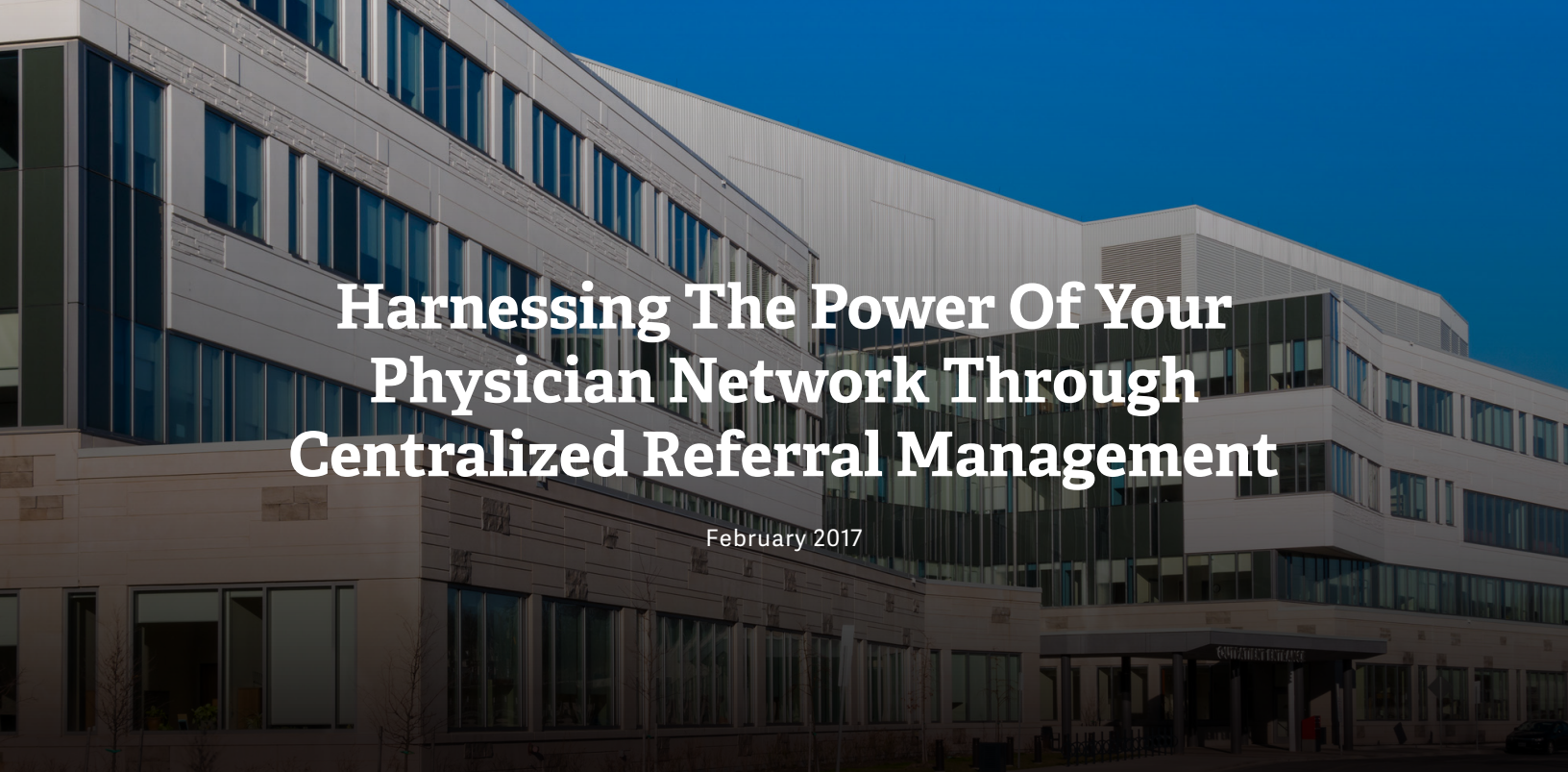




Harnessing The Power Of Your Physician Network Through Centralized Referral Management

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Current processes for managing patient referrals are preventing health systems from providing coordinated care, which is a critical building block for value-based care. Weak coordination of patient care transitions across providers and care settings drives up administrative costs, compromises quality, and results in lost revenue as patients forgo recommended care or exit a health system's network out of frustration. More often than not, providers are unable to effectively manage patient care transitions due to complexity arising from the fragmentation of care and health plan requirements. As health systems look for ways to improve

care coordination, many are choosing to centralize the mechanism for managing referrals. This is a relatively low-cost, non-intrusive undertaking and one that can reap real benefits—particularly when compared to other value-based initiatives. By employing a centralized approach, a health system can maximize its investment in referral management, elevating care coordination to the level required by the ambitious new cost and quality goals that characterize today's healthcare landscape.



