Improving Referral Tracking Processes

Juliana Macri, Franklin Primary Health Center, Mobile Alabama
Introduction

- Referral tracking is an **important element** of patient-centered primary care
  - It facilitates *care coordination* and *continuity of care*
- Referral tracking is **required** by key accrediting organizations
  - *For NCQA PCMH:* “5B - Referral tracking and Follow-Up” is a MUST PASS element
  - *For Joint Commission:* requirements to support continuity, coordinate care, and maintain complete records
- Franklin Primary Health Center **struggles** with referral tracking:
  - The unannounced Joint Commission identified a need for “efficient and effective tracking of labs, referrals, and diagnostic procedures”
  - Multiple issues contribute to difficulty with tracking (EHR changes, volume, staffing, processes, challenging population, etc)
1. PCP Initiates Referral
   • “Orders” referral with form
   • Inputs pertinent data into EHR
   • Tasks scheduling to nurse

2. Nurse Arranges Referral
   • Schedules appointment
   • Notifies patient of date, time, location, special instructions
   • Faxes referral form and relevant records to specialist, confirms receipt

3. Nurse Documents Referral
   • Check “referral made” in the EHR checkout template
   • Place referrals in binder or enter in log file

Outside of Franklin:
   • Patient keeps appt
   • Appt affordable / accessible for patient
   • Specialist willing/able to complete request
   • Consult note sent back to PCP
   • Etc.

4. Nurse Checks on Referral
   • 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

5. PCP Receives Consult Note
   • Reviews consult note
   • Requests necessary follow-ups
   • Initials report

6. Consult note filed
   • Medical records files report in patient’s record

Based off “Procedure for Medical Referrals”, Franklin Policies and Procedures Manual, revised 2/11
Methodology

• Quantitative
  • Review 100 records of MLK Adult Medicine patients whose PCPs had requested referrals January 1 - February 28 of 2013
  • Document whether and when the referral made it through each stage of the current tracking system. When not followed through to completion or unnecessary delays occurred, identify gaps

• Qualitative
  • Map recommended referral tracking process using Franklin’s Policies and Procedures Manual
  • Observe current processes used in the clinic and discuss process with clinic staff
  • Conduct literature review of best practices in referral tracking
  • Make recommendations to Franklin for improved referral tracking process
Results: Drop-Out Analysis

1. PCP Initiates Referral
2. Nurse Arranges Referral
3. Nurse Documents Referral
4. Nurse Checks on Referral
5. PCP Receives Consult. Note
6. Consult. note filed

* EHR analysis needed to confirm

N/A
No
Uncertain
Yes
Results: Time Lapses

1. PCP Initiates Referral
   - Median: 0 days
   - Mean: 2.9 days
   - Range: 0 to 53 days
   - N=71

2. Nurse Arranges Referral
   - Median: 6 days
   - Mean: 9.0 days
   - Range: -11 to 113 days
   - N=64

3. Nurse Documents Referral
   - Median: 12 days
   - Mean: 22.0 days
   - Range: -106 to 114 days
   - N=67

Appointment

4. Nurse Checks on Referral

5. PCP Receives Consult Note
   - Median: 3 days
   - Mean: 12.2 days
   - Range: 0 to 52 days
   - N=34

6. Consult note filed

NOTE: Times ONLY include referrals that make it to a particular stage. High-drop out rates are noted.

Best Case Scenario:
* 5 days from start to finish

Worst Case Scenario:
* 84 days from start to finish

Average (Median) Case Scenario:
* 23.5 days from start to finish
Results: Qualitative

- Gaps in process exist at all following stages:
  - 1. **PCP Initiates Referral**: Urgency of referral rarely specified
  - 2. **Nurse Arranges Referral**: Necessary documents often not included in faxed referral form; appointment not made in consultation with patient (timing, cost)
  - 3. **Nurse Documents Referral**: Inconsistency in how nurses document referral in online template and binder
  - 4. **Nurse Checks on Referral**: Done when free time, without consideration for timing or urgency of appointment; no shows inconsistently followed up on; outstanding referrals lost in the shuffle
  - 5. **PCP Receives Consult Note**: Missing reports not followed up on
  - 6. **Consult note filed**: Occasional reports go missing

- No system for pulling up all referrals made by a provider in a time period → uncertainty whether all referrals even enter the tracking process in the first place!!
Discussion

• Causes for concern
  • While many referrals are adequately followed up on, there is no consistency or process that guarantees timely completion
  • No-show rates for appointments are very high (48.8%), and the cause(s) of this must be better understood
  • Staff frustrated by cumbersome process
  • It is very easy for patients to fall through the cracks at any stage in the process, and to have no one notice
• Causes for optimism
  • The NextGen system may allow for improved processes
  • Systems that assign tasks and track progress electronically are successfully used in other aspects of clinic workflow
Recommendations

- Develop an improved template for referral ordering and tracking in the NextGen system
- Run regular (weekly or monthly) reports of recent referrals and referral appointments that require follow-up
- Assign referral follow-up tasks to employees with clear expectations for how much, when, and by whom they need to be completed
- Keep track of referral stages and completion in a central, electronically accessible location
- Regularly assess and analyze referral tracking data for essential patterns (time lapses, drop-out, no-show rates, specialist accessibility and consistency, etc)
Conclusion

• An efficient and effective referral tracking system is essential to creating a patient-centered care environment

• The current system does not consistently guarantee timely follow-up

• There are many opportunities to streamline the current system using electronic system

• Acknowledgements
  • Thank you to Ms. Mitchell, Ms. McAuthor, Ms. Singleton, Ms. Perry and the staff of MLK Adult Medicine for their assistance with this project.
  • Thank you to GE-NMF Primary Care Leadership Program for sponsoring this program.