Improving Referral Tracking Processes at a Community Health Center in Southern Alabama

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Introduction

With high prevalence of complex chronic conditions and the fragmentation of health care delivery that comes with medical specialization, communication and coordination between primary care providers and specialists becomes increasingly important. Coordinating care and ensuring continuity are important elements of patient-centered primary care. Referrals made by primary care providers, arranging specialty consultation and co-management of complex conditions, are an important element of this communication and coordination. Referral tracking, which I am defining as all efforts to arrange and follow up on referrals made, provides an opportunity to improve communication and coordination between primary care providers (PCPs) and specialists. By focusing on the improving the transfer of patient information between providers, one may improve the quality and continuity of care provided to patients.

In addition to being an essential element of patient-centered primary care, referral tracking is required by key accrediting organizations. The NCQA PCMH accreditation

includes "Referral tracking and Follow-Up" as a MUST PASS element.[1] The Joint

Commission also has requirements that the clinic "support continuity, coordinate

care, and maintain complete records".[2]

Despite having a policy and processes in place, referral tracking is something that

Franklin Primary Health Center and its staff struggles with. Nurses and support staff

find the referral process cumbersome and time consuming, an additional burden

that there is little time for among their already non-stop daily duties. Providers also

become easily frustrated when their patients do not attend the specialty

appointments they are referred to, or when reports with findings and

recommendations do not come back from a specialist. There are many obstacles to

keeping up on referral tracking, including volume of referrals, transitions to the new

EHR system (NextGen), lack of staff dedicated to this role, cumbersome and time-

consuming manual processes, and a challenging population that often does not keep

appointments (for various reasons). Franklin's unannounced Joint Commission site

visit in June 2013** further confirmed that referral tracking is an important area of

improvement, identifying Franklin's need for more "efficient and effective tracking

of labs, referrals, and diagnostic procedures".
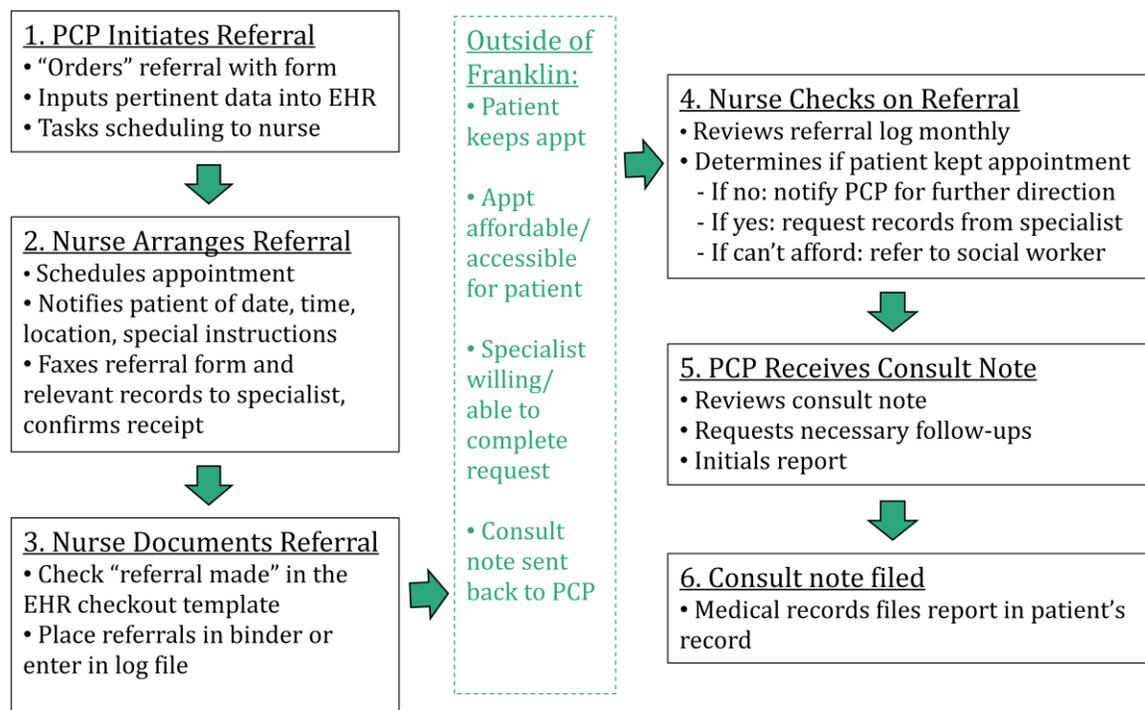
Background

