California Health Care Foundation

SB 1004 PROMISING PRACTICES

Referral Processes

Background

Referral processes can have a huge impact — positive or negative — on the proportion of eligible patients who eventually receive services. This summary outlines considerations and strategies that Medi-Cal managed care plans and palliative care (PC) provider organizations can use to engage referring providers and reduce the barriers to referrals and enrollment in SB 1004 PC services.

For more SB 1004 resources, go to **www.chcf.org/sb1004**.

Common Challenges and Barriers

Referring Provider Barriers

➤ Providers misunderstand what PC is, or don't appreciate its value.

> ➤ Providers are concerned that PC referral equates to limiting treatments for a patient, or that it will "take the patient away" from their care, or conversely, they have unrealistic expectations that the PC provider will be able to take over all care for the patient. It is surprisingly common for providers to think that PC is the same thing as hospice.

➤ Providers are too busy — they forget to refer, lack the time to have serious illness conversations with patients, and/or can't spend time learning about new programs.

➤ Providers are hard to reach; they might not read emails or newsletters.

➤ Providers may be unfamiliar with the PC organization and therefore might hesitate to refer patients to it.

➤ Providers may not know patients well enough to refer them (for example, a patient who has been assigned but never seen, or has not been seen for an extended period).

➤ Providers stop referring due to frustration that only certain patients qualify.

➤ Providers don't see how a referral can be beneficial to them and think referring the patient will increase their workload, especially if they are expected to manage medications or facilitate delivery of services the PC team recommends.

Referral Workflow Barriers

➤ Neither the plan nor the PC organization may have access to the clinical information needed to confirm disease-specific eligibility criteria for SB 1004.

➤ PC organizations and referring providers are unsure who to contact at the plan to refer patients and to address problems when they arise.

➤ PC organizations that are accustomed to providing hospice or clinic-based services may be unfamiliar with the authorization and administrative processes they need to work effectively with plans.

> Referred patients often have urgent needs, but the plan authorization process may not be rapid enough to appropriately meet those needs.

Strategies for Improving Referral Processes

Strategies that health plans and PC provider organizations have identified as being most effective in engaging referring providers and optimizing referral workflows are described below. The efficacy of any referral strategy will vary depending on local and organizational factors, so many plans and providers recommend using multiple approaches.

Engaging Referring Providers

1 Focus on building relationships.

Rationale. Since the PC organization may be unknown to referring providers, referrals will be slow until providers know about and trust the organization.

EXAMPLES:

> Prioritize face-to-face interactions between referring and PC providers (many see this as an especially effective strategy).

> Leverage health plan relationships with primary care providers and specialists to introduce PC organizations and services.

> Identify PC champions in key clinics, hospitals, and community programs.

Partner involvement. Best when undertaken collaboratively by plans and PC providers.

Things to consider. Relationship-building can require significant time investment (particularly in large geographic areas), but most well-established programs view this as an essential strategy.

2 Make direct contact about specific patients, provider-to-provider.

Rationale. Doing this creates opportunities for building trust and delivering education in a focused way regarding a specific person the referring provider is already invested in.

Partner involvement. Typically managed by PC provider only.

Things to consider. Effort depends on referral volume; organizations see this contact as being very impactful in early stages of a program or when working with new referring providers and groups.

3 Be creative, flexible, and persistent.

Rationale. Providers are busy and have many competing priorities, so getting frequent face-to-face time solely for education may be difficult.

EXAMPLES:

> Engage nonphysician staff to get information to physicians.

>> At referring provider offices (e.g., nurses and medical assistants)

>> From hospice or PC organization (e.g., liaisons already making visits to clinics and hospitals)

> Participate in patient care conferences to offer input and to identify eligible patients.

> Conduct telephone- or web-based education to maximize efficiency.

> Follow up repeatedly; routine communication is almost always needed.

> Share PC program outcome data (e.g., patient satisfaction, avoiding emergency department visits).

> Focus on benefits for the referring provider, as well as the patient and family (e.g., "we can be your eyes and ears in the home").

Partner involvement. Often undertaken by both plans and PC providers, with PC providers typically playing a larger role.

Things to consider. The effort required varies depending on the outreach frequency, strategy, and region; the impact can be significant when thoughtfully targeted (e.g., focus on high-volume provider groups or those that care for many high-risk patients).

Optimizing Referral Workflow

1 Conduct routine meetings between plan and provider organizations.

Rationale. This helps to identify and remove patient-level or operational barriers before they become huge problems. High-performing plan-provider partnerships often view optimizing the referral process as an iterative exercise, with adjustments expected over time.

Partner involvement. Involves both plans and PC providers.

Things to consider. The time and effort involved varies depending on how — and how often — meetings are held. For high-performing, established programs, this collaboration is often seen as a critical component of their success.

2 Identify a single point of contact at the plan for SB 1004 referrals and questions.

Rationale. Ensures that appropriate referrals are authorized in a timely manner and provides a liaison between other plan divisions, members, and PC organizations.

Partner involvement. Led by plans.

Things to consider. May require staff reallocation and/or training investment up front; otherwise, requires minimal ongoing investment.

3 Make the referral process easy for referring providers.

Rationale. If referrals are too time-consuming, confusing, or slow, providers may be less likely to refer their eligible patients.

EXAMPLES:

➤ Empower nonprovider office staff to complete the referral.

➤ Allow primary care and specialist providers to directly refer patients to the PC program, eliminating the authorization process entirely.

Partner involvement. Can involve both plans and PC providers, depending on local process choices.

Things to consider. Investment in this area requires relatively little effort, with potentially significant impact.

4 Develop a pre- or retro-authorization process for patients with urgent needs.

Rationale. Patients are often referred at transition points (e.g., hospital discharge) when they are particularly vulnerable to rapid clinical decline. To have the greatest impact, PC organizations should be equipped and supported (including appropriate compensation) to deploy rapid interventions to stabilize new patients.

Partner involvement. Led by plans.

Things to consider. Investment in this area requires relatively little effort with potentially significant impact.

Key Lessons Learned in Referral Processes

➤ Investments in relationship building between referring providers and the PC organization — through education sessions, case reviews, and outreach about specific patients — can promote appropriate patient referrals.

➤ Small investments to streamline the referral process can make all the difference in whether providers decide to refer patients, and whether the PC organization can meet patients' urgent needs.

➤ Plans can help streamline communication by identifying a single point of contact familiar with the PC program who can act as a liaison for other plan divisions and services, and respond to referral questions and member needs.

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