# The Medical Neighborhood

## Connecting Care:

## Ensuring Quality Referrals and Effective Care Coordination

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- American College of Physicians – chaired workgroups & policy papers on the Medical Neighborhood & Referral Process
- Faculty co-chair for Transforming Clinical Practice Initiative
  - Implementation support for improving the referral process & patient-centered care
- Faculty for Tribal Diabetes ECHO clinic
- Faculty for Colorado Specialty CareConnect (eConsult program)

# Parallel Universes of Care

How often did you feel that you and the referring PCP worked well together in caring for patients?

***"We are not really working together; there is not a collaborative concept or a team approach. I have never really thought of PCPs that way."***

**Silo Effect** - a lack of information flowing between groups or parts of an organization

"The accelerating advances and complexity of modern healthcare have driven **greater specialization** and a **'silo approach' to healthcare** consistent with the *isolationist history and professional culture"*

# 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 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*
  - Expectations of the *Referral Response*
  - Utilizing Patient-Centered Team-Based Care around the *Referral Process*

# 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

- On average, 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 for the cost in time, effort, dollars)
  - Delay in care
  - Increased (unnecessary 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, longer 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!

- Patient reveals the 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 the 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 thought process is &/or what they are going to do
      - what they recommend the PCP do
      - what they told the patient to do

# Example from a PC colleague: Case #3

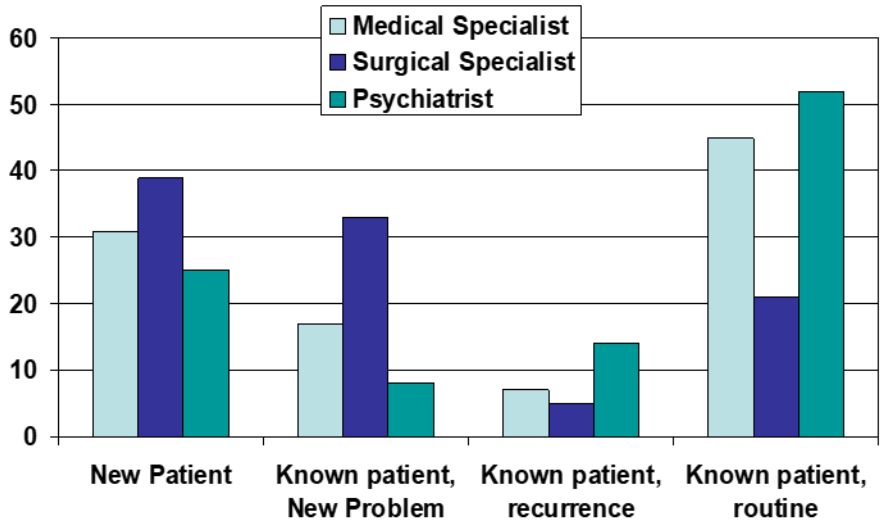
- 54-year-old male with thyroid nodule evaluated by endocrinologist
- Report to PCP indicates *“cytopathology from FNA shows Papillary Thyroid Cancer. Needs surgery.”*

OOPS!

- F/u appt with PCP a year later shows thyroid intact and nodule still palpable…

# The Current State of Referrals

- PCPs and specialists rarely discuss the preferred **role for specialty care** (SC) and who will be responsible for what aspects of care
  - Often the PC prefers to manage but patients are kept in SC
- ~ 50% of specialty care visits are for follow-up specialty care, often “routine check-up” (often for care PCP could manage) – “stuck in SC”
  - Limits specialty access for higher acuity patients
  - Increases patient cost, burden
  - Fragments care




# Example from a Health Care System: Case #4

- PC clinicians frustrated –
- can’t get sick patients with Inflammatory Bowel Disease, End-Stage Liver Disease, etc. into GI care while GI clinicians continue to follow patients stable on Proton Pump Inhibitors (PPIs) …

- GI clinicians frustrated that PC clinicians won’t follow patients stable on PPI medications…

Poor Referral Processes create Back-end Messes & Work for Practice Teams

# Patients take the brunt of the impact for poor referral processes

- Do not get the care they need → worse outcomes
- Don't get the time they want or need with the appointment
  - Do not get questions asked or answered; confusion, concerns, etc.
  - Worse outcomes
- Lost time (*patient's time is proposed quality metric*)
- Cost from lost wages, co-pays, deductibles
  - With high deductible plans, patients pay for duplicated, unnecessary care
- Cost of travel, parking, babysitter, etc.