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[1] This is element 5B, NCQA. It includes: provides specialist with reason and key information for the referral; tracks referral status; follows up to obtain specialist reports; has agreements with specialists documented in the record; asks patients about self‐ referrals and request specialist reports; demonstrates electronic exchange of key clinical information; provides electronic summary of care for more than 50% of referrals.
[2] Joint Commission

Franklin does have an official policy in place for how referral tracking should be executed. The policy is that "the PCP will utilize an organized referral system that facilitates effective coordination of care and continuity among primary and specialty care." This process is outlined in Figure 1.[3] This flow chart outlines the recommended process for a traditional PCP-initiated referral. However it is also common, especially in the case of Medicaid patients, to see a referral initiated by a specialty provider who needs "approval" from a PCP before delivering specialty services. The process in this case is similar, though the PCP does not order and the nurse does not schedule or notify the patient of the appointment.

Figure 1:

1. PCP Initiates Referral	Outside of Franklin:	4. Nurse Checks on Referral

• "Orders" referral with form
• Inputs pertinent data into EHR
• Tasks scheduling to nurse
	• Patient keeps appt
	
	• Appt affordable/ accessible for patient
		• Reviews referral log monthly
		• Determines if patient kept appointment
		  - If no: notify PCP for further direction
		  - If yes: request records from specialist
		  - If can't afford: refer to social worker

2. Nurse Arranges Referral • Schedules appointment • Notifies patient of date, time, location, special instructions • Faxes referral form and relevant records to specialist, confirms receipt	• Specialist willing/ able to complete request	**5. PCP Receives Consult Note** • Reviews consult note • Requests necessary follow-ups • Initials report
3. Nurse Documents Referral • Check "referral made" in the EHR checkout template • Place referrals in binder or enter in log file	• Consult note sent back to PCP	**6. Consult note filed** • Medical records files report in patient's record

[3] Figure 1 is based off "Procedure for Medical Referrals" in Franklin Policies and Procedures Manual, revised 2/11

This process is divided into two phases. The first phase involves arranging the referral. The provider "orders" a referral in the EHR, just as they would any other lab or diagnostic service (Step 1). The nurse receives this order and calls up the specialist's office to get the patient an appointment and the patient is notified of the date, time, location, and any special instructions for the appointment (Step 2). The nurse faxes the referral form and any relevant records to the specialist office, confirms receipt of the records, and then documents that the referral was made in the EHR checkout template and by placing a copy of the faxed forms in a 3-ring binder located near the nurses station (Step 3).

The second phase of the process occurs after the patient has, ideally, had their appointment. The nurse is expected to do a monthly review of the referral log to determine whether the patient has kept their appointment (Step 4). If the patient has kept their appointment, the nurse requests the consult report; if the patient has not, the nurse is to consult with the PCP or social worker if cost is a concern. When consult reports are received, the PCP is expected to review and initial the report, and arrange for any necessary follow-up (Step 5). Finally, the report is sent to medical record where they scan it into the EHR system (Step 6).

In between these two phases is a series of steps that need to occur outside of Franklin. This includes: having the specialist be willing and able to see the patient; the appointment being affordable and accessible to the patient; the patient keeping

the appointment; and the specialist sending the consult note unprompted. These elements are seen as outside of Franklin's control and so staff typically does not make efforts in these areas.

