



Closing the Loop on Referrals

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Learning Objectives

1. Describe best-practice methods to determine whether or not a referral was completed
2. Define roles and responsibilities for clinic staff in referral follow-up
3. Identify a change idea to test

Closing the Loop: What's the Problem?



- Closing the loop is time consuming and often unsuccessful
- Uncertainty around whether patients needs are being met
- Staff feel an overwhelming sense of responsibility to take this on

What are your pain points?

What strategies can we use to better close the loop on referrals to social services?

Think about:

- What am I doing that is already working well?
- What is something I could try out within my clinic?

Strategies to Close the Loop

1. Improve the Referral Process
2. Developing Partnerships
3. Technology Solutions
4. Patient Follow-Up

Strategy #1: Improve the Referral Process

Change Idea: Active Referrals

The referring provider makes a direct connection to the community-based organization (i.e. by calling or online) rather than asking the patient to just go on their own.

Test it!

- Try making an active referral to your community-based partner for the first 3 patients who screen positive next week.

Strategy #1: Improve the Referral Process

Change Idea: Teach Back

A method to check understanding by asking patients to state in their own words what they need to know or do about their health.

Test it!

- Identify a care team member who frequently utilizes teach back and have them test the methodology on a patient who screens positive on Thursday

Strategy #1: Improve the Referral Process

Change Idea: Engaging the Family

Family members can play an important role on the patient's care team. Develop care plans in partnership with the patient and family members. Provide families and caregivers an opportunity to review each community resource and provide feedback on ease of referral and utility of each resource.

Test it!

- Develop a list of community-based options for patients who screen positive. Ask the first patient and family member who screens positive on Friday about their preference.

Strategy #2: Developing Partnerships

Change Idea: Follow up with the community partner instead of the patient

Formalize relationships with community-based organizations who have been developed for referrals and develop communication channels to share referral and completion information.

Test it!

→ On Monday, call someone you know at your community-based partner and see if you can develop a process for reporting back on referrals and test it with one patient.

Strategy #3: Technology Solutions

Change Idea: Utilize a Resource and Referral Database

Resource databases (i.e. Healthify, Aunt Bertha, OneDegree, etc.) provide for sourcing, referral, and follow-up to various community resources via a technology platform.

Test it!

- Tomorrow, call a fellow clinic who has utilized a resource database and inquire about the pros and cons. Develop a listing of ways technology might improve your closing the loop process and share it with senior leadership.

Strategy #4: Patient Follow-Up

Change Idea: Follow-up with the patient the next time they come into the clinic

Patient registries can be helpful to maintain a record of all patients who screen positive for a social need. Flagging these patients prior to their next appointment can allow for targeted follow-up to see if they connected with the community based partner and if not, what barriers they faced.

Test it!

- On Tuesday, conduct a chart review of the first 10 patients who have scheduled appointments at the clinic on Friday. Make a list of any who have previously been referred to a community partner and ask them if the referral was completed during their appointment.

Discussion

What strategies are you employing to close the referral loop?

What ideas have you heard that you might want to test?

Other Considerations

How are you tracking referrals that have been issued/completed?

When you have been able to successfully close the loop – was anything done differently?

What roles and responsibilities should clinic staff take on in closing the referral loop?

Who is responsible?

Who is responsible for closing the referral loop at your clinic?

- How were they selected?
- Do they have clearly defined roles/responsibilities?

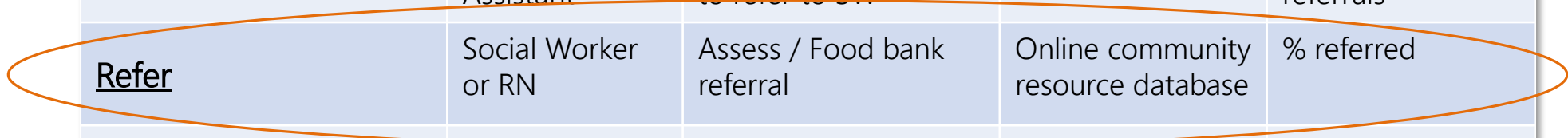
Who can you tap into to close the loop?



