The referred-to subspecialist/specialist assumes first call & elements of care for the referral disorder)
  - __I prefer to manage this condition once stable on care plan
  - __I prefer that you (specialty care) manage this condition on on-going basis

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)

- Ideally, Specialty Care practice provides *referral guidelines*

The requesting practice needs to know - what is pertinent…

Ideally SC practices will establish referral guidelines *(Pertinent Data Sets)*

- Define:
  - Information needed
  - Testing needed
  - Therapeutic trials
  - What not to do
  - Alarm signs & symptoms
    - Urgency
  - Should not be burden to referring clinician
    - Essential data set, not exhaustive
    - Can ask for more info through pre-visit assistance

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

https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit/pertinent-data-sets

Patient's Core (general) Data Set

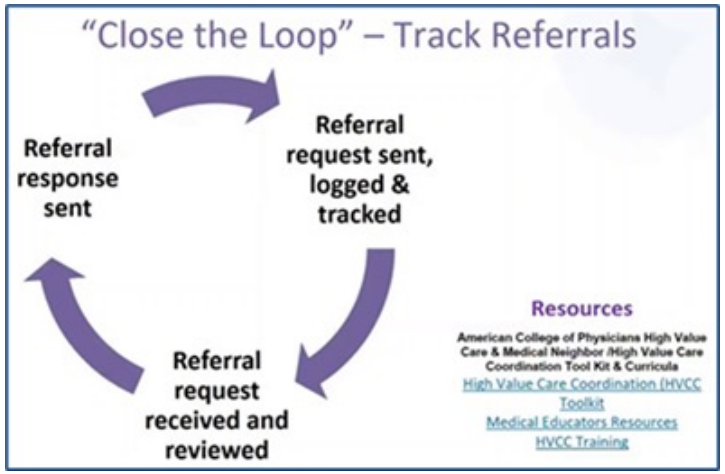
- Active problem list
- Past medical and surgical history
- Medication list
- Medical allergies
- Preventive care (e.g., vaccines and diagnostic tests)
- Family history
- Habits/social history
  - SDoH
- List of providers (care team) (other specialists caring for patient)
- Advance directive
- Overall current care plan and goals of care

- Pain Contracts
- Care Management
- Behavior Health

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

- Referral request sent, logged & tracked by PC team
- Referral request received and reviewed by SC team
  - Referral accepted with confirmation of appointment date sent back to referring practitioner
  - Referral declined due to inappropriate referral (wrong specialist, etc.) and referring practice notified
  - 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)

- Referrals made from one specialty to another (e.g., secondary referrals) include notification of the patient's primary care clinician



The Referral Request Elements

- Applies to ALL referral requests- whenever a patient is referred to another clinician or service:
  - Primary Care to Specialty Care (including Behavioral Health, Radiology, Pathology and Hospital Medicine)
  - Specialty to Specialty (“Secondary Referrals”)
  - Specialty to Primary Care
  - ED to Primary or Specialty Care
  - Primary or Specialty Care to Ancillary & other services (Diabetes Ed, Physical Therapy, Nutrition, etc..)

Agree to supply what is needed for High Value Care

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

Intended to expedite/prioritize care

- Pre-visit Request for Advice
  - Does the patient need a referral
  - 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 the patient's referral needs)
- Urgent Cases
  - Expedite care
  - Improved hand-offs with less delay and improved safety

Addressing Uncertainty

Many academic & community programs now utilize ***eConsults*** to provide advice around uncertainty and next steps

- Request for guidance regarding whether referral is appropriate and/or necessary
- Request for guidance for work-up or management – either in preparation for a referral or in place of a referral
- Request for guidance on the urgency of the referral & interim steps

Through these interactions, patient care is optimized and cooperation & an educational process around that care occurs between the practices

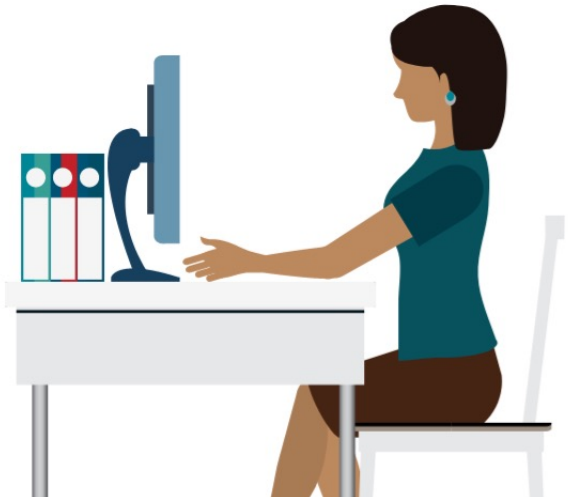
Telementoring (ECHO programs) provide Indian Country care team members with an opportunity to ask about issues of uncertainty or management issues & provide an educational process