- Delay (*hefty cost to mental & physical health*)
  - Worry
  - Unable to work, reduced ADL
  - Unresolved or Worsening condition
- Often get the *blame* for lack of information with the referral
- Safety issues

# 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?
- How often is there “closing-the-loop” on referrals (what %)?
  - Is your clinic tracking referrals?
- Is the referral response information useful or helpful?

# What about Specialty Care Referrals from American Indian Clinics?

- ***"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/
  - Rural **New Mexico** and rural **Montana*** - compared the perceptions (surveys) of primary care providers working in *rural tribal and IHS sites* in those 2 states with those working in *nearby rural non-Indian care sites* regarding their patients' access to non-emergent medical and surgical specialty services and barriers to service receipt.
    - *Montana's rural Indian clinic providers* reported nearly uniform *poorer specialty care access* for patients than rural non-Indian clinic providers.
    - *New Mexico's rural Indian clinic providers reported specialty care access that was generally comparable* to that reported by rural non-Indian clinic providers.

- *At time of survey:
  - New Mexico had fewer specialty care clinicians / population & fewer hospital employed PCPs than Montana
  - The IHS developed specialty care resources for New Mexico's Indian patients, including an IHS hospital in Gallup with specialists, as well as the University of New Mexico Hospital and private hospitals in Albuquerque contracted with the IHS.
  - Unlike New Mexico, Montana's Indian clinic providers are dependent on referral to community-based specialists alone.
  - Explains some differences between Non-AI providers (NM vs M) and lack of difference for some items between AI and non-AI providers

# Specialty Access Barriers – survey of providers

- 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 another 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, Medicare).

# Specialty Access Barriers – survey of provider

- Barrier #2 = ***patient lack of referral follow-through***
  - This could represent
    - insufficient understanding of specialty care importance;
    - fears regarding information or suggested treatment plans;
    - competing life priorities;
    - ineffective provider-patient communication about specialty care;
    - transportation barriers, especially in harsh winter climates;
    - financial concerns.
  - Alternatively, patients may have difficulty negotiating the IHS contract care and health care systems…. [or sense of futility *("why bother, nothing will help")* or too many unknowns]

Can include
- Failure to schedule
- Cancellation
- No show

| | 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% |

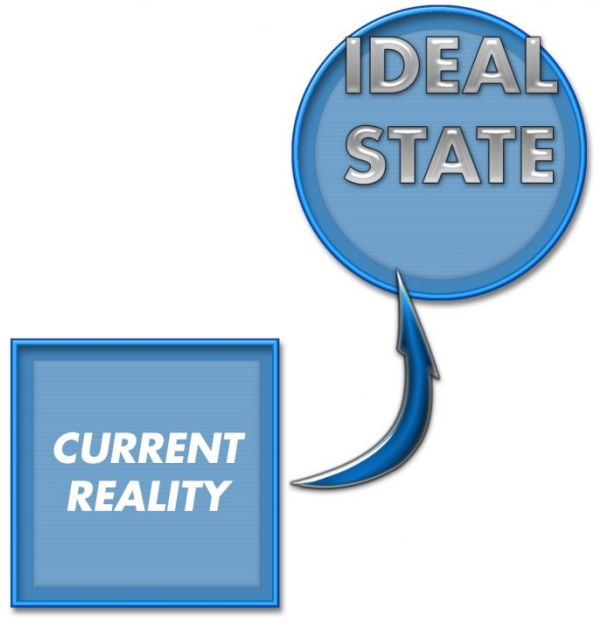
# Specialty Access Barriers – survey of providers

- Other ***frequently reported barriers*** included
  - excessive travel time to specialists (long distances)
  - lack of transportation
  - excessive appointment wait times
  - patient lack of knowledge regarding how to use the medical system
  - cumbersome referral process

- Substantial proportions of *non-Indian clinic providers* also reported moderate to big problems with financial, transportation, health care system, cumbersome referral process and personal barriers, especially in New Mexico.

# How do we start connecting care for our patients?

How to move from **Current State** toward **Ideal State**?