Franklin's referral tracking policy, as written, is relatively aligned with many current best practices recommendations. Experts recommend having a paper or electronic database that records all referrals and tracks key landmarks in a referral process (e.g., referral appointment made, patient information received, appointment completed, consultation note returned, etc).[4] The goal is to "close the loop" on every referral made, meaning to have a complete consultation note filed in the patient record. By continuously monitoring the key steps necessary to close the loop, clinical staff can identify gaps and remedy problems. Better care coordination may result in more satisfied patients, less frustrated providers and staff, fewer errors, lapses and delays in care, and less waste overall.[5]

Methodology

My project had both qualitative and quantitative components. The quantitative component involved reviewing of the records of MLK Adult Medicine patient in the downstairs clinic whose PCPs had requested referrals between January 1 and February 28 of 2013. I looked through every referral matching this criteria that was filed in the binder tracking system, and documented whether and when the referral

[4] Safety Net Medical Home Initiative. "Care Coordination: Reducing Fragmentation in Primary Care." April 2011.
[5] Linda Thomas-Hemak and Ed Wagner. "Closing the Loop with Referral Management." Group Health Research Institute, Presentation, February 26, 2013

made it through each stage of the current tracking system as outlined in Figure 1. This process allowed me to identify when the loop was not closed on a referral or unnecessary delays occurred. I also ran a query in the EHR system of all referrals made between these dates and by the relevant providers. This allowed me to assess what proportion of referrals overall were even entered into the binder tracking system in the first place.

The qualitative component of my project involved several components. First, I mapped out the recommended referral tracking process using Franklin's Policies and Procedures Manual (*see Background and Figure 1*). Then I observed how these processes are actually implemented in various clinics within Franklin (Adult Medicine, Pediatrics, and OB-GYN) and discussed the benefits and limitations of these processes with clinical staff. Finally, I conducted literature review of best practices in referral tracking, relying heavily on sources provided by the AAFP, The MacColl Institute for Healthcare Innovation, and other organizations that work with safety net clinics. The goal of this research was to identify gaps in current processes and make recommendations to Franklin for improved referral tracking.

Results

Most significantly, only a quarter (25.2%) of the referrals that were requested and initiated by the PCP in the EHR ever made it into the paper-based referral tracking system. Between the service dates of January 1 and February 28 2013, an EHR query

shows a total of 325 referrals initiated by the four MLK 1st floor Adult Medicine providers. For this same time period, I identified only 82 records in the MLK 1st floor Adult Medicine binder tracking system, representing only 25.2% of the referrals made.

Figure 2:
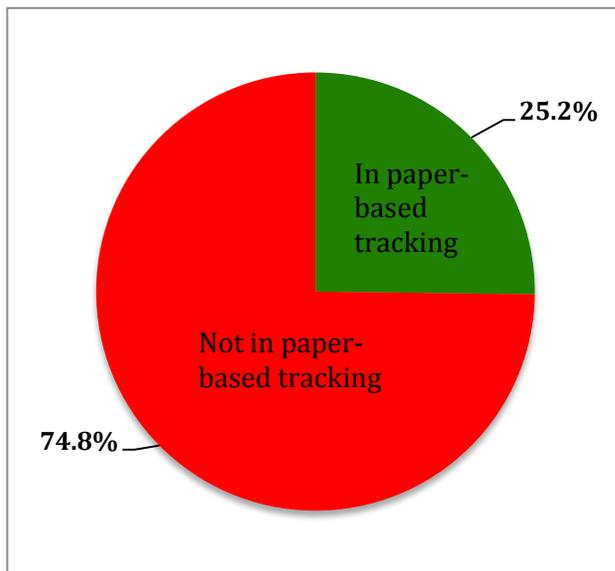
My analysis of referral tracking focused only on the one-quarter of records (n=82) that made it into the paper-based referral tracking system, as no tracking was conducted on referrals not in the system.

