Referral and Care Coordination

May 2015
We Want To Hear From You!

Type questions into the **Questions Pane** at any time during this presentation.
Oregon’s PCPCH Model is defined by six core attributes, each with specific standards and measures

• **Access to Care**  “Health care team, be there when we need you”

• **Accountability**  “Take responsibility for making sure we receive the best possible health care”

• **Comprehensive Whole Person Care**  “Provide or help us get the health care, information and services we need”

• **Continuity**  “Be our partner over time in caring for us”

• **Coordination and Integration**  “Help us navigate the health care system to get the care we need in a safe and timely way”

• **Person and Family Centered Care**  “Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness”

Learn more: [http://primarycarehome.oregon.gov](http://primarycarehome.oregon.gov)
Introduce Presenter

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CareOregon
Yamhill Community Care Organization

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Project Manager

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Member Engagement Specialist
Learning Objectives

• Describe clinic approaches to develop and implement systems of patient care coordination and referral tracking in patient-centered medical homes

• Name the four characteristics of effective care coordination

• Identify at least two strategies to engage and work with community partners in care coordination and referral tracking
Why Care Coordination and Referral Tracking?

• Key to good patient care

• Hub is a key function of a primary care home

• The system is complex, so tracking can be challenging for patients and families
What is care integration?

“Patient care that is coordinated across professionals, facilities, and support systems; Continuous over time and between visits; Tailored to the patients’ needs and preferences; And based on shared responsibility between patient and caregivers for optimizing health”

Strategies for care integration

Comprehensiveness: Bringing services into primary care
- Colocation of additional services into primary care
- Capacity building of primary care providers

Coordination: Building relationships with services outside of primary care
- Defining and developing a network of service providers
- Improving patient navigation and engagement
- Improving communication and collaboration
What’s the difference?

**Care coordination:** Referral or transition management, limiting its use to describe the essentially non-clinical but important functions such as providing information and logistical help to referred patients, assuring timely and effective transfer of patient information, and tracking referrals and transitions to identify and potentially remedy glitches.

**Often done by:**
- Front Desk
- MA
- Referral Coordinator
- LPN

**Care management:** More of a clinical role, providing health coaching, clinical care and social work/mental health support for patients with poorly controlled illness or inappropriate use of healthcare resources. Care managers also do care coordination but practice staff with care coordination responsibilities do not do care management.

**Often done by:**
- RN
- Case Manager
- Social Worker
- Health Coach
POLL – Which Tasks are Performed by a Care Coordinator?

A. A referral coordinator in a primary care practice checks with a health plan to see if it has approved a CT scan for a patient.

B. A social worker has a discussion with a high-utilizing patient about alternatives to calling 911.

C. A front desk staff member emails the emergency department of both hospitals every morning to see if any of the practice’s patients have been to the ED in the past 24 hours and to get the ED record.

D. An RN provides coaching on using inhalers for COPD.

E. A medical assistant goes over the referral log and contacts specialists who have not sent reports from the specialty visits that the patients were scheduled to make.
What do you think?

- What would you say is your top barrier you’ve encountered in doing this work?

Use the **Questions Pane** to share answers to these questions.
Common Referral Tracking Story

Prior to System

• No idea if patient followed up with specialist
• Disjointed care
• PCP not sure what is going on
• Over 500 open referrals going back over a year (at just one clinic)

After System

• Referrals closed in timely manner
• Able to track if received note back
• PCP & Care Team able to follow-up on recommendations
• Have clean up process in place
Staffing Models
POLL: What works best?

