Closing the Referral Loop:
An Improvement Project of the American Medical Association, The Wright Center for Graduate Medical Education and Pennsylvania Department of Health

February 14, 2014
Kick Off Webinar
CRL Steering Committee

• Kavitha Neerukonda – American Medical Association
• Connie Sixta – Quality Improvement Leader
• Marcela Myers – PA Department of Health
• Jennifer Miller – PA Department of Health
• Linda Thomas – Wright Center
• Samir Pancholy – Cardiologist, Wright Center
• Nimesh Patel – Cardiology Fellow, Wright Center
• Shikha Shrestha – Team Leader
• Jumee Barooah – Physician Champion
• David Knorek – Recruitment & Engagement
• Joseph Featherall – Project Management
• Teresa Lacey – Clinical Operations
• John Janosky – Information Technology & Data Support
• Brian Ebersole – Mission Delivery

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Accessing Information

• [www.thewrightcenter.org/closing-the-referral-loop](http://www.thewrightcenter.org/closing-the-referral-loop)
• Listserv email address [twc-crl@thewrightcenter.org](mailto:twc-crl@thewrightcenter.org)
PCPI Quality Improvement Program

 Closing the Referral Loop Initiative
2020 Vision for the PCPI

The PCPI is a national catalyst to achieve optimal health outcomes

**Guiding Principles**

- Align with the national goals of better care, better health and lower cost
- Focus on improvement within the health care system
- Leverage the unique attributes of the PCPI (e.g., physician led, convener of diverse perspectives)
- Engage a membership inclusive of all stakeholders*
- Lead through partnerships with PCPI member organizations and other health care stakeholders
- Develop a hub within the health care learning system
- Increase scope and impact as resources become available to meet priorities

* Stakeholders include physicians, other health care professionals, health care provider organizations and systems, patients, consumers, purchasers, employers and performance improvement organizations
PCPI Model to Improve the Quality and Efficiency of Health Care Delivery

Because we believe the intersection is critical to achieving the Triple Aim

Because at the intersection, we can engage with care teams, patients and other collaborators

Because the intersection provides for feedback on measures, data, what works where and how
Overall Goals of QI Program

Promote the triple aims of healthcare through
   (1) Advancing the culture & science of improvement
   (2) Specific cross-cutting improvement opportunities
Goals: Advance Culture & Science of Improvement

• Advance, with PCPI membership, a culture shift among physicians and care teams to elevate improvement as a professional responsibility (PCPI acts as a catalyst for improvement as it has done re: measurement)

• Create forums for PCPI members and practicing clinicians with whom they engage to learn about & share QI models

• Engage with & learn from experts in the science of improvement
Goals: Specific Cross-cutting Improvement Opportunities

• Focus on Closing the Referral Loop as a first project in a long-term commitment to improving care coordination nationally
• Demonstrate measureable, meaningful improvement in Closing the Referral Loop through a small scale collaborative
• Conduct Closing the Referral Loop campaign and collaborative and determine if it should be expanded
Closing the Referral Loop Project Aims

• To improve the process of physician to physician referrals in the ambulatory setting by establishing accountability and improving information transfer.

• Higher satisfaction and understanding of the referral process among patients and physicians.
PCPI Objectives for Closing the Referral Loop Project

- Demonstrate measureable, meaningful improvement in specific cross-cutting improvement opportunities
- *Test a model for quality improvement spread that includes “intermediate” organizational support for projects (eg state model)*
- Build collaborative relationships with organizations that have complimentary improvement expertise and infrastructure to the AMA
- Assess the AMA’s role as a developer and stimulator of quality improvement at the national level through the PCPI program
- Grow the number of “closing the referral loop” experts and build a learning community
- *If the pilot project is successful, expand the CRL project with external funding*
- *Share learnings through PCPI membership meetings and other communication channels of the PCPI and the AMA*
Partnerships

3 Way Collaboration between
-The Wright Center for Graduate Medical Education (WCGME)
-Pennsylvania Department of Health (PA DOH)
-American Medical Association (AMA-convened PCPI)
Why Pennsylvania?

• PA DOH – State Innovations Grant, Chronic Care initiative, Practice Transformation & Engagement along with proven success
• WCGME – graduate medical education consortium that includes Internal and Family Medicine Residents as well as Cardiology Fellows
• AMA – Unifying organization and Coordinator of PCPI and the QI initiative, Content experts
Engaged Content Experts:

- Jay Gold, MD (Metastar Inc QIO)
- Carol Greenlee, MD (ACP)
- Linda Thomas-Hemak, MD (WCGME)
- Mary Ann Kliethermes, B.S., Pharm.D.
- Keith Mandel, MD (Cincinnati Children’s Hospital Medical Center – PHO)
- Julie Schilz (WellPoint)
- Jonathan R. Sugarman, MD (Qualis Health QIO)
- Sam Weir, MD (UNC)
- Hal F. Yee, Jr, MD, PhD (LA Co. DOH; formerly UCSF)
Identified 3 Focus Areas for Improvement

1) Did the referring (requesting) physician get the answer to their question/get the help they asked for/needed?
2) Did the specialist (receiving physician) get what they needed to do the referral that was requested and
3) Did the patient feel that the care was coordinated and did they get what they needed?
Key Areas of Interventions

- Accountability
- Relationships and agreements
- Connectivity
- Patient engagement
Closing the Referral Loop

Connie Sixta, PhD
What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Model for Improvement

Act

Plan

Study

Do

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Characteristics of the Aim Statement

States that we are going to change (redesign) the clinic practice.