We need defined Steps to Improve the Referral Process & move from Fragmented to Connected, Coordinated Care

# ACP Medical Neighbor & High-Value Care Coordination

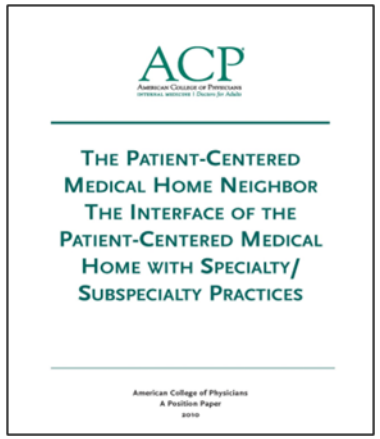
The **Medical Neighborhood** –

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

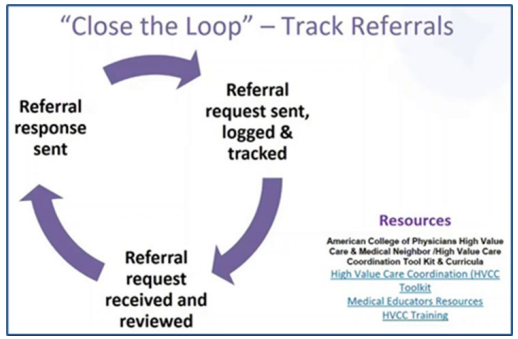
*Fosters a mindset of cooperation, collaboration & cohesion*

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…..*

# A Prepared Patient helps reduce Incomplete & Inappropriate Referrals

- **Patient as partner in care**
  - Patient included in the process (are they willing & able to go to SC appointment?)
  - The patient's needs & goals considered
- 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
    - Info on the specialty practice (parking, contact info, other logistics)*
- Appropriate **patient-centered "handoff"**
  - Specialty practice alerted of any **special needs** of the patient
  - **Appropriate specialist at appropriate time to meet the patient's needs**
  - **Appropriate preparation with testing or therapeutic trials prior to referral**

# 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.)
  - Does patient have concerns about the referral or the specialty practice?
  - Consider “burden” for patient
    - Location/ hours/transportation/appropriate wait time
  - Provide information on logistic information
    - directions, contact info, what to bring, etc.
    - consider providing patient with referral “one pager”
      - At Denver Health (FQHC) reduced “no show” rate for referrals

# 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.)

# 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 (clarify with SC practice) whether
  - Specialty practice should contact the patient (usually preferred)
    - Allows for pre-visit assessment/referral disposition
    - Allows for tracking of referrals / accountability
  - Patient should call to schedule (challenges to referral tracking)
    - 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.

# 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
  - Often misused – label everything urgent to try to get patient seen sooner
    - Specialty Care should triage urgency & have "urgent" appointment slots

    vs "first call, first serve"
- **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, 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?
- 21-year-old female with T1D - please manage during pregnancy.

# 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 elements of care for the referred disorder – SC provides input)
- _____ Co-Management with Principal Care (Referred to subspecialist/specialist assumes elements of care for the referred 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*
  - What information needs to be sent with the referral
    - E.g., Test results, therapeutic trials

# 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:<br>  • Rapidly progressive cognitive difficulties<br>  • Focal findings on examination<br>  • Associated abnormal movements<br>  • Use of psychotropic medications<br>• Provide:<br>  • TSH<br>  • Vitamin B12<br>  • Folic acid<br>  • CBC with differential<br>  • CMP |
| Additional patient information, if available | • Images<br>• Neuropsychological testing<br>• Drug screen<br>• 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:<br>Rosenbloom MH. *The Neurologist* 2011;17:67-74<br>Brodaty, Am J Geriatr Pshchiatry, 2006<br>Patient Information:<br>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

# “Backwards” care ➡ Inappropriate Care

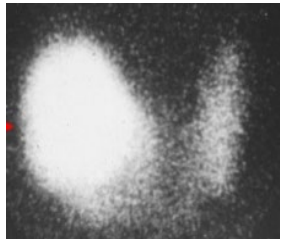
Two Cases from an Academic Medical Center

- Patient comes for “uncontrolled” T2DM,
- no A1C available (did not have POC A1C at AMC)
- spent visit discussing insulin
- subsequent A1C 7.1%
- called patient to tell her to ignore everything we talked about and just adjust current oral regimen

- Patient drove 3 hours for appointment to get FNA of thyroid nodule ,
- no TSH available
- Patient insisted the biopsy be done that day
  - biopsy done
  - TSH obtained
- found to have suppressed TSH due to “hot” nodule *(FNA not indicated)*

**Information Void – Value Void**

Low Value Care (No Benefit/ Cost)