A. One dedicated referral coordinator for seven providers
B. MA for the provider originates the referral and front desk tracks
C. Pod coordinator includes this task among many
D. Offsite referral coordination with communication through inbox messaging
Additional Skill Sets

• Bilingual
• Customer service skills
  – Internal and external rapport
• Some medical knowledge (i.e. in work hx); but not too much where they may get pulled!
• Multi-task; project management experience
Process Needed

- Standard referral ordering process for all providers
- Partner agreements for feedback loop, accountability
- Number outreach attempts (to specialist and patient);
  - Create standardized messaging and scripts for efficiency
- Tracking mechanism (i.e. excel, EMR)
- When is a referral considered complete?
- Clean up guidelines (i.e. referral closed by the provider)
Ideal Workflow

Provider/Care Team Member Orders Referral

Referral Created

Logged Into System

Referral Paperwork Sent to Specialist

Patient Goes to Specialist

Specialist Sends Back Note to Clinic

Note Reviewed by Provider

Changes to plan of care

Referral Closed
Example Clean Up Workflow

1. Referral Coordinator runs report in EMR for list of “open” referrals.
2. Looks in chart for report.
   - Close Referral if report in chart.
   - No Report:
     - Call Office to see if patient went to appointment.
       - Yes:
         - Request report be sent to office.
         - Close referral when report received.
         - Give report to PCP for review.
       - No:
         - Let Care Coordinator know patient did not attend.
         - Care Coordinator to follow up with patient and team.
About Yamhill CCO

- Grassroots startup
- Community owned, 501c3
- One single county, which makes us unique
- Pop = 100,000, 25% OHP, 65% of those are children,
- Hispanic pop = 30%
- Geographically rural, with two urban-ish areas (Mac & Newberg)
- Community EMS Program – West Valley Fire District

- Community Health Worker Hub
- Project Able Peer Support
- Persistent Pain Program
- Chronic Self-Management Programs
- Maternal Medical Home model
- Early Learning Hub is the YCCO
- Behaviorists imbedded in PCPCH
- PCPCH (VG) in YC HHS
Physician’s Medical Center – has recreated our Family CORE Referral Form and the Community Health Hub Referral Form in their EHR and have already seen increased referrals.
Family CORE
Coordinated 0-5 years Referral Exchange
Referral form for prenatal, infant and young children home visitation prog
Those with chronic medical conditions are eligible up to age 21 years

Please fax this form to 503-472-9731
The person or family being referred will be contacted.
We will provide a follow-up letter to you regarding the outcome of the referral.
For questions or mailed submissions please call Public Health 503-434-7525
412 NE Ford Street, McMinnville, OR 97128

Date: ______________

Child OR pregnant women being referred:

Due Date (if applicable) ____________________________ Date of Birth: ______________

Parent or Guardian names (If a child):

_________________________ Relationship:__________ Date of Birth: ______________

_________________________ Relationship:__________ Date of Birth: ______________

Phone number ____________________________
Home address ____________________________

Primary Language________________________

Does the family know about this referral  O YES  O NO

Please check all that apply

O Medical condition
   Please specify________________________

O Teen parent

O Parent with developmental delays

O Child with or at risk for developmental delays

O Infant feeding/weight gain problems

O Risk of maternal depression

O Isolation/lack of support

O Challenging child behaviors

Additional Information:

__________________________________________

Referring Source Information:
Person (provider) to receive referral follow-up information: ________________________
Person/Organization completing referral form: _______________________________________
Phone Number: __________________________ Fax Number: ___________________________
Yamhill Community Care Organization
Community Health Hub Referral

All referrals should be faxed to:
503-857-0767

Use this form if you have a patient who needs additional support. You may request a specific service (see back/page 2) or simply describe the patient’s needs and we will direct the patient to appropriate care.

PATIENT/MEMBER/INDIVIDUAL BEING REFERRED

Name: ___________________________ DOB: ___________________________

Phone #: _________________________ YCCO/Medicaid ID #: ___________________________

Address: __________________________ Language: ___________________________

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

Please provide as much information as possible so that your referral can be assigned to the appropriate resource. (see back/page 2 for more information.)