Describes the target population for improvement in terms of site, provider and disease.

Describes in general terms how we are going to improve care for the population (Chronic Care Model).

Describes the most important outcomes that we want to improve for the population that define our success (Diabetes Measures).
Aim Statement: To improve the quality and timeliness of the patient referral process from a PCP to a Cardiologist (Dyad) including clarity of the clinical question asked by the PCP of the Cardiologist and thoroughness of the answer (to the clinical question) by the Cardiologist to the PCP. This will be evidenced by improvement in:
Targeted PCP Population: IVD
(i.e. NQF 0073 and NQF 0075)

• Patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year.
The Total Population (TPOP) of IVD Patients in the Practice

PCP “Population of Focus” (POF) for IVD patients

Small-scale tests of change

PCP IVD Population

IVD Data
PCP POF
PCP Practice TPOP

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Referred POF Population

Patients Referred by Dyad PCP to Dyad Cardiologist

Population of Focus

PCP IVD Population

Total PCP Patient Panel

PCP Practice Patients Referred to Cardiology Practice

Total Panel of Patients in the Cardiology Practice

Small-scale tests of change

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Identification of Populations

• PCP Practice
  • Population of patients with **IVD (POF and TPOP)**
  • **PCP TPOP: Total population** (TPOP) of patients in the Dyad PCP Practice who have been referred to the Dyad Cardiology Practice.
  • **PCP POF: Population of focus** (POF) or **Pilot Population** of patients paneled to the Dyad PCP who have been referred to the Dyad Cardiologist.

• Cardiology Practice
  • **Cardiology TPOP: Total population** (TPOP) of patients in the Dyad Cardiology Practice who have managed referrals from the Dyad PCP Practice.
  • **Cardiology POF: Population of focus** (POF) or **Pilot Population** of patients seen by the Dyad Cardiologist who had been referred from the Dyad PCP Cardiologist.

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Measures:

PCP Measures
1. % decrease in number of open cardiology referrals.
2. % increase in number of closed cardiology referrals.
3. % decrease in the number of days from referral created to referral sent.
4. % of complete summary of care records sent with referral to Cardiologist.

Cardiologist Measures
5. % decrease in the number of days from referral sent to appointment.
6. % decrease in the number of days from appointment to referral closed.
7. % of complete cardiology referral reports sent by Cardiologist to PCP.

Overall Measures
8. % decrease # of total days from referral created to referral closed.
9. PCP satisfaction with the referral process.
10. Cardiologist satisfaction with the referral process.
11. Patient satisfaction with the referral process.

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The Total Population (TPOP) of IVD Patients in the Practice

PCP Practice “Spread Population” or “Total Population” (TPOP) of Patients Referred to the Cardiology Practice

PCP Practice IVD Patients referred to the Cardiology Practice

The Total Population (TPOP) of IVD Patients in the Practice

Dyad PCP’s IVD Patients referred to the Dyad Cardiologist

PCP “Pilot Population” or “Population of Focus” (POF) Patients referred to the Dyad Cardiologist

PCP Referral Data
1. # of cardiology referrals
   1.a. POF
   1.b. TPOP
2. # of open cardiology referrals
   2.a. POF
   2.b. TPOP
3. # of closed cardiology referrals
   3.a. POF
   3.b. TPOP
4. # of complete summary of care records sent with referral request.
   4.a. POF
   4.b. TPOP

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The Patients Referred from Other PCPs to the Cardiology Practice

Cardiology Practice “Spread Population” or “Total Population” (TPOP) of Patients Referred by the PCP Practice

Dyad Cardiologist “Pilot Population” or “Population of Focus” (POF) Patients referred from the Dyad PCP

Cardiology Referral Data
5. % of complete cardiology referral reports sent by Cardiologist
1.a. POF
1.b. TPOP

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Referral Process

PCP Data
6. # of days from referral created to referral sent
   6.a. POF
   6.b. TPOP

Overall Data
9. # of total days from referral created to referral closed
   9.a. POF
   9.b. TPOP

Cardiology Data
7. # of days from referral sent to appointment
   7.a. POF
   7.b. TPOP
8. # of days from appointment to referral closed
   8.a. POF
   8.b. TPOP