THE CONSEQUENCES OF WEAK REFERRAL MANAGEMENT

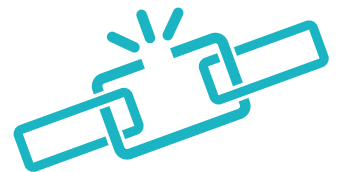
Significant Patient Leakage

Patients often experience multiple barriers to following through with a referral, including cumbersome authorization processes, long wait times, and confusion about required testing or documentation; sometimes they may even have trouble getting a busy practice to just answer the phone. Some patients give up on receiving care altogether, while others seek care outside the network. Today this results in significant lost potential downstream revenue. In tomorrow's value-based world, the ability to keep patients in network will have a larger-scale impact, with financial penalties attached to patients exiting the system.



Poor Clinical Outcomes

Each provider's office has its own process, which may not include a set of standards to see referrals through to completion. This can result in "broken" handoffs, often shifting the burden of care coordination to the patient, which may result in the patient delaying or even forgoing the recommended care. This also puts patients at risk for poor clinical outcomes during individual episodes of care—and over time, it can create a threat to overall patient health. Under value-based models that establish metrics for quality, health systems can expect to be penalized for these types of outcomes.



Inability to Compete With New Market Entrants

Higher premiums, deductibles, and co-pays have shifted greater responsibility for the cost of care to patients, causing many to adopt a more consumer-oriented mindset. Patients have become far less tolerant of the challenges they face in navigating traditional healthcare settings and are increasingly willing to engage with new market entrants such as retail virtual care providers that promise more convenient care and better value for each healthcare dollar. Faced with this new competition, it is now more important than ever for health systems to work on improving the patient experience.



THE ARGUMENT FOR CENTRALIZATION

Successful centralization of referral coordination is about creating a patient-centered approach to patient care transitions that is operationally efficient and supported by technology. When done correctly, it solves the problems created by the weak referral processes in place today. Centralization also ensures that health systems can meet value-driven cost and quality goals by improving patient retention and thus increasing revenue, as well as decreasing clinical and administrative costs and supporting providers’ efforts to deliver patient-centered care.

Comparison of Traditional and Centralized Referral Services

	Traditional Referral Management	Best Practice Centralized Service
Staff	• This is often a shared responsibility among multiple staff members who are busy with other functions. • Staff are often not trained on clinical documentation and insurance requirements.	• Dedicated staff handle referrals. • Staff are trained on medical terminology and insurance processing.
Processing Time	This can range from a few hours to weeks depending on staff availability.	Referrals are addressed within 48 hours.
Patient Responsibility	Patients are often expected to research the referred-to provider's contact information and call that office, obtain insurance authorizations, and coordinate the scheduling of multiple appointments.	Staff call the patient, handle insurance authorizations, schedule all appointments, and manage registration updates.
Continuity of Care	The operational hurdles that patients must overcome to get an appointment at the referred-to physician's office often prevent them from receiving the recommended care.	Staff stay in touch with patients to ensure they complete their referrals. If a patient does not want to complete the referral, the referring physician's office is notified so it can follow up with the patient.
Out-of-pocket Costs	Referrals are made without checking if the patient's insurance is accepted by the referred-to office, which can lead to high out-of-pocket costs for patients.	Staff complete prior authorizations and direct patients to providers that are in network.

Improving Patient Retention



With a centralized approach, patients are relieved of the administrative burden associated with a referral. This enhances their overall experience and helps ensure

that a higher percentage of patients stay in network and receive recommended care. Referrals are routed from the provider's office to a central repository, where a team of trained personnel handles all associated tasks for patients—verifying eligibility, obtaining insurance authorizations, managing prerequisite testing, coordinating appointment scheduling, and closing the loop by communicating the referral status back to the referring office. Referral staff use a technology platform that gives them visibility across the system, allowing them to adjust to changes in insurance and provider information in real time.

Lowering the Cost of Care



Under value-based reimbursement models, providers financially benefit when they keep their patients healthy at a lower cost. This is accomplished by ensuring that patients

receive the appropriate care in the appropriate setting at the appropriate time. This provides more than a competitive advantage—it is an imperative for health systems today. Once a provider recommends a patient care plan, the system needs to be mechanized to ensure those needs are met. A referral center can engage with patients and direct them to the appropriate clinical and cost-effective setting.