# Patient's Core (general) Data Set

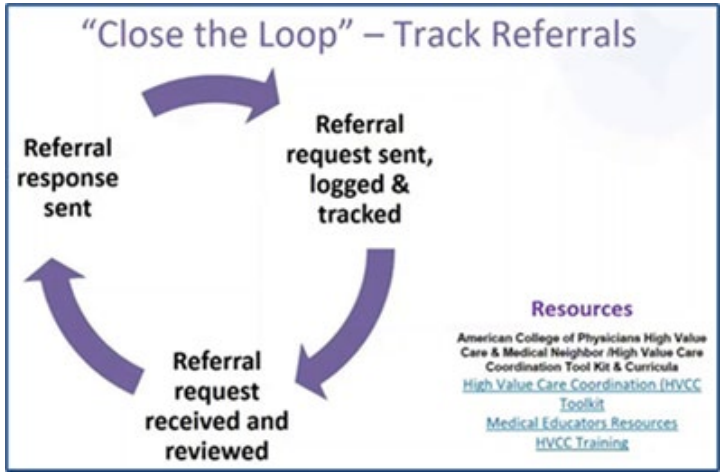
- Active problem list
- Past medical and surgical history
- Medication list
- Medical allergies
- Preventive care (e.g., vaccines and diagnostic tests)
- Family history
- Habits/social history
- List of providers (care team) (other specialists caring for patient)
- Advance directive;
- Overall current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

- Pain Agreements
- Care Management
- Behavioral Health
- Social Factors/ Services

# 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



# Open Loop – Open Ended

53-year-old man had skin lesion resected by PCP

- Pathology showed melanoma
- Referred to Dermatology for the needed further management
- Patient was No Show for Dermatology appointment

…and neither clinician was aware…


Role for tracking referrals for both PC & SC practices

# REASONS FOR NO-SHOWS

Usually not defiance or being a contrarian

- Overscheduling/forgetting about appointment
- Feeling that condition has worsened and opting to go to the emergency room instead
- Not understanding why appointment is necessary
- A limited relationship with their physician making them less concerned about skipping an appointment
- A language barrier that causes them to misunderstand when appointment is scheduled
- Some patients may simply feel better and not need the appointment but fail to notify the office.
- Worries about receiving bad news and hoping to avoid the situation
- Socio-economic factors
- Annals of Family Medicine

- Poor communication/instructions
- Intimidation – “cold feet”
- Long wait
- Sense of futility

Good to have a plan for how to approach patients who “No Show” their referral appointment with SC

- Seek first to understand (not punitive) ….
- Best when the referring PC care team handles it – ask to be notified by SC if patient No Shows

# 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.

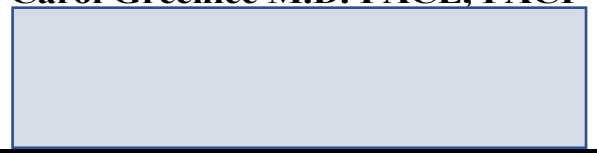
☐ Patient was NO SHOW for appointment on _____.

| **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*

# 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

# 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

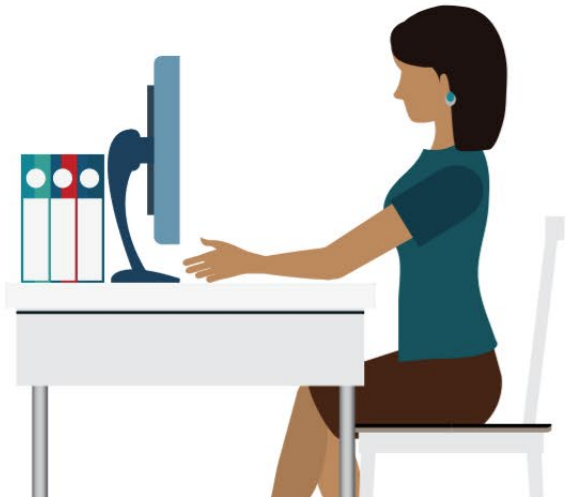
Telementoring (ECHO programs) provide Indian Country care team members with an opportunity to ask about issues of uncertainty or management issues & provide an educational process

# Reasons to Use (Benefits) of ECHO

- Reduce uncertainty
- Reduce care fragmentation
- Reduce delay in care
- Enhance PC team clinical knowledge & skills
- Support – cohesion (in it all together) vs isolation (in it all alone)
- Help with insurance requirements (e.g., HCV med approval)
- Learn solutions that will work, from colleagues working in Indian Country to provide holistic care (e.g., implementation of professional CGM)
- Reduce referral rate – limited funds
- Provides Substantial Cost Savings –
  - HCV - *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/

