

Reducing Waits and Delays in the Referral Process

Mark Murray, MD, MPA



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Tool inside

By formalizing your referral relationships, you can make life easier for you and your patients.



Our current health care system is plagued by long waiting times and delays in care. These waits and delays dissatisfy patients, medical staff and physicians, while increasing health care costs, reducing potential income and adversely affecting clinical outcomes. Patients experience long waiting times in the health care continuum in three major areas: first, in waiting for access to an appointment in primary care; second, in the medical office itself; and third, in waiting for access to specialty care once the primary care physician has decided to refer the patient. While many articles have focused on reducing waiting times and delays in primary care,¹ this article will focus on reducing waiting times and delays between primary and specialty care.

The access problem

Not only are there long delays and waits between the primary care visit and the specialty care visit, but the referral process itself is often cumbersome and confusing for patients and physicians alike. Patients are often informed that they will be “referred” but have little or no influence on the process nor knowledge about who they will be referred to or how long the expected wait will be. This inevitably leads to an increase in patient telephone calls, both to primary care and specialty care offices, and to an increase in unnecessary visits to other primary care doctors, urgent care centers or emergency departments as patients probe the system trying to find other ways across the chasm and into the referral specialist’s office. This, in turn, leads to increased use of unnecessary laboratory tests and services, spreading inefficiency, waste and dissatisfaction throughout the health care system.

At some point, when the wait becomes unbearable, patients resort to calling their primary care doctors and enlisting their help in getting in to see referral specialists sooner. This leads to a situation where the primary care doctor may feel pressured to exaggerate symptoms to obtain timely care for his or her patients.

An access problem such as this represents a delay between the initiation of the demand and the application of the supply. The goal in any system is to balance the demand with the supply. When this balance is achieved,

Dr. Murray, a family physician, is principal of Murray, Tantau & Associates, Sacramento, Calif. In partnership with Catherine Tantau, RN, MPA, he led the creation and implementation of advanced access. He is also a faculty member of the Institute for Healthcare Improvement (IHI) and served as chair for the IHI’s Breakthrough Series Collaboratives on Reducing Delays and Waiting Times. Conflicts of interest: none reported.



ILLUSTRATION BY TIM LEE



The current health care system is plagued by long waiting times and delays in care, including access problems between primary care and specialty care.



Long waits and delays in specialty care are dissatisfying to family physicians because of fears about patients' clinical outcomes and frustrations with the referral process itself.



Primary care-specialty care referral agreements can begin to address the problem.



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waiting times can be eliminated. If this balance cannot be achieved, waiting times will continuously extend or will reach a point of equilibrium based on patient dissatisfaction.

The current gap between demand and supply in specialty care is dissatisfying to patients because of the delay itself, the anxiety caused by this delay and the potential of adverse clinical outcomes. The delay is dissatisfying to referral specialists because they cannot see patients in a timely manner. Finally, the delay is dissatisfying to family physicians because of fears about patients' clinical outcomes deteriorating and frustrations with the referral process.

Creating referral agreements

Primary care-specialty care