Creating Process Efficiencies



Centralizing referral management brings order and efficiency to what has historically been an unstructured and time-consuming administrative function. Dedicated

referral staff are trained on clinical documentation and insurance plan processing requirements, making them more effective at communicating with payors. Staff can

also streamline and batch-process prior authorizations electronically, establish direct contacts with insurance companies to expedite authorizations, and work staggered shifts to ensure that patients can be reached later in the day. By creating a single point of contact for processing, tracking, and scheduling referrals, a centralized approach also eliminates any overlap in efforts between referring and referred-to locations. These and other technology-enabled efficiencies cannot exist when referral processes are disparate.

Providing Patient-Centered Care



To meet value-based care goals, providers need to reimagine the way they practice, as well as reevaluate the time spent on care coordination activities. In addition

to diagnosing and treating patients, they must also treat them through new avenues of care (e.g., telehealth visits via phone or video); ensure their medications are filled on time; educate and engage them, as well as their families, about their health; and follow up with them to encourage compliance with care plans. The only way that providers will have adequate time to meet these new clinical demands for patient-centered care is if administrative processes become less taxing. Referral coordination is a natural place to start making operational improvements, because the associated processes can be changed without hindering a provider's ability to track and care for patients.



KEY SUCCESS FACTORS

In assisting our clients across the country with implementing referral management centers, we have identified the following as key success factors in making this cultural, operational, and technological transformation:

Referral Standards



Every organization approaches centralized referral management a bit differently. But one rule of thumb applies across the board—the more standardized the processes in the referring and referred-to clinics are, the more efficient and effective referral processing becomes. In fact, the success of centralization efforts really hinges on the development of standard clinic operations for documenting and scheduling referrals—and equally as important, providers' adherence to these standards.

At a minimum, referral standards must establish baseline criteria for the following:

- Entering referral orders or requests accurately and completely
- Identifying and prioritizing urgent referrals
- Managing prerequisite testing and information requests across a specialty
- Defining appointment types used to schedule referrals
- Communicating results/following up with the referring provider



Physician Champions



Identifying physician leaders to participate in the design of the referral management process is critical, both in developing work flows that support the link between the patient care transition and the ongoing care of the patient and in ensuring provider adherence to these work flows. Health systems will be most successful when they employ a collaborative approach to referral management design, recruiting physician champions who can engage their peers across the network and advocate the benefits associated with standardization.

Technology-Enabled Routing, Sorting, and Tracking



Utilizing an EHR or technology platform specifically designed for referral management is a requisite element of effective centralization. To process referrals efficiently, dedicated referral staff need real-time access to frequently changing insurance and provider information. While they will vary by organization, all platforms should ideally meet these core requirements:

- Provide support for the efficient identification, routing, and processing of a referral
- Incorporate financial clearance rules that enable staff to process insurance requests in a timely manner
- Function as a central repository for provider and insurer requirements for efficiently tracking, updating, and modifying referral processes

Communication



By themselves, referral standards and technology are not sufficient to ensure a seamless patient care experience. A key factor in the success of any centralization effort is the level of communication between referring and referred-to physicians. It is important that both parties agree on the appropriate workup for a patient and understand which diagnoses the referred-to specialist sees. This communication serves as the foundation for algorithms that pair patients with specialists. Referring physicians also need confirmation that their patients receive recommended care, and referred-to physicians need to know that the appropriate follow-up care is in place once they have treated patients. Referral management centers can generate status reports to keep clinicians up to date on their patients. At a minimum, these reports should include the referring physician, the referred-to physician or specialist, the referral status, and the processing time. Health systems can generate additional reports based on the requirements of their clinics and providers.

Metrics



It is also critically important for referral management centers to track process and performance metrics. Metrics such as referral turnaround time provide insight into staff efficiency and cost savings gained, while performance metrics like the referral conversion rate can be used to identify downstream revenue. Health systems should identify the metrics they wish to track before they begin building their referral management center infrastructure, as the metrics often need to be built into the technology platforms.

A WIN FOR ALL STAKEHOLDERS—PHYSICIANS, PATIENTS, AND HEALTH SYSTEMS

Centralized referral management is a win for both physicians and patients—and a cost-effective, manageable first step toward meeting new value-based goals for health systems. Efficient care coordination helps attract and retain patients. In many instances, health systems already have front-office staff performing many of the tasks associated with coordinating referrals and using their EHR for tracking them. Therefore, it entails a relatively minimal investment to build upon the existing infrastructure by centralizing and designing the necessary standards, processes, and technology platform. Centralizing referral management provides a way for health systems to improve patient satisfaction without significant capital investment and disruption to physician practices.

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