☐ Frequent ED visits
☐ No PCP engagement
☐ Complex health issues
☐ Lack of support system (crisis management, socialization)
☐ Chronic disease management
☐ Tobacco addiction
☐ Needs MDT discussion (see back/page 2)

Additional Information: __________________________

PERSON MAKING THE REFERRAL

Date of Referral: ________________ Your Name: ___________________________

Name of Clinic/Hospital/Organization: __________________________

Contact Phone #: __________________________

Preferred Method of Contact (fax # or email address): __________________________
<table>
<thead>
<tr>
<th><strong>Community Health Hub Resources</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multi-Disciplinary Team</strong></td>
</tr>
<tr>
<td>Patients should meet at least one of the criteria for referral. Check box to refer.</td>
</tr>
<tr>
<td>Multiple members of a high-need patient’s care team (primary care, behavioral health, etc.) meet to discuss intensive coordination of care for their patient. Attendance by the person who made the initial referral is encouraged. MDT meetings occur monthly at the CCO offices on the 4th Thursday of the month, 8-9pm. Each discussion is estimated to take approximately 15 minutes.</td>
</tr>
<tr>
<td>Available only to CCO members 65 years or older:</td>
</tr>
<tr>
<td><strong>Community Health Worker</strong></td>
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<tr>
<td>Community Health Workers partner with members to remove barriers to being healthy, receiving health care, and navigating resources.</td>
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<tr>
<td><strong>Criteria for referral</strong></td>
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<tr>
<td>High utilizer of inpatient hospital stays</td>
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<tr>
<td>Has one or more chronic conditions</td>
</tr>
<tr>
<td>Not engaged with Primary Care Provider</td>
</tr>
<tr>
<td><strong>Persistent Pain Clinic</strong></td>
</tr>
<tr>
<td>This 8-week program aims to reduce opioid misuse and help patients manage chronic pain in more holistic, effective ways.</td>
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<tr>
<td><strong>Criteria for referral</strong></td>
</tr>
<tr>
<td>Patient with chronic pain who is struggling to manage it</td>
</tr>
<tr>
<td>Available to all patients who meet criteria:</td>
</tr>
<tr>
<td><strong>Community EMS Services</strong></td>
</tr>
<tr>
<td>Community EMS services offers mobile healthcare, reducing the transportation barrier and reducing expensive and preventable ED visits.</td>
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<tr>
<td><strong>Criteria for referral</strong></td>
</tr>
<tr>
<td>High utilizer of healthcare services in Yamhill County</td>
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<tr>
<td>Patient with chronic diseases needing routine care</td>
</tr>
<tr>
<td>Care does not qualify for Home Health Services</td>
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<tr>
<td>Needs post-discharge follow-up care</td>
</tr>
<tr>
<td><strong>Health and Wellness Workshop</strong></td>
</tr>
<tr>
<td>Health workshops, like Living Well and Walk with Ease, encourage patients’ empowerment in their own care and small steps towards healthier lifestyles.</td>
</tr>
<tr>
<td><strong>Criteria for referral</strong></td>
</tr>
<tr>
<td>Anyone with a chronic disease</td>
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<tr>
<td>Family members or caretakers of someone with a chronic disease</td>
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<tr>
<td><strong>Project ABLE</strong></td>
</tr>
<tr>
<td>Project ABLE provides peer, team-based, and phone support to vulnerable patients, as well as employment resources and wellness activities.</td>
</tr>
<tr>
<td><strong>Criteria for referral</strong></td>
</tr>
<tr>
<td>Are coping with serious health, mental health, or co-occurring disorders</td>
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<tr>
<td>Have children with complex health, mental health, or co-occurring disorders</td>
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<tr>
<td>May be isolated or lack a support system</td>
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<tr>
<td><strong>Tobacco Quit Line</strong></td>
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<tr>
<td>Oregon Tobacco Quit Line offers free phone support and quitting tools.</td>
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<tr>
<td><strong>Criteria for referral</strong></td>
</tr>
<tr>
<td>User of any form of tobacco who is 18 or older and ready to quit</td>
</tr>
</tbody>
</table>
What Questions Do You Have?

Type questions into the Questions Pane at any time during this presentation.
Resources & Thanks!

Thank you for your participation! Please take a moment to complete our post-webinar survey.

For your reference we have listed the resources sited in this Webinar on the Institute website located here: http://pcpcii.org/resources/webinars/referral-tracking-care-coordination
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