# 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** as part of process improvement

# Action Steps inside the Practice

- **Look at your internal referral process** (*get your own house in order*)
  - Perform a ***Process Map of the referral process*** within the practice – define your current state (as it really is right now)
    - Identify any gaps in critical elements
    - Develop an Improvement Plan to close the gaps
  - Define who the ***team members*** are for the practice referral process
  - Initiate a ***Policy & Procedures*** document for your practice team's internal referral process (will be a work in progress)

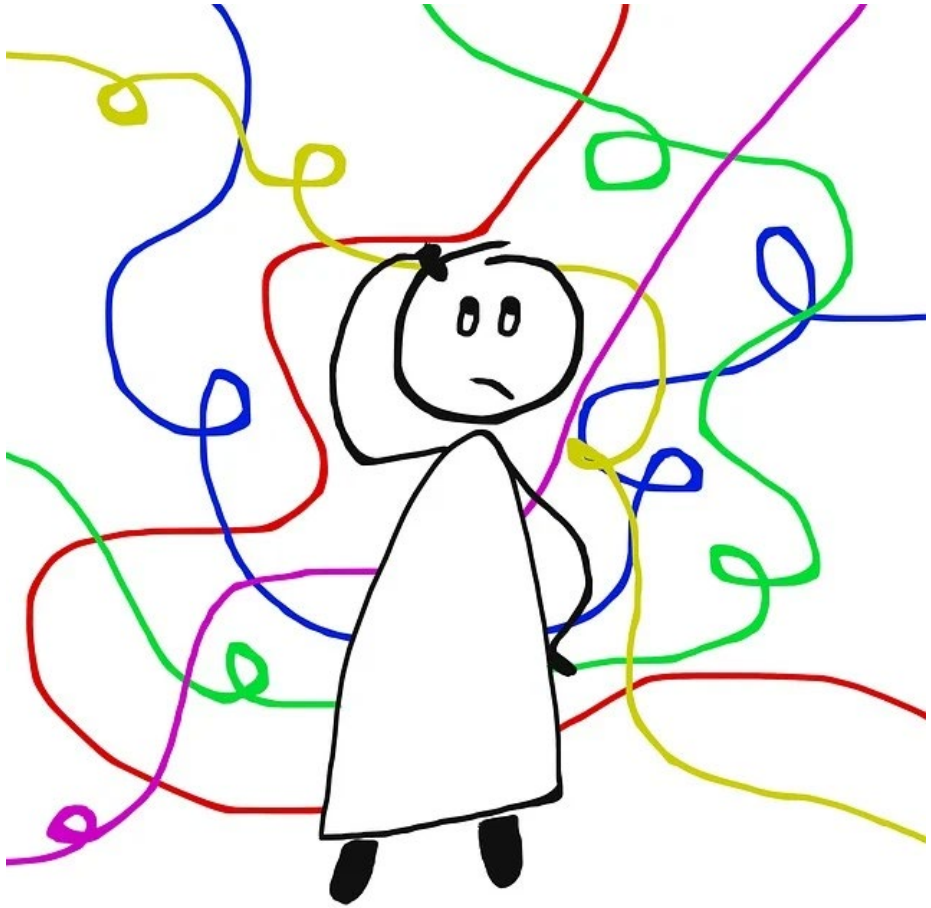
# Develop a P&P (Policy & Procedures)

- Set a practice policy for referrals
    - Example primary care policy: *“Our policy is to provide standardized referrals with a clear reason or question stated and attach the appropriate information so that our patients get the care they need efficiently, effectively and safely”*
    - Example subspecialty/specialty policy*: “Our policy is to provide high value, patient-centered referrals appropriate to the needs of the patient”*
- Design the Procedures the way you want it to work
    - See if it works
    - Make improvements/changes as needed to get it working well

# Summary / Key Points

- Improving the referral process can help reduce fragmented care
  - 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
- AI/AN patients can have additional barriers to access for SC referrals
- ECHO (tele-mentoring) can help improve the referral process
  - Addressing uncertainty and supporting primary care management
    - 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).
  - Indian Country ECHO programs cover a wide range of areas & conditions
- A high value referral process requires care coordination within the practice as well as between practices

