Section 4.5 Implement

Referral Tracking and Follow-Up

This tool provides an overview of tracking and follow-up on patient referrals within a community-based care coordination (CCC) program, identifies key connection points and relationships, and includes some additional tools to manage patient referrals.

Time required: 3 hours

Suggested other tools: CCC Patient Plan (and template); Patient Action Plan (and template); Patient Visit Agenda and Preparation Checklist Template

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Table of Contents

How to Use

1. **Review** the importance of referral tracking and follow-up in a CCC program.
2. **Review** various connection points and forms of connections in making and following up on patient referrals, as well as the relationships with key persons in the process.
3. **Become familiar with** and consider using additional tools to manage and follow-up on patient referrals, including the patient visit agenda and patient preparation checklist.

Importance of Referral Tracking and Follow-Up in Community-Based Care Coordination

The expression "connecting the dots" is often used to describe the role of the community-based care coordinator (CC). Following up on lab results and referrals has always been a challenging task within a provider office setting. And while discharge planning is a fairly routine task performed by hospitals today, little – if any – follow-up occurs to determine that transitions of care have gone as planned. A primary role of the CC is to track and follow-up on *all* of the actions to be taken as transitions of care are conducted and to support high-risk patients maintain and improve their health status.

Tools for Making the Connections

To manage all of the connections that need to be made, the CC must have the following key tools at hand:

- **CCC Patient Plan** is the primary means to track all of the connections needed for a given patient. This CCC Patient Plan must be kept up-to-date and changed as the patient's needs change for more or less support.
- **Patient Action Plan** and **Patient Health Diary** are derived from the CCC Patient Plan, but are created and maintained *by the patient*. These tools help the CC determine if the patient understands and is carrying out the desired health interventions.
- **Notifications** from all provider participants in the community, where "community" extends to any provider (e.g., PCP, hospital/ED, specialty provider, nursing home, home health, behavioral health) where the patient may be seen – locally and remotely when a patient travels or lives away for part of a year. In order to ensure that such notifications are made to the CC, the CC must maintain an up-to-date **Provider Resource Directory** and arrange with each provider how the notification will be made. Ideally the process should be part of a written **Business Associate Agreement** with the providers.
- **Documentation**, such as discharge summaries, visit summaries, ED reports, consultation reports, orders and results for ambulant diagnostic studies (labs and radiology), medication lists, prescriptions and any other necessary documentation should be made available to the CC. These may be available through an HIE, via a portal, directly by logging onto a provider's electronic health record (EHR) as a user, or in paper as may be received via fax, e-fax, or email attachment. Any paper document that is received by the CC should be scanned and archived electronically for future reference as needed.
- **Follow-up** with patients, family/caregivers, and all providers and community services to whom the patient was referred is essential, and can be done in-person, verbally (telephone call), or written (via letter, email, or text message).
- The CC should maintain a **Community Resource Directory**, not only to know who to contact for support, but also to document details surrounding service provision, including positive and negative experiences. It is the CC's responsibility not only to follow-up with the patient or family/caregiver that the service was

provided, but to follow-up with the healthcare providers and community service providers if there are details to relay or problems to report.

- **Technical tracking support** is needed to track all of the connections for all of the patients. It would be ideal for all providers to be able to connect to one central health information exchange (HIE) service to exchange the notifications and other documents. However, there currently are very limited HIE resources for the intensive level of tracking needed for CCC in most communities. **The CC must maintain a database or, at a minimum, calendaring function to conduct all follow-up activities**.

Who is Included?

While follow-up upon hospital discharge would seem like the most important connection a CC can make, it should be considered only one of many "dots" to connect. In addition to other transitions of care, the CC should be making connections with clinicians and community resource providers to ensure that the care plan is carried out and available services are utilized.

The following table *illustrates* many of the connection points[1], what form of connection is needed, and with whom connections may be necessary.