Figure 3 describes the proportion of referrals that made it through each stage in the tracking process (as outlined in the Background section).

- Step 1: A total of 82 referrals were either initiated by a PCP or an outside specialist (100%).

- Step 2: A referral appointment was successfully arranged in 68 cases (82.9%). Of these, the nurse made the appointment for 55 (67.1%) and the appointment was already arranged for 13 (15.9%). Of the remainder, the responsibility for arranging the appointment was given to the specialist for 9 (11.0%), and the remaining 5 (6.1%) have no documentation regarding appointments.

- Step 3: The nurse documented the referral for all 82 (100%).

- Step 4: The nurse checked on the status of the referral at least once in 73 cases (89.0%). In 8 cases (9.8%), the status of the referral was never checked, and in one case (1.2%) the documentation is unclear.

- Step 5: The PCP received a consult note in 35 referral cases (42.7%). They did not receive a consult note in 5 cases (6.1%) despite the patient having kept their appointment and the records being requested. In 42 cases (51.2%), this was not applicable due to the patient not keeping their appointment or uncertainty regarding whether they kept their appointment.

- Step 6: The consult note was filed in 33 cases (40.2%). No note was filed in 6 cases (7.3%) despite the patient having kept their appointment and the records being requested. In 42 cases (51.2%), this was not applicable due to the patient not keeping their appointment or uncertainty regarding whether they kept their appointment. In one case (1.2%), it was unclear whether the correct notes were filed.

The patient kept their appointment in 38 cases (46.3%) and did not keep it in 40 cases (48.8%). In 4 cases (4.9%), it was not clear whether or not the patient kept their appointment. Out of the appointments not kept, 34 (41.5%) were no shows, 2 (2.4%) cancelled their appointment, and 4 (4.9%) never scheduled an appointment.
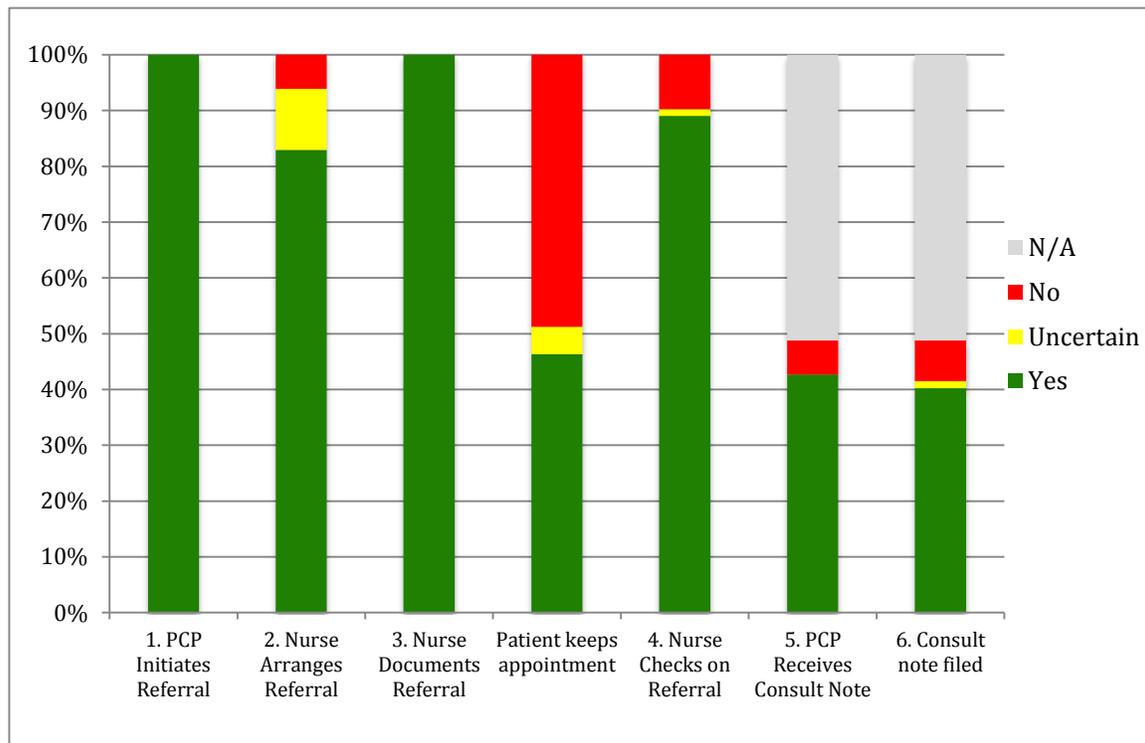
Figure 3:

Figure 4 outlines the average time between each stage in the process. After the PCP initiated the referral, it took an average of 2.9 days and a maximum of 53 days (mean= 2.9, median = 0, range = 0 to 53 days, n = 71) for the nurse to arrange and document the referral. After the referral was arranged, the patient's appointment occurred an average of 9 days later (median = 6, range = -11 to 113 days, n = 64), though the appointment may have occurred up to 11 days before the referral was

even requested and as late as 113 days (almost 4 months later). There was wide variation in when the nurse checked on the status of the referral, averaging around 22 days after the appointment, but ranging from 160 days before the appointment even occurred to 114 days afterwards (median = 12, range = -106 to 114 days, n = 67). The PCP received a consult note an average of 12 days after the appointment (median = 8, range = 0 to 12 days, n = 35) and the consult note was filed an average of 12.2 days after being received by the PCP (median = 3, range = 0 to 52 days, n = 34).

Figure 4:
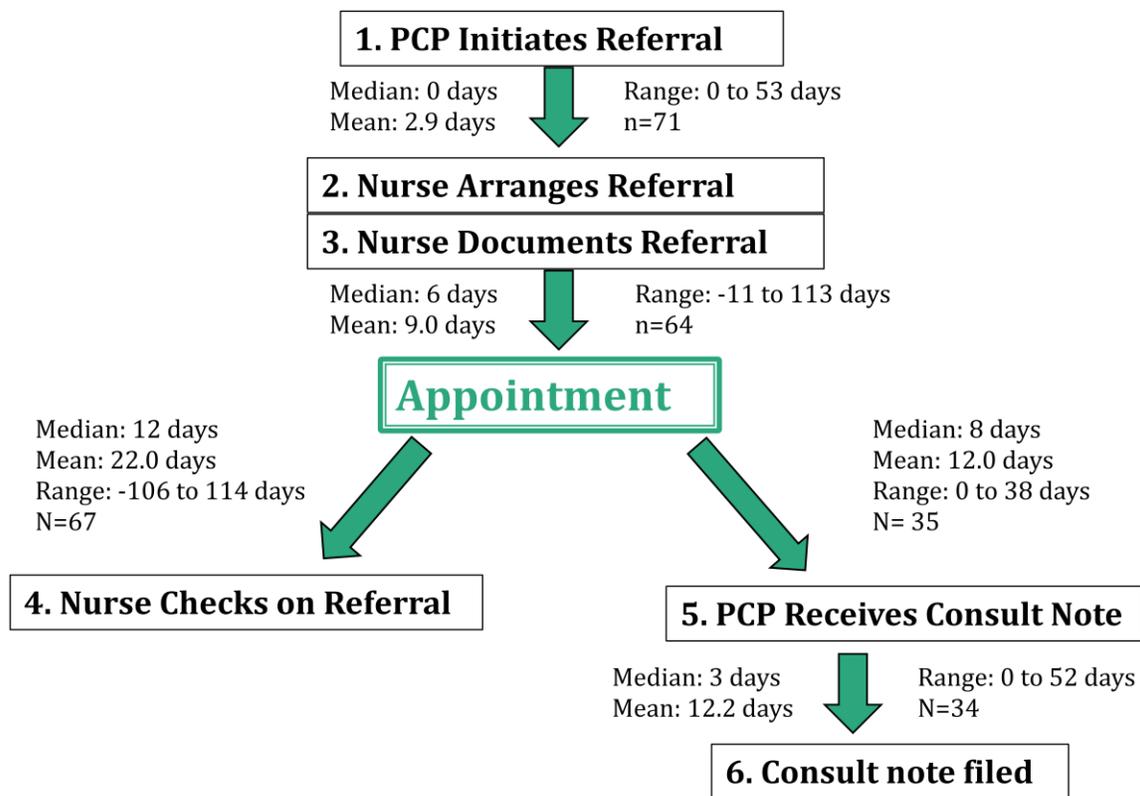
The qualitative analysis of the process revealed gaps at all stages.