# Questions, Comments, Clarifications, etc.



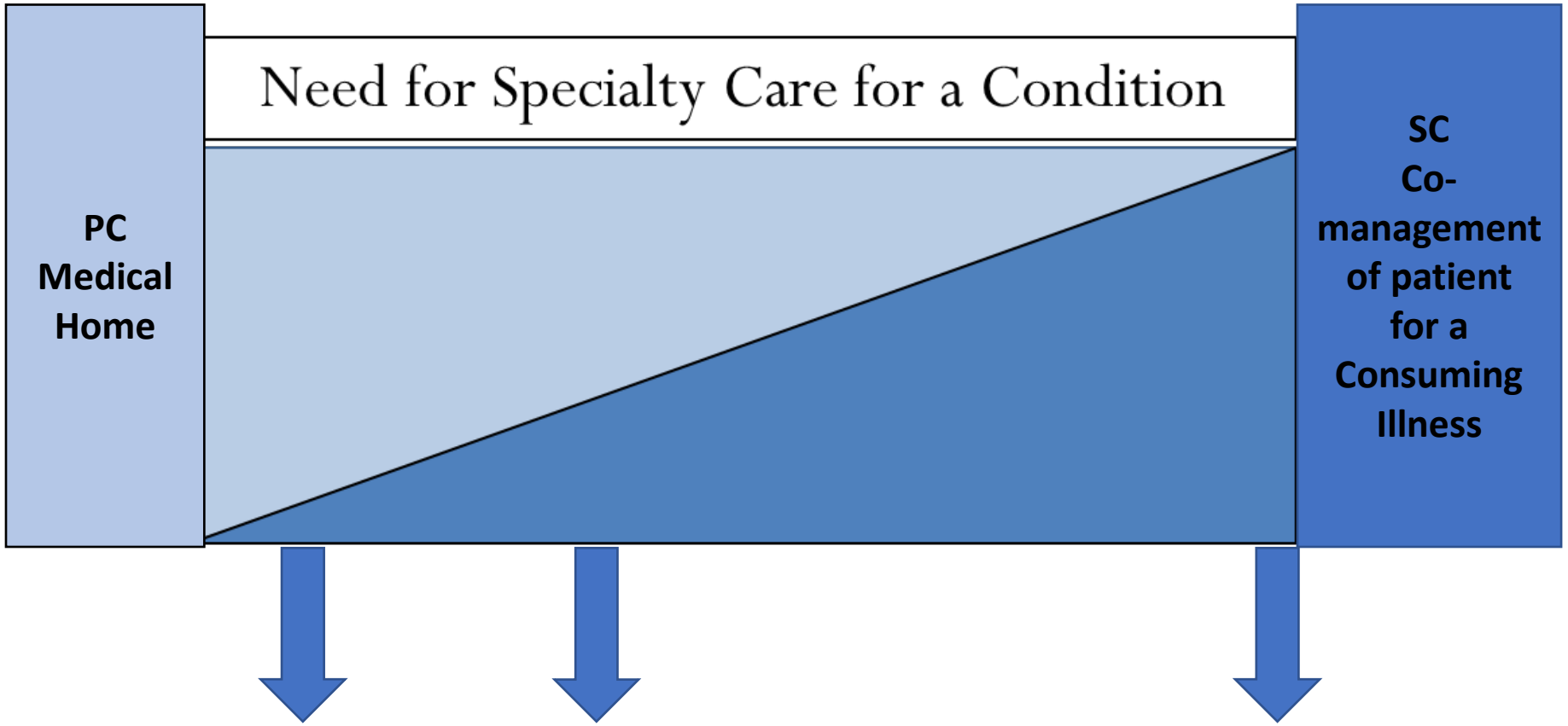
# References & Resources

- 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

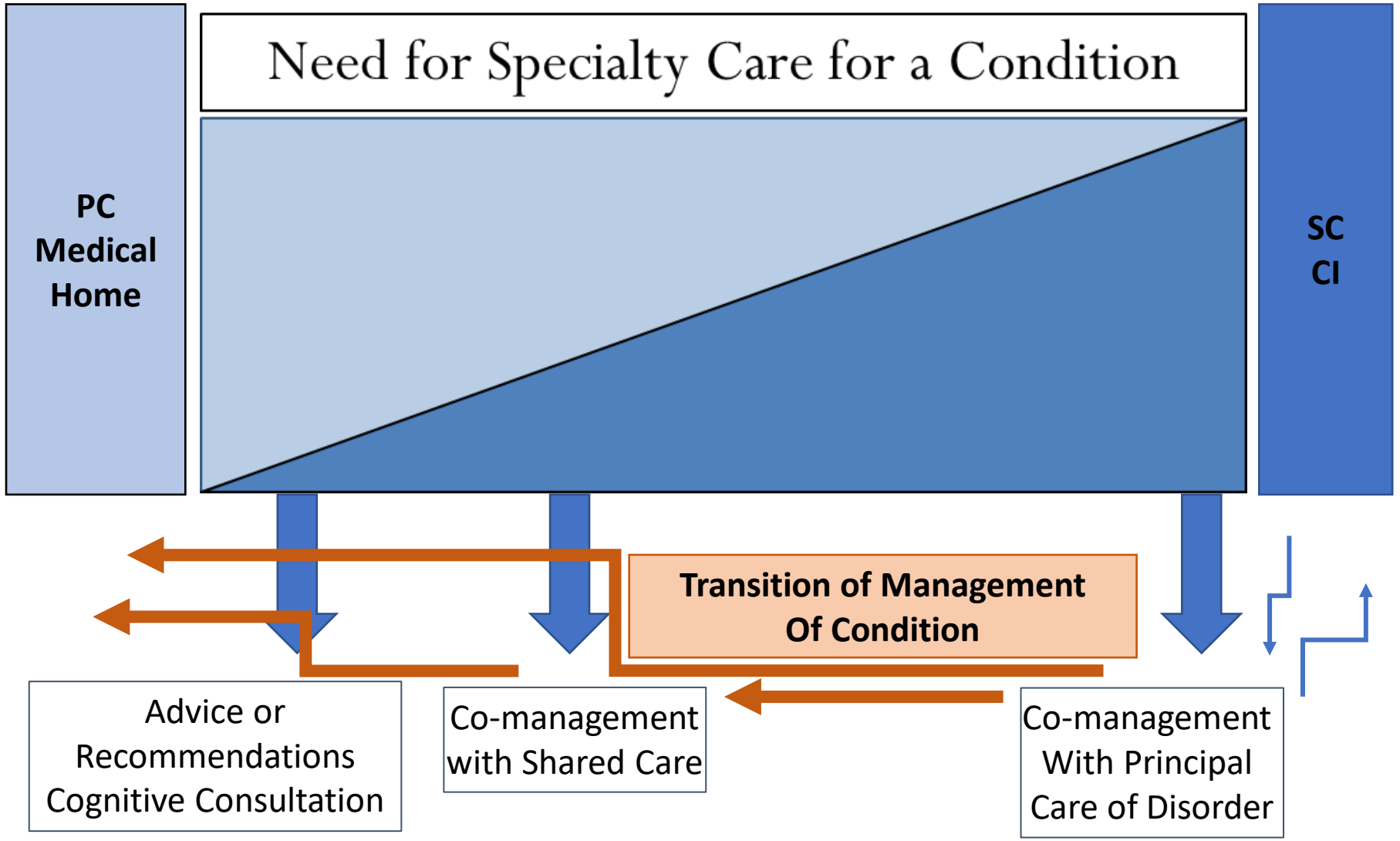
# Resources

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

# Extra Slides




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




Sometimes as a condition /patient stabilizes – management can Transition back to Primary Care

# “Graduation” - Transition of Management from SC to PC

- Definition: *“The transition of co-managed care from SC back to PC for patients with a stable problem and treatment plan that can be safely, reasonably and effectively managed by primary care.”*
  - Patients with minor or resolved issues
  - Patients who were referred with an unstable condition that are now stable and are appropriate for management by their primary care team
  - Patients for whom additional specialty testing and treatment are no longer indicated (e.g., appropriate for move to end-of-life care with palliative care or hospice)

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

# Transition of Management of a Condition Back to PC From SC

"Many patients continue to be followed in SC that could easily be followed by PC.

One reason this has occurred is **the lack of a process** for returning the management of a co-managed condition back to PC."

## Helpful Elements - Establish **mechanisms for the transition.**

Ideally, incorporate into technology or referral form.