Reasons to Use (Benefits) of ECHO

- Reduce uncertainty
- Reduce care fragmentation
- Reduce delay in care
- Enhance PC team clinical knowledge & skills (capacity building)
- Support – cohesion (in it all together) vs isolation (in it all alone)
- Help with insurance requirements
- Learn solutions that will work, from colleagues working in Indian Country to provide holistic care
- Reduce referral rate – limited funds
- Provides Substantial Cost Savings - *59% cost savings per patient compared to conventional care; Over 20 years, the telementoring ECHO model was projected to save over $50 million in HCV care-related costs in a tribal service area

Indian Country ECHO Program Areas

- Cardiology
- Community Health Aide Learning Collaborative
- Community Health Representatives (CHR)
- COVID-19
- Dementia (Clinical & Caregiver)
- Dermatology
- Diabetes
- Emergency Medical Services (EMS)
- Emergency Medicine
- Emergency Medicine
- Ending the Epidemics
- Grand Rounds
- Harm Reduction
- Hepatitis C
- HIV/ AIDS
- Trauma Rounds
- Infectious Disease
- Journey to Health
- Liver Disease
- Maternal & Child Health
- NW Elders
- Oral Health
- Palliative Care
- Peer Recovery
- Pharmacy-Led SUD Treatment & Recovery Teams
- PrEP (Pre-Exposure Prophylaxis)
- Rheumatoid Arthritis
- Substance Use Disorder (SUD)
- Trans & Gender-Affirming Care
- Virtual Care Implementation



Learn more and join at: https://www.IndianCountryECHO.org/

Summary / Key Points

- Improving the referral process can help reduce fragmented care & improve patient outcomes
  - Including the patient in the referral process & ensuring their understanding of and agreement with the referral is critical
    - Providing logistic information can reduce “cold feet” and “no-show” rates
  - Providing a clinical question or reason for referral and appropriate supporting information can expedite care/reduce delay
  - Tracking referrals is essential to “close-the-loop” on referrals & recommendations
- ECHO (tele-mentoring) can help improve the referral process
  - Addressing uncertainty and supporting primary care management
    - Provide support & capacity building for PC care teams
    - Reduce referrals to better optimize use of available contract service funds
  - Identify when referral is needed, best specialty care type to refer to and assist with preparation for optimizing the referral (and interim management).

More detailed review

Advancements in Diabetes Webinar – July 12, 2023

The Medical Neighborhood; Connecting Care

- Webinar link: https://hhs-ihs.webex.com/hhs-ihs/j.php?MTID=mec9d794f0ed3941c3719e634c6a83493
- Webinar details:
- Password: yXyHvUZY542 (99948899 from phones and video systems)
- Phone number: 415-527-5035
- Access Code: 2764 052 2610

- For information about the Advancements in Diabetes Webinar
  - Many presentations on native, traditional foods
  - join the LISTSERV at: https://www.ihs.gov/diabetes/ihs-diabetes-listserv/

References & Resources

- Medical Neighborhood
  - ACP (acponline.org)
- High-Value Care Coordination
  - https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit
- Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration
  - https://www.acponline.org/acp_policy/policies/beyond_the_referral_position_paper_2022.pdf
  - https://assets.acponline.org/acp_policy/policies/beyond_the_referral_playbook_2022.pdf

Extra Slides

Template for “One Pager” for Patient about the Referral - Reduce the Unknowns

Patient name_____ Referred on_____

Reason for Referral:_____ Patient Goal_____

Type of referral(role requested of specialty care)*: (recommend have options to be circled)

To: Practice name/ physician name(s) - Practice address & phone

Info about practice: including link to website for additional info

Role Requested of you -the Patient/Caregiver: Wait to be contacted, what to do if... ..

Appointment scheduling: will SC practice call, time frame to expect, etc.

Visit preparation: Previsit forms, who /what to bring, fasting for test, etc.

What to expect: what care team members involved, time allotment, etc.

Directions: (bus & train routes & stops; parking & costs; door entrance, elevator bank, floor, etc.)

Examples of Forms for sharing Referral Tracking information

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.

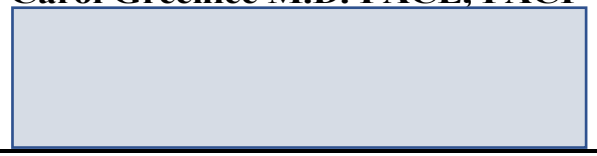
☐ Patient was NO SHOW for appointment on _____.

Person completing confirmation:	**Date of Confirmation:**

Mesa County Physicians IPA

This was sent as part of the referral form from PC – could be incorporated into EMR form

Western Slope Endocrinology
Carol Greenlee M.D. FACE, FACP



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