- Step 1: The PCP rarely specified the urgency or importance of the referral, such that the nurse did not have this information when arranging the appointment and communicating with the patient.

- Step 2: The necessary documents (e.g. PCP notes, relevant labs and x-rays, etc.) were often not included in faxed referral form. The appointment was often not made in consultation with patient, such that the patient was not asked about the affordability of the appointment, their availability at a given time, their ability to access the specialist's office, or there willingness to even go to this appointment.

- Step 3: There was inconsistency in how nurses document the referral in the online template and binder. Not being able to interrupt workflow and other pressing duties in the clinic seemed to get in the way of completing the referral in a timely fashion and then documenting completion by placing the referral in the binder.

- Step 4: Follow up was done in the very rare moments when the nurses had free time, without consideration for timing or urgency of appointment. The binder system increases inconsistency in how referrals are followed up on and makes it unlikely that they be followed up on more than once. Outstanding referrals are often lost in the shuffle

- Step 5: Missing reports were not followed up on more than once.

- Step 6: Occasional reports go missing and are not scanned into the EHR.

Nurses and MAs expressed their frustration with the referral tracking system. They felt that making referrals took up an enormous amount of their time and interrupted

their clinical workflow, including time with patients. They found in nearly impossible to do anything with the referral forms once they were placed in the binder. I noticed that the majority of follow-up entries occurred in clusters (most frequently on February 1, February 15, and May 8). When I asked the Nurse Manager about this, she said she had periodically reassigned a nurse from other duties to go through everything in the binder when they needed to catch up on referrals. This allowed for a periodic, yet somewhat uncoordinated approach to "cleaning out" the referral back-log.

Discussion

Maintaining parallel systems with an electronic patient record and a paper-based referral tracking system seemed to create many obstacles to the successful coordination of patient care and referrals.

The first problem identified was that only a quarter (25.2%) of the referrals that were requested and initiated by the PCP in the EHR ever made it into the paper-based referral tracking system. This means that, by virtue of maintaining a dual system and not cross-checking the paper and electronic records, three quarters of requested appointments were likely never made or appropriately followed up on.

The second problem identified was that of those 82 referrals that made it into the paper-based referral tracking system, staff at Franklin "closed the loop" (i.e. completed Step 1- Step 6, from requesting the appointment to filing the completed

consult report in the EHR), on only 33 (40.2% of those in tracking; 10.2% of total referrals in the EHR) of them. The most "drop out" occurred in between Steps 3-4, with patients not keeping their appointments in at least 40 cases (48.8% of the time), mostly due to no-shows. While Franklin has historically seen the no-show rate for specialty appointments as outside of their control, the staff might save themselves some trouble (and avoid frustrating the physicians they refer to) by only scheduling appointments which patients are willing and able to keep in the first place (see Recommendations). Other areas where referrals were lost from the tracking process include the arranging the referral (<u>Step 2</u>: 11.0% to be arranged by the specialist and 6.1% with no documentation); checking on the referral (<u>Step 4</u>: 9.8% were never checked and 1.2% had unclear documentation); receiving the consult note (<u>Step 5</u>: 6.1% not received); and filing the consult note (<u>Step 6</u>: 7.3% not filed). The cumbersome nature of the paper-based referral tracking system made it difficult for staff to identify, at quick glance, which referrals still required additional follow up. As a result, many of these referrals fell through the cracks without anyone being aware.