Connection Point	Form of Connection	Whom to Connect With
Admission/discharge at local/remote hospital or tertiary care facility	• Notification to CC • Discharge Summary • Instructions to Patient	• PCP • Case manager • Family/caregiver
Discharge from local ED	• Notification to CC • ED Report • Instructions to Patient • Creation of CCC Patient Plan	• PCP • Family/caregiver
Ambulant diagnostic studies ordered / performed	• Notification of orders to CC • CCC Patient Plan • Patient Action Plan • Patient Health Diary	• PCP • Specialists • Community services
Ambulant referral to specialty physician	• Notification of orders to CC • Visit Summary or Consultation Report • CCC Patient Plan • Patient Action Plan	• PCP • Specialists • Community services
Ambulant referral to behavioral health specialist	• Notification of Orders to CC • CCC Patient Plan • Patient Action Plan • Patient Health Diary	• PCP • Behavioral health specialist • Social worker • Community services
Prescription assistance	• Medication List • CCC Patient Plan • Patient Action Plan • Patient Health Diary	• Pharmacist • PCP • Community services
PCP visits	• Visit Summary • CCC Patient Plan • Patient Action Plan • Patient Visit Agenda	• PCP • Community services
Community services needs for transportation, nutrition, housing, financial assistance, etc.	• CCC Patient Plan • Follow-up with Patient • Follow-up with Community Service	• Community services
Education for diabetes, tobacco/substance use, etc.	• CCC Patient Plan • Follow-up with Patient • Follow-up with Educator	• PCP • Community services • Health educator
Therapies	• CCC Patient Plan • Follow-up with Patient • Follow-up with Therapists	• PCP • Community services
Counselors for exercise, nutrition, weight loss, etc.	• CCC Patient Plan • Follow-up with Patient • Follow-up with Counselors	• Community services
ADL services	• CCC Patient Plan • Follow-up with Patient • Follow-up with home health aide or homemaker service	• Community services

Relationships with Key Providers and Resources

The CC obviously works closely with the providers and other resource persons in the community, but it is important to ensure that all parties to the communications are on board with the nature of the communications and their roles. (See *Establishing the Care Team: Communications and Roles*.)

The following describe some of the relationships that may be unique in the CCC process:

- **Patient, family, and/or caregiver** should be the primary persons with whom the CC connects. The CC's relationship to the patient should be one of "coach," "navigator," or "troubleshooter" – all terms frequently used to describe the CC. It is important to bear in mind that as the coach, the CC is neither the provider nor the patient or patient's family/caregiver. Even if the CC is also the patient's provider (which may happen in a small and/or rural environment), the CC must clearly separate these two functions.

  While it may seem odd to observe that the CC is not the patient or patient's family/caregiver, the point here is that the CC should promote self-management. Doing everything *for* the patient will not return the patient to independent living within the home environment – which should be the ultimate goal of CC. So just as a coach does not throw the ball or run the bases, the CC should guide, help navigate, motivate, celebrate, sympathize, etc. – but not perform the functions the patient should be performing.

- **Primary care provider (PCP)** is the person ultimately responsible for diagnosing and making treatment decisions (potentially with other consulting providers or hospitalists) for the patient. But just as the CC is not the provider or the patient, the PCP is not the CC. The PCP should be able to rely on the CC to perform the CCC functions, and the CC should know when to escalate an issue to the PCP. As providers are brought into the CCC process, mechanisms to communicate with them should be established up front. Routine communications (such as of lab results, or notice of a referral) should be incorporated into an EHR or other process that enables the CC and PCP to assimilate the information at their convenience – although within a defined timeframe in the event action needs to be taken.

  There should also be a process for urgent communications – where the CC needs to report a change in the status of the patient that might require a medication change or other action, but which is not a true emergency, which would be handled through an emergency process. Similarly, the PCP, ED staff, or hospital needs to be able to contact the CC when a new patient may be in need of immediate CCC functions. Expectations should be established as to timeframe in which a CC can respond.

