CPCPracticeSpotlight41

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Following Data Over the Long Term Aids in Maintaining Improvement

Central Oregon Family Medicine, Redmond, Oregon; independent, 2 physicians; 3,100 patients

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This strategy stems from **CPC Change Driver 1: Comprehensive Primary Care Functions**

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.3: Risk Stratified Care Management
- 1.5: Coordination of Care Across the Medical Neighborhood

Change Driver 3: Continuous Improvement Driven by Data

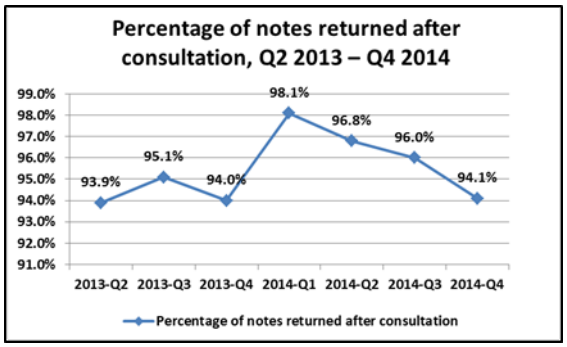
- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: At the start of 2013, **Central Oregon Family Medicine** (COFM) identified tracking and follow-up on specialist referrals as an opportunity for improvement. Anecdotally, the team at COFM knew that gaps existed in documenting and confirming specialist referrals, appointments, screenings and other treatment notes. However, without a standard workflow and method to capture and analyze data, they were unable to determine how much improvement was needed or how to assess where the practice could intervene to improve the process.

Strategy: COFM looked to develop a workflow that would touch on several points in the referral process and the ensuing follow-up to ensure patients were seeking and receiving timely specialty consultations recommended by their PCP.

By the second quarter of 2013, **Mark Hughes, DO,** and partner **Bruce McElroy, MD,** along with the practice team, had designed a process that would "tag" each outgoing referral in the electronic patient record, and that tag would remain open until the specialist's notes were received in the practice. Additionally if testing and/or screenings were recommended in conjunction with the referral, those would be tagged in the EHR and remain open until results were received. Tagging the referral and the labs/screens separately effectively wraps around the referral process to ensure completion.



COFM has tracked percentage of referral notes returned to the practice since Q2 2013. COFM attributes the uptick in Q1 2014 to the practice identifying trends among providers and reaching out to them specifically.

Each week the practice's medical assistant (MA) runs a report to identify open tags in patient records. If she can reconcile a lab report or the specialist's consultation notes to each tag, she closes the tags. Other tags may be marked pending (i.e., patient not yet evaluated or notes not yet received). If a consultation note is not received within four weeks of referral, the MA calls the specialist's office to follow-up. However, the RN care manager makes the contact if the patient in question has been assigned to her due to high or escalated risk. Her familiarity with these patients' complex conditions is often pertinent in these contacts.

If the specialist indicates the patient has not scheduled the appointment, the MA (or RN care manager if appropriate) reaches out to the patient to assist with setting up the appointment and resolving barriers as needed.

Dr. Hughes can run the reports by provider or service, allowing him to track communications patterns and pinpoint specialties where follow-up consistently lags beyond four weeks. The practice mails a letter to these providers, reminding them of the necessity of timely follow-up and requesting compliance with this standard of care. COFM has found this strategy highly effective. In the rare instances where communications and notes remain delinquent after the letter is sent, a practice physician sends a follow-up letter to the lead physician in the specialty practice. This physician-to-physician outreach generally resolves remaining issues.

The practice has tracked four metrics related to referrals since Q2 2013: total patients referred, patients seen/consult notes returned, patients seen/no consult notes returned and patient not seen. The data from 2013 show incremental improvement nearing the practice's goal of 100% follow-up. Over the following months, improvement dipped slightly, prompting the practice to again make additional efforts with identified providers. While the practice can consistently monitor the referrals and take corrective action as appropriate, 100% compliance remains dependent on specialist practices' willingness to collaborate on timeliness.

To help maintain the COFM team's focus on these metrics, Dr. Hughes and Dr. McElroy use the weekly practice-wide QI/CPC meeting to review their efforts and brainstorm new approaches. One tactic has been networking within the physician community at professional events. Dr. Hughes reports that discussing COFM's focus on specialty follow-ups as well as other CPC-related work has sparked the attention of his peers. Knowing that COFM tracks response rates has appeared to influence more timely communication among specialists.

While COFM has not reached its 100% goal of follow-up from specialists, this process has increased the likelihood that patients are seeing their specialists and getting their recommended screenings and tests.

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