The third problem identified related to the time frames for the referral tracking process. Though the average number of days between steps suggests that referrals were tracked and dealt with in a reasonable time frame, these averages do not reflect a wide variation in the speed and patterns of follow up, with little overall consistency to the effort. Checking on the status of a referral, for example, happened 160 days before the appointment even occurred in one case and 114 days

afterwards in another. This reflects the haphazard approach to following up on referrals. Because the binder system does not allow nurses to sort by appointment date, referrals are simply followed up on in clusters whenever someone is tasked with the responsibility, not following any recommended sequence or time-frame. This results in premature tracking efforts in cases where appointments have not yet happened, and delayed continuity of care and exchange of information where appointments occurred many months back. Delays between the initiation and arranging of a referral (up to 53 days in one case); and between the request of the referral and the appointment (up to 113 days in another case) also suggest delays that may damage efforts at care coordination and be harmful to patient care.

The fourth and final problem identified in my analysis is regarding the challenges faced by the MAs and nurses tasked with the responsibility of initiating and maintaining the referral tracking system. These staff members struggle to keep up with arranging referrals on top of their already hectic and full schedules. The nurse does not automatically receive information about the urgency or importance of the referral and the request often does not include necessary documents like patient notes and labs in faxed referral forms. The nurses station is not set up to facilitate communicate with patients about their needs as nurses arrange appointments; because these appointments are not made in consultation with patients, it is unsurprising that many patients do not go. Finally, the multiple steps required to maintain a paper-based system in parallel with the EHR means that many referrals are not properly documented and get lost in the shuffle. Because there is no system

for pulling up all the referrals made by a provider in a time period three quarters of referrals never enter the tracking process in the first place.

The process of following up on referrals is equally vexing for staff members. With no specific person typically assigned to follow-up on referrals, these tasks are completed in a haphazard manner by an assortment of team members in rare moments of free time. In addition, the paper-based binder system makes it quite cumbersome to "clean out" the referral back-log by determining which referrals need follow-up at that particular time. This poorly coordinated approach resulted in a great deal of inconsistency in how referrals are followed up on, and problems with both the efficiency and effectiveness of the entire process. All in all, it appeared that staff members not provided with the tools and systems they need in order to be able to successfully implement referral tracking.

More research should be done to understand and address the causes of high (48.8%) no-show rates for specialty appointments. Though this has not traditionally been seen as Franklin's responsibility, high no-show rates suggest that patients are not receiving the care recommended by the PCP (perhaps for reasons related to cost, access, or misunderstanding). This has implications on the quality of care patients receive. There is also a large impact on the workloads of staff members, if patients do not go to nearly half of the appointments that nurses spend time arranging and then following up on.

These findings suggest several reasons for Franklin to develop an improved referral tracking process. An improved referral tracking system has the potential to decrease the referrals lost from tracking; increase the proportion of referrals that Franklin has "closed the loop" on; create a consistent standard for the time frames of tracking and follow-up on referrals; reduce frustrations and obstacles to good tracking faced by staff members; and improve the overall efficiency and effectiveness of the referral tracing process.

Recommendations

There are several reasons for Franklin to develop a more efficient and effective referral tracking system, outlined in the discussion above. In addition, referral tracking and care coordination are key elements of NCQA PCMH and Joint Commission accreditation, both of which are being sought by the clinic.

The large proportion of referrals that never make it into the referral tracking system in the first place (74.8% of referrals in the EHR system) demonstrates that the approach of maintaining a paper-based system in parallel with the new EHR is clearly ineffective. Fortunately, the NextGen system does have a way of running "reports" that show all referrals made in NextGen by a specific provider during a given time period. These NextGen reports are already used in other Quality Improvement efforts in the clinic, and if run at regular intervals (weekly or monthly) can provide an accurate, and most importantly complete record of referrals that require tracking.