- Going forward -The preference of the PC clinician/care team to resume management of the referred condition once stable or to have care remain with SC should be *communicated at the time of the initial referral*
  - **I am referring the patient for:**
    - **___Principal Care Co-management:** Please assume principal care for the referred condition:
      - **___I prefer to resume management of this condition once stable**
      - **___Please assume long-term (ongoing) management for this condition**
- If a condition has been co-managed long-term by SC with no prior indication regarding the preference of PC, then *any party (patient/family, PC clinician, or SC clinician) can suggest transition of management back to PC*

# 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:<br>• List of all foods consumed and drugs taken within the 4 to 6 hours preceding the event<br>• Circumstances of a preceding bite or sting<br>• 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<br>• 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:<br>Lieberman et al. The Diagnosis and Management of Anaphylaxis Practice Parameter: 2010 Update. J Allergy Clin Immunol. 2010; 126: 477-80<br>Update on influenza vaccination of egg allergic patients: Ann Allergy Asthma Immunol 2013; 111: 301-302<br>Healthcare Professional and Patient Information:<br>http://www.aaaai.org<br>http://www.acaai.org |

# 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:<br>  • Rapidly progressive cognitive difficulties<br>  • Focal findings on examination<br>  • Associated abnormal movements<br>  • Use of psychotropic medications<br>• Provide:<br>  • TSH<br>  • Vitamin B12<br>  • Folic acid<br>  • CBC with differential<br>  • CMP |
| Additional patient information, if available | • Images<br>• Neuropsychological testing<br>• Drug screen<br>• 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:<br>Rosenbloom MH. *The Neurologist* 2011;17:67-74<br>Brodaty, Am J Geriatr Pshchiatry, 2006<br>Patient Information:<br>http://www.alz.org/dementia/mild-cognitive-impairment-mci.asp |

ACP | High Value Care

Pertinent Data Sets

# Immunodeficiency

| | |
|---|---|
| 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 | Description of:<br>• Infections<br>• Failure to thrive<br>• Family history of immune deficiency |
| Additional patient information, if available | • Immunoglobulin (Ig GAME)<br>• CBC<br>• Any lymphocyte analysis |
| Alarm symptoms/conditions | Serious infections: sepsis, CNS infections |
| Tests/procedures to avoid prior to consult | • Do not give immunizations before consultation. The evaluation of the immune response is critical to the diagnosis.<br>• Do not administer live vaccines. |
| Common rule-outs to consider prior to consult | None provided |
| Relevant "Choosing Wisely" elements | Do not administer parenteral immunoglobulin without proving the lack of response to antigenic stimuli |
| Healthcare professional and/or patient resources | Healthcare Professional Information:<br>Practice Parameter for the Diagnosis and Management of Primary Immunodeficiency.<br>http://www.allergyparameters.org/app/download/7984506970/2005+Immunodeficiency.pdf?t=1373021808<br>Ann Allergy 2005; 94:S1-S63 at<br>http://www.bragid.org.br/download/practice_parameter.pdf<br>www.jcaai.org/page/Practice_Parameters/<br>Healthcare Professional and Patient Information:<br>http://www.aaaai.org |

# Having a method for Pre-consultation Request & Review / Referral Triage - very high 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 – enhances cohesion (working together)
- Improves access
- Improves safety
- Reduces waste

# Ensure Appropriate & High Value Secondary Referrals - *Avoid the Referral Black Hole*

- ***Secondary referrals*** arise from a referral request to another specialty/ subspecialty practice for consultation, procedures, or co-management by a specialty practice (**by one specialty practice to another specialty practice**)
  - In some instances, the referral for additional special services may require some specialty knowledge and may expedite care & best be managed by the specialty/subspecialty practice
- There needs to be clear expectations for when the PCP wishes (or is required by insurance plan) to be involved in secondary referrals
- *In all cases, the PCP needs to be included in the communication regarding the secondary referral*

# Tips to Help with Internal Referral-Process Process Map

- Map your process “as is”
  - resist the tendency to “fix” as you map
- Include those who actually “do” this process
  - Not just the office manager or administrator
  - Different people may vary in how they do the job
- With complex processes such as this one, consider multiple passes, allow time to revisit & tweak
  - Include:
    - Who: Include handoff details, Patient involvement
    - What: Time parameters? Documentation and notification parameters?

# Tips to Help with Internal Referral Process Process Map

**Requesting a Referral**

- **Process Start and End**
  - Start = Decision to refer
  - End = Referral reconciled
- **Referral reconciled means:**
  - Referral response received and recommendations are incorporated into the patient's care in partnership with patient OR
  - Referral incomplete and next steps have been made in partnership with patient

**Responding to a Referral**

- **Process Start and End**
  - Start = Receipt of referral request
  - End = Referral Response sent
- **Referral Response can be :**
  - Redirection to more appropriate specialist
  - Referral not needed or Answer to simple question without appointment
  - Notice of No Show or Cancel
  - Completed Referral with note