TBC

Team Based Care

# Referral Management

**Ensuring timely linkage to and completion of services outside the primary care office and facilitating a timely exchange of information among providers.**

## Key Changes

- **Assume** team accountability for ensuring that all referrals meet the time sensitive needs of the patients and providers.
- **Select** and **train** staff to track and manage referrals.
- **Reach out** to specialists, hospitals, and community service agencies to **develop** partnerships to facilitate the referral process.
- **Develop** standard ways of exchanging referral information.
- **Create** workflows to ensure the referral loop gets closed.

## Examples

- Identify staff with excellent communication skills to work with patients, families and specialty care providers.
- Establish standards for assuring complete referrals to specialty care.
- Work with frequent referral providers to streamline the process for the patient.
- Use care compacts to list explicit expectations for referrals regarding return of information and the patient to the practice.
- Reach out to all patients who fail to keep referral appointments-document reason for no-show. Understand and address no-show causes.
- Set up process to decrease the number of open referrals that includes confirming with the patient that they intend to go to the specialist (creating fewer referrals). Establish standards and scripts for confirming that the patient wants the referral.
- Use EHR tracking software to record all referrals.
- Set up process to close referrals once results are returned and reviewed by PCP.
- Set up process to track and follow-up with all open referrals.
- Ask patients how to best support their referral experience.

# Primary Care Team Guide Assessment-Related Questions

**Layperson (Individuals without formal clinical training (e.g. Community Health Workers, Patient Navigators))**

| | Components | Level D | Level C | Level B | Level A |
|---|---|---|---|---|---|
| 11 | Laypersons in our practice… | are not involved in clinical care. 1☐ 2☐ 3☐ | mostly provide non-clinical patient-facing roles such as reception or referral management. 4☐ 5☐ 6☐ | include individuals who do one or more of the following: provide self-management coaching, coordinate care, help patients navigate the health care system, or access community services. 7☐ 8☐ 9☐ | perform the functions in Level B and are key members of core practice teams. 10☐ 11☐ 12☐ |

**Referral Management**

| | Components | Level D | Level C | Level B | Level A |
|---|---|---|---|---|---|
| 22 | Patients in need of specialty care, hospital care, or supportive community-based resources… | cannot reliably obtain needed referrals to partners with whom the practice has a relationship. 1☐ 2☐ 3☐ | obtain needed referrals to partners with whom the practice has a relationship. 4☐ 5☐ 6☐ | obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance. 7☐ 8☐ 9☐ | obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs. 10☐ 11☐ 12☐ |

**Clinic-Community Connections**

| | Components | Level D | Level C | Level B | Level A |
|---|---|---|---|---|---|
| 27 | Linking patients to supportive community-based resources… | is not done systematically. 1☐ 2☐ 3☐ | is limited to providing patients a list of identified community resources in an accessible format. 4☐ 5☐ 6☐ | is accomplished through a designated staff person or resource responsible for connecting patients with community resources. 7☐ 8☐ 9☐ | is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person. 10☐ 11☐ 12☐ |

## How Primary Care Teams Achieve the Quadruple Aim