Regularly running a complete excel-file list of all the recent referrals and referral appointments that require follow-up would positively impact other stages in the referral process. A spreadsheet enables staff to see all referrals made in one place, and, with assistance of the "sort" features in excel, quickly identify all the gaps in care and patients who require follow up. Because the spreadsheet contains the date of the appointment and other key information, this also reduces the number of tracking efforts that are premature (for appointments that have not yet happened) and delayed (for appointments that occurred many months back). This strategy is implemented with great success in the MLK Ob-Gyn department, which has not yet switched to the EHR. They manually enter all referrals into a spreadsheet that they can all access, edit, and work on. As such, they are always aware of the patients and care coordination issues that require additional effort, and they follow up on these issues at fixed intervals to ensure that the loop is closed on all referrals in a timely manner.

In addition to a complete record of referrals, there needs to be better coordinated efforts to make and act upon referrals. The current model of having nurses and MAs squeeze these tasks into their already packed days whenever they have a free moment means that it often does not get done. In the best case scenario it is done haphazardly and inefficiently. Centralizing responsibility for making and following up on referrals to one or two staff members would allow for this process to happen more effectively and efficiently. University of South Alabama's Family Practice

Center has its own Referral Department that is responsible for these tasks so that they do not interrupt the workflow of the clinical staff. The Referral Department itself has clear expectations for what needs to be completed, when, and by whom. Instead of spreading the responsibility over a large and already burdened staff, centralizing the effort makes tasks and responsibilities are clear.

In addition, they are able to do things that the nurses and clinical staff at Franklin simply do not have the time or resources for. The Referral Department is able to make appointments in consultation with patients to ensure the patient is willing and able to go to their appointment and understands the cost to them; they also fax appropriate records and labs to the specialists, ensuring better communication between providers. Because their effort are centralized, they are able to follow up on appointments in clusters, requesting multiple patient records at a time, instead of one at a time. This improves the efficiency of their operation and has the potential to encourage a more coordinated relationship with specialist offices in general.

Because my proposed system involves tracking the completion of each step of a referral in a central, electronically accessible location, the record created also allows for later analysis and quality improvement. Currently there is no way to assess how the clinic is doing on referral tracking other than through completely a time-consuming manual chart review such as the one I did. A new centralized record of referrals allows QI staff to regularly assess and analyze referral tracking data for essential patterns in terms of time lapses, loss to follow-up, no-show rates, specialist

accessibility and consistency of referral tracking. The Referral Department at USA's Family Practice Center switched the ophthalmology group that they referred as a result of one such QI assessment; they identified that this particular group had a pattern of never returning consult reports and so switched to a new group in order to ensure better continuity of care. This is an excellent example of how collecting data empowers primary care offices to notice and act upon such trends.

Conclusion

An efficient and effective referral tracking system is essential to creating a patient-centered care environment, an important priority for Franklin in the coming years. Maintaining parallel systems with an electronic patient record and a paper-based referral tracking system seemed to create many obstacles to the successful coordination of patient care and referrals. My research suggests that a high proportion (74.8%) of referrals are lost from tracking; it is rare to "close the loop" on a referral (40.2% of those in tracking; 10.2% of total referrals); there are very inconsistent time frames for tracking and follow-up on referrals; and staff members feel frustrated by the many obstacles to good tracking efforts.

However, relatively simple changes to the current process could improve the overall efficiency and effectiveness of the referral tracing process. These changes include: switching from a paper-based to an electronic-based tracking system using the reporting features of the EHR; and adjusting staffing responsibilities in the clinic such that there is a centralized department responsible for arranging and tracking

all referral appointments. These strategies have proven effective in similar settings and will help Franklin achieve their goals of improving care coordination and continuity of care on behalf of their patients.

Acknowledgements