- **Case manager**, typically in a hospital or large physician practice, performs the bulk of discharge planning. This person is most likely the person who also manages or arranges for assistance with issues of medical necessity, financial arrangements, and other administrative processes associated with moving the

patient to a different level of care. The CC should work closely with the case manager in order for the transition between case management and CCC to be seamless for the patient.

- **Pharmacists** are playing an increasingly important role in CCC. Many hospitals are having their pharmacists conduct follow-up calls with patients, and local retail pharmacists are actively working with providers where patients have not filled prescriptions, where medication counseling would be helpful, or where advice on drug dosage adjustment is needed. The CC should feel comfortable calling upon the services of the applicable pharmacist as part of the CCC team.

- **Diagnostic studies** are often required for managing medications and other health needs for patients. The CC should monitor not only that the diagnostic studies are performed, but that results are reviewed. As part of the communication process, the CC should ensure that results are reviewed and the applicable providers are attending to them.

- **Specialty** providers, behavioral health specialists, therapists (physical, occupational, respiratory, and other), health educators, exercise counselors, nutritionists, etc. may be touch points for the CC to ensure the patient received services and to obtain any additional instructions or other information. Such care providers must also be selected carefully to ensure they are on board with the CCC program and its principles of quality, costs, and experience of care. The CC may need to provide the PCP guidance in making such referral decisions.

- **Community services**, including those providing transportation, nutrition, housing, financial and other assistance, may be among the most important for the CC to work with regularly. High-risk patients often do not have the transportation necessary to get to the PCP, lab, education session, etc. Nutrition suffers as a result of many factors, including lack of transportation to a grocery store, poor food choices, and many others. The CC should keep track of how well the community services perform and be prepared to intervene when necessary and potentially refer patients to alternative services if necessary and available. Reaching beyond the physical boundaries of a community to include telehealth and web-based support will likely be necessary in rural environments.

Patient Tools to Manage Referrals

Tools that may be useful for patients to have as they are referred or introduced to specialists, therapists, community services and other resources include the visit agenda and preparation checklist.

- **Visit agendas** help the patient remember important information to convey to the person being seen and to keep the patient and care delivery person on track during the visit. (See *Patient-Provider Agenda* in this Toolkit and the sample patient visit agenda below.)

- **Preparation checklists** help a patient understand the purpose of the visit, be prepared for the visit, and guide expectations for after the visit. (See example next page.)

Patient Visit Agenda	
My name:	Date of birth:
Main reason for today's visit:	
Other concerns I would like to discuss if there is time:	
Check all that apply: ❑ I have prescriptions that need to be refilled ❑ I need the attached forms filled out. ❑ Other:	

Patient Preparation Checklist for Referrals

- ❑ Do I know who I am seeing?
- ❑ Do I know why I am seeing this person?
- ❑ Do I know how I am getting there?
- ❑ Do I have my questions for this person written down?
- ❑ What do I need to prepare for this visit:
  - Bring medications?
  - Bring records and/or x-rays?
  - Change my usual eating?
  - Other?
- ❑ Is there anything else I should know about the visit?
- ❑ Will my insurance cover the visit?
  - If so, will there be co-pays or other charges?
  - If not, how is the cost of the visit being covered?
- ❑ Who do I call if I have trouble getting to the visit? Getting home from the visit?
- ❑ What can I expect after the visit?
  - Who will tell me what will happen next?
  - Will I have to see this person again?
  - How will my primary care provider know about my visit?

(See *Patient Visit Agenda and Preparation Checklist Template* for a reproducible and fillable form.)

Additional Resources Managing Patient Referrals

Making the Most of Your Doctor Visit (Sutter Health). Available at: http://www.sutterhealth.org/thedoctorforyou/doctorvisits.html

How to Get the Most Out of Your Doctor Visit (wikiHow). Available at: http://www.wikihow.com/Get-the-Most-out-of-Your-Doctor-Visit

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Reference

[1] Adapted from *Reducing Care Fragmentation: A Toolkit for Coordinating Care*. The Commonwealth Fund. Available at: http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

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