Referral Order Written by PCP
Referral Order Ready and Cardiology Appointment Requested (Payer approval & Summary of Care Record Ready)
Referral Order Received by Cardiology and Appointment with Patient Completed
Cardiology Referral Report sent to PCP

# of days

Measure 9 (total time)
Measure 6
Measure 7
Measure 8

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Measures:

PCP Measures
1. % decrease in number of open cardiology referrals.
2. % increase in number of closed cardiology referrals.
3. % decrease in the number of days from referral created to referral sent.
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How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Model for Improvement

Act

Plan

Study

Do

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Informed,
Activated
Patient

Productive
Interactions

Prepared,
Proactive
Practice Team

Improved Outcomes

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2011 NCQA PCMH Change Concepts

• Data Review and Improvement Plan
• Identify and Manage the Population
• Access and Continuity
• Provide Self-Care Support
• Track and Coordinate Care
• Plan and Manage Care

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Use Process Redesign Principles

- Do tasks in parallel
- Use multiple processes
- Minimize handoffs
- Synchronize
- Use a pull system
- Move steps closer together
- Use automation
- Consider people to be in the same system
- Use multiple processing units
- Have specialists do only the tasks that require their specific skills
- Convert internal steps to external steps that do not require direct provider supervision.
Eligible Professional MU Core Measure 15

- PCP Sends **Summary of Care Record** with Referral to Cardiologist including:
  - Patient Name
  - Referring Provider and contact information
  - Procedures
  - Encounter diagnosis
  - Laboratory test results
  - Vital Signs (Ht. Wt., BP and BMI)
  - Smoking status
  - Functional Status (ADLs, cognitive, disability status)
  - Demographic Information (preferred language, sex, race, ethnicity, date of birth)
  - Care Plan field (goals and instructions)
  - Care team (other providers)
  - **Reason for Referral – Clinical Question**
  - Current problem list
  - Current medication list
  - Current allergy list

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Components of the Cardiology Referral Report
(American College of Physicians White Paper)

• New or changed diagnoses
• Changes in medications and medical equipment
• Diagnostic studies completed with results
• Diagnostic studies ordered (results pending) and/or recommended indicating who is to order
• Procedure performed and outcome
• Procedure planned or scheduled
• Patient education completed or recommended
• Patient self-management expectations agreed upon
• Recommended follow-up plan by the cardiology practice
• Thorough answer to the PCP clinical question (not in original paper)

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Organizing the Improvement Work
Collaborative Learning Model
(Breakthrough Series)

Select Topic
Planning Group
Identify Change Concepts
Prework
Participants

Institute for Healthcare Improvement

Supports
E-mail
Visits
Web-site
Phone
Assessments
Senior Leader Reports

LS 1 → LS 2 → LS 3 → Nat’l.C.

(13-16 month time frame)

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Practice Improvement Team Members

Champion physician/provider
Day-to-day leader/administrative contact
Clinical/technical expert
EMR contact (if applicable)
Other team members
<table>
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<tr>
<th>Team Member Role</th>
<th>Name</th>
<th>Title/Job Function</th>
<th>Office Phone</th>
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<td>Champion PCP</td>
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<tr>
<td>Champion Cardiologist</td>
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<td>PCP Day-to-day leader/administrative contact</td>
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<td>Cardiologist Day-to-day leader/administrative contact</td>
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<td>PCP Clinical/technical expert*</td>
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<td>Cardiologist Clinical/technical expert</td>
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[69x468]Practice Dyad: __________________________  __________________________
Mailing Addresses: __________________________  __________________________

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Learning Sessions (location to be determined)

• May 15, 2014 from 5 – 9 pm
• November 13, 2014 from 5-9 pm
Monthly Conference calls (12 pm 2\textsuperscript{nd} Friday)

- February 14, 2014 (Kick-off)
- March 14, 2014
- April 11, 2014
- May Learning Session – no call
- June 13, 2014
- July 11, 2014
- August 8, 2014
- September 12, 2014
- October 10, 2014
- November Learning Session – no call
- December 12, 2014

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Next Steps – Pre-work Activities

- Set up individual team conference call
- Select the practice improvement team (PCP Office and Cardiologist Office)
- Develop Aim Statement
- Build PCP IVD Registry (TPOP and POF)
- Identify Patients referred from PCP to Cardiology (TPOP and POF)
- Map out current referral processes (PCP Office and Cardiologist Office)
- Generate baseline data for referral measures
- Participate in monthly conference calls
- Attend Learning Session in May
Communication system

• Email address for the listserv (for announcements and questions)
  twc-crl@thewrightcenter.org

• Feel free to contact the following faculty for assistance
  • Connie Sixta, PhD csixta@mindspring.com
  • Shikha Shrestha, MD shresthas@thewrightcenter.org
Questions ??