REFERRAL MANAGEMENT CC 4

Purpose

The Clinic coordinates referrals for all patients.

Policy

It is the policy of the Clinic to coordinate referrals for all patients.

Procedure

When they establish with the Clinic, patients are informed that they should communicate with the Clinic if they are seen by another health care provider. As the patient's medical home, the Clinic encourages patients to contact the office in order to schedule specialty appointments and coordinate care. Patients are encouraged to communicate this information in order to maintain a complete record of their care in order that their chosen personal provider and care team can coordinate their care. This encouragement is also made available through the Clinic intake paperwork and, when applicable, in other Clinic promotional efforts. Providers routinely ask patients if they have seen a specialist or are receiving care form a specialist. If the patient has been treated by a specialist, the report is requested for inclusion in the patient's medical record.

The Clinic tracks referrals to specialists, including medical, behavioral health and substance abuse specialists, using an electronic reporting system. Referrals tracked are those determined by the patient's primary provider and care team to be important for a patient's treatment or as indicated by evidence-based guidelines.

1. Clinical Provider generates referral through electronic health record.
2. Clinical Provider writes referral information on half sheet for patient visit. Visit sheet is routed to Drug Assistance Coordinator (Tuesday, Wednesday, Thursday) or Care Coordinator's (Monday) desk.
3. Staff member calls specialty office to schedule appointment for patient.
4. If multiple physicians of the same specialty are located in the same office, the Clinic keeps track of this and rotates patients to spread referrals evenly between offices.
5. Staff member completes referral form in patient medical record with all necessary information then prints and faxes referral form, exam notes (including reason for referral, patient demographics and language preference, medication list, allergies, current treatment, hospital medical home, recent lab/testing results, etc.) and date/time of appointment to specialty office.

6. Staff member calls patient to inform them of appointment.
7. Staff members enters referral appointment date/time into patient electronic health record.

The Clinic tracks the following factors for referrals in the electronic health record and this information is included in the referral sent to the specialty provider's office:

- ✓ Date of initiation of referral;
- ✓ Ordering provider;
- ✓ Reason for the referral;
- ✓ Referral type: Consultation, Single Visit, Co-Management of patient
- ✓ Relative urgency of the referral. Per current protocol, the urgency is defined by: STAT – within 24 hours; Urgent – 24 to 72 hours; Routine – 72 hours to two weeks;
- ✓ Relevant clinical information as it pertains to the referral including current medication list; diagnoses; allergies; medical and family social history; substance abuse and behaviors affecting health; and recent test results;
- ✓ Date/time of specialty appointment;
- ✓ Whether consultation/referral report is received from specialist;
- ✓ Required communication or follow-up for the referral.

Once referral is made and appointment date has passed, the specialty office sends the notes to the Clinic via fax or Clinic inbox in the hospital electronic health record. If Clinic staff need to obtain specialty notes not already sent, there are two mechanisms to obtain them. Clinic staff retrieves specialty visit notes from hospital electronic health record (if available) or calls the physician's office to request notes be faxed to CHCC for offices that do not exchange electronic health records. Once notes are obtained, they are entered into referral section of clinic patient record, and sent to the patient's primary provider, who reviews and signs the specialty notes. They are then placed in the patient's paper chart. All referrals are entered and tracked in the patient's EHR. The Care Coordinator runs a weekly report to ensure all referrals are made within the specified time frame. At least monthly, Operations Manager and/or Care Coordinator will run referral report to ensure all referrals are made and all specialty notes are obtained from referral visits that occurred the previous month.

For patients who are regularly treated by a specific specialist, the patient's provider and the specialist enter into an agreement that enables co-management of the patient's care and includes timely sharing of changes in patient status and treatment plan. For co-managed patients, the patient's provider gives information to the specialist and receives information from the specialist within a period agreed to by both parties. All communications, including the agreement(s), are documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

At least weekly, the Care Coordinator reviews the referral report in the EHR to ensure all referrals have been made and makes any appointments that are outstanding. At least monthly, CHCC staff reviews the referral report in the EHR to ensure all referrals have been made and specialty notes have been obtained and entered into patient EHR. Any referrals not yet made, will be made immediately and/or staff will consult with referring provider to determine if referral is still necessary. If no longer needed, change in treatment plan will be updated in EHR.
The Clinic considers available performance information regarding specialists, facilities and other external providers to whom referral recommendations are made. Sources may include, but are not limited to, local hospital privileging systems, state physician report cards, and state licensure database.

Quality Control

The Clinic monitors the policy and procedure in the following manner:

Annual monitoring of consultative reports, to include turnaround time and the volume of outstanding referrals. If one type of referral is deemed to be untimely in notification, the Executive Director reviews the situation to determine if an intervention with the specialist's office is in order.

Quarterly review of provision of summary of care records to show the total number of referrals made and how many of those referrals had a complete transition of care (referral sent, notes obtained and entered into clinic EHR, and medication/care follow-up complete).

Approved 6/1/14