BHICCI

Core Competencies, Chapter 14

Subject: Coordinating and Tracking Referrals

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Why Coordinating and Tracking Referrals is Important to Integrated Complex Care

A central goal of Patient Centered Medical Home and BHICCI is to reduce fragmentation of care. Referral management constitutes a critical component of care coordination. Without it being done effectively, there is risk for loss of continuity in care, as well as frustration and confusion for patients, especially those with high needs and limited or poor access to specialty care. Poor coordination and tracking of referrals leads to reductions in the quality, safety, and effectiveness of care, lower levels of client/patient engagement, and greater costs.

Best practices based on Patient Centered Medical Home guidelines and lessons learned from the field can provide clear steps and solutions for developing better referral management approaches. Coordinating and tracking referrals is a “must have” element for the BHICCI.

Example

Karen, a 47-year-old mother of three teenagers and returning to nursing student, is diagnosed with poorly controlled diabetes mellitus Type I. She is currently maintained on an insulin pump. She also has poorly controlled hypertension, body mass index=32, a history of complex post-traumatic stress disorder and a recent reoccurring episode of major depression. She presents to an emergency room physician for chest pain and is diagnosed with panic attack but also expresses concern about her poorly controlled and erratic blood sugars levels. When the emergency room physician learned that she hadn’t attended a scheduled referral appointment made by her primary care provider to an endocrinologist three months ago, the emergency room physician told her “You’ve got to think more about taking better care of yourself.” He arranged appointment with her primary care provider the next day.

At the primary care provider appointment, Karen and her primary care provider collaborated to create a new action plan to start a new anti-depressant, and short-term benzodiazepine. The primary care provider also used Motivational Interviewing to assess the patient’s conviction to work on stress management and panic to reduce how it interfered with her life.

Understanding the need for frequent contact by phone and in-person until Karen was stable, the primary care provider asked permission of the patient to meet her behavioral health clinician. He also requested a weekly check-in for the next month. The patient agreed, cried, and expressed relief.

The primary care provider established the following **referrals**:

1. Behavioral Health Clinician
2. Care Manager for weekly check-in for the next month

The primary care provider created new referrals in the electronic health records.

Narrative Description

An effective referral tracking and management system includes the following components:

Assigning responsibility for tracking the making and follow up of referrals. This includes tracking appointments made, patient information received, appointments completed, consultation note received, and clinical follow-up on recommendations. The latter two processes are often referred to as “closing the loop”.

Supporting patients during the referral process. Provide patient support. Referrals in a complex health system can be overwhelming and difficult to understand. Safety net client/patients have higher rates of low health literacy and can be further compromised by their complex conditions. Staff should be prepared to offer extra assistance to patients to help them to understand, find, schedule, and offer reminders for patient follow up. Staff should leverage the trust and respect engendered by the current caregiver team to maximize likelihood of patient follow through. The use of personal linkages such as "warm handoff" techniques should be considered whenever possible.

Listening for a client/patient's level of readiness and activation to accept a referral such as a specialty medical service, a mental health or substance use disorder service, or community resources will increase the likelihood of the healthcare team members creating a referral that client/patient understands, wants, and is confident they can pursue. A key distinguishing feature of a BHICCI Approach to coordinating and tracking referrals is the simultaneous attention to the evidence-based skills of effective communication skills based on motivational interviewing and empathic listening.

Maximizing communications between providers in a referral relationship. The quality of information contained within referrals and consultations affects the quality of care. A goal in this area might address creating standardized structured information, formats, and forms to promote efficiency.

Available Resources

1. Referral Coordinator Job Description- http://www.improvingchroniccare.org/downloads/4_referral_coordinator_job_description.pdf
2. Referral Coordinator Curriculum- http://www.improvingchroniccare.org/downloads/5_referral_coordinator_curriculum.pdf
3. Care Coordination http://www.safetynetmedicalhome.org/change-concepts/care-coordination
4. Closing the Loop with Referral Management- http://www.safetynetmedicalhome.org/sites/default/files/Webinar-Closing-Loop-ReferralManagement.pdf
5. Enhancing continuity of information: Essential components of a referral document- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2567257/

BHICCI Plan for Learning / Teaching / Coaching

- Agency reads the materials presented in Core Competency 13 - Coordinating and Tracking Referrals, and discuss with the practice coach.
    - Audience: Leadership, Clinical Leadership & Referral Coordinator

- Webinar Presentation/discussion: Review of basics of Coordinating and Tracking Referrals.
    - Assess their current capacity for complex care referral management, map a current and future state workflow and a gap analysis.
    - HCO's identify areas of strengths, barriers, and areas of improvement for consultation and coaching.
    - Develop a Plan for next steps of implementation at end of Webinar or training to implement Coordinating and Tracking Referrals using PDSA.
        - Audience: Leadership, Clinical Leadership & Referral Coordinator.

- Follow up Coaching (call, in person or materials sent) by JCC team. Could include:
    - Webinar training
    - Coaching call
    - Coach on site observation of skill set
    - Sent materials

- Option for continued Coaching by JCC team on Coordinating and Tracking Referrals.

How will Competence in this area be Measured?

Following completion/verification of the above learning/teaching/coaching plan, each clinician will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician's competency in each of the following by:

1. Case discussion of 3 or more complex care patients, or
2. Chart review of 5 or more patients, or
3. Direct observation of clinician interaction and conversation with patients/clients and other departments.

COMPETENCY AREA	EVIDENCED BY	SUPERVISOR'S RATING*
All providers engage the patient and create specific service provider referrals during the point of care.	• Patient/client is engaged in the referral process and understands reason for referral. • Special focus of referral is noted by provider in notes section • Specialty visits driven by patients. drive referral creation.	1 2 3 4 5
Clinicians will demonstrate efficacy in Motivational Interviewing	• Acknowledges the perspectives of the patient/client during discussions to decide on appropriate referral • Motivational interviewing strategies are used to help patient/client identify what services they are willing to engage in.	1 2 3 4 5
Clinicians will support patient/client in developing health goals and referrals.	• Support patient/client in developing self-selected specialty referrals in collaboration with provider. • Support patient/client in developing a treatment plan related to their own health goals to include referrals to specialty providers. • Documentation contains patient/client voice.	1 2 3 4 5

*1= Excellent results with no need for prompting or support.
3 = good results and/or required some prompting or support.
5 = required much support and/or was unable to complete necessary skills.