Improving Access and Referral Management
CP3 Toolkit: Building and Strengthening the Care Team

The following is adapted from a September 21, 2016 presentation by Carolyn Shepherd, formerly of Clinica Family Health in Colorado. It describes the goals and action steps involved in improving access to care and the referral process. Download the complete presentation.

Steps to Improving Access to Care
- What is the goal of access?
  - Provide the right care, at the right time, in the right place by the right people 100% of the time
  - Engage and assume accountability for the clinic population
  - Gain an understanding of the individual needs and tailor services to those needs
  - Optimize our care team resources

- What are the components?
  - Optimize the Care Team
  - Reduce demand for in-clinic visits
  - Develop contingency plans
  - Measure and report access
  - Change the scheduling paradigm

- Optimizing the Care Team
  - Set expectation for care and outcomes, not visits
  - Set the expectation for team work not individual autonomy
  - Include the patient in the team
  - Work at "top of license"
  - Initiate appropriate care with standing orders
  - Drive for 100% continuity

- Options to reduce demand for in-clinic visits
  - Improve continuity
  - Alternative visits-phones, text, skype, secure messaging, EHR portals, groups (SMAs)
  - Time/stagger outreach
  - Extend visit intervals when appropriate
  - Same day access
  - Max pack when possible

- Develop contingency plans to increase visit supply
    - Mondays, holidays, flu season, August
    - Control high demand vacation times
    - Plan vacancies, scheduling FMLA
    - Hiring in early so trained and ready
    - Providers and nurses get flu vaccines
    - DIGMAs or cluster visits on each pod in heavy seasons
    - Accept 4th year medical students for rotations
    - Adjust meeting schedules
    - Increase nurse/pharmacist/BHP time for visits

- Develop contingency plans to reduce demand
    - Give as many flu shots as possible
    - Adjust periodic care off high demand days and seasons
        - Routine prenatal, well exams, chronic care not on Mondays
        - Well-child checks in April and May
        - Well exams for seniors, adults, OCPs, kids>2 not Jan-Mar
    - Stagger flu card mail out
    - Master schedule Mondays in flu season
    - Decrease unnecessary provider visits-excuses
    - Increase alternative visits when demand goes up
    - Insured patients get lab work off site when possible

- Measure and report access
    - Patient reported experience measure
    - Time to third next appointment
    - Percent future capacity open
    - Continuity

- Scheduling paradigm-consider Advanced Access
    - Decrease appointment types
    - Balance demand and supply daily
    - Max-pack visits
    - Reduce backlog
    - Comb schedule to pull work to today
    - Process for resetting intervals

Steps to Improving Referral Management

- What is the goal of referral management?
    - Assume accountability
    - Provide patient support
    - Build relationships and agreements
    - Develop connectivity

- Alignment with Care Coordination
    - Care Coordination: logistical (e.g., referral management, tracking hospitalizations, ED visits, labs and radiology)
    - Clinical follow-up care: logistical (e.g., clinical monitoring)
    - Clinical care management: medication management, addressing social determinants of health, logistical, clinical monitoring

- Staffing
    - Select and train staff to track and manage referrals
    - Select referral coordinator
    - Develop referral tracking system
    - Help patients identify sources of service and make appointments
    - Ensures transfer of information
    - Design standardized referral entry in EHR
    - Track referrals
    - Work with CMO to develop outside referral guidelines
    - Develop workflows to optimize internal referrals

- Communicating across the care team
    - Reach out to specialists, hospitals & community agencies
        - Primary care leader role
        - Address specialist's legitimate concerns
        - Agreements in writing or incorporated into e-referral systems.
    - Create workflows to ensure the referral loop gets closed (e.g., with providers, with patients and families)

- Develop standard ways of exchanging information
    - Streamline data entry
    - Address complaints from both PCPs and specialists focus on communication
    - Standardized formats increase provider satisfaction
        - Shared EMR

3

- E-referral
- Structured referral forms

- Support patients
  - Review patient's intentions
  - Help patients identify sources of service
  - Help make appointments
  - Track referrals—help resolve problems
  - Ensure transfer of information

- Communicate test results and care plans to patients/families