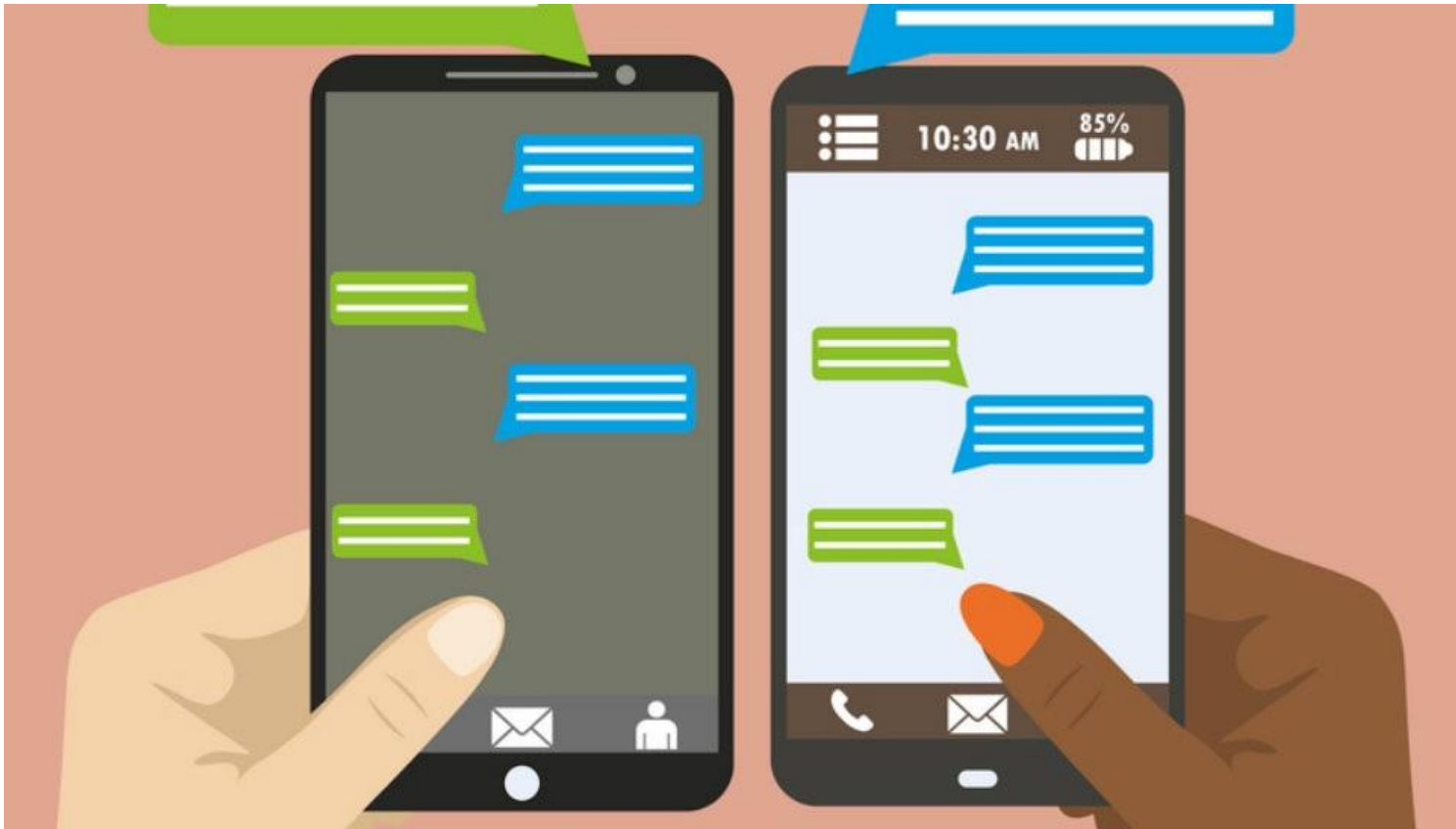
Examining Existing Workflows

How can you identify other referral processes within your clinic (i.e. referral to a specialist) and integrate community-based referral into those existing workflows?

Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Clinical-Community Partnership Team	Upstream QI committee	Project Team oversees & tracks PDSAs	"Upstream Project Canvas"	# QI team participation # PDSAs
<u>Pre-visit</u>	Patient	Patients receive automated info on food resources	Automated SMS (e.g. via CareMessage)	# Message open rate
<u>Screen</u>	Medical Assistant	Ask during vitals of diabetics	2-item food insecurity screener	% screened
<u>Triage</u>	Medical Assistant	Flag in EMR	Triage Protocol	% positive % flagged
<u>Exam</u>	PCP	Review / Adjust treatment plan if food insecure	EMR autopopulates Problem List	% plans updated
<u>Chart/Code</u>	Medical Assistant	Scribe, standing order to refer to SW	EMR	% internal referrals
<u>Refer</u>	Social Worker or RN	Assess / Food bank referral	Online community resource database	% referred
<u>Post-visit</u>	Social Worker or RN	Q1month or more check-in based on risk	EMR CRM	% decrease in food insecurity & utilization



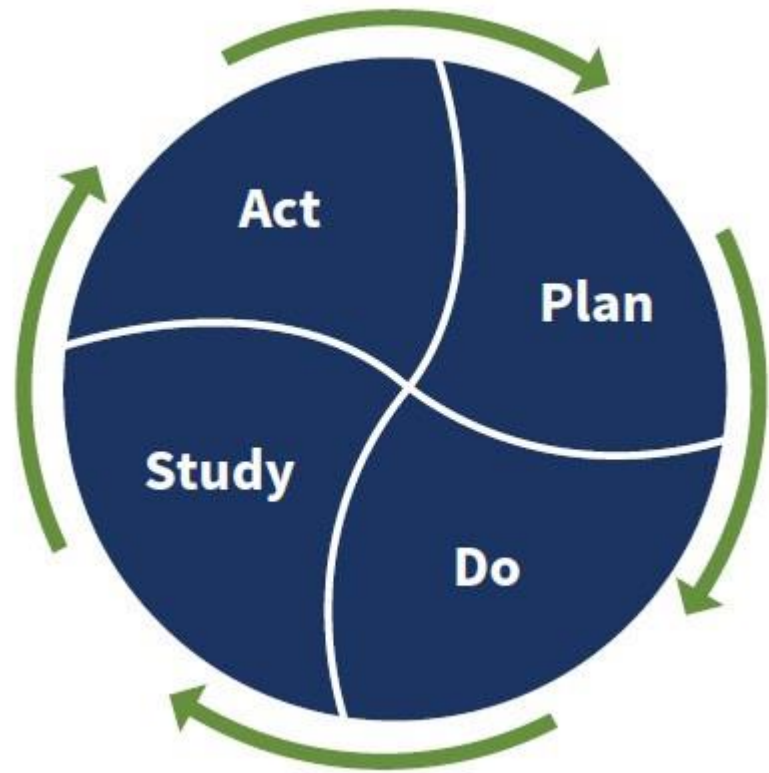
Different Ways to Follow-Up



As you think about defining workflows for follow-up, what are alternatives to telephone calls that might better meet patients where they're at?

- HIPPA-compliant Texting
- Email
- MyChart

Food for thought: When is enough,
enough?

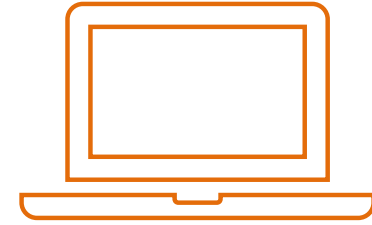


What are you
going to do
by next
Tuesday?

Thank you!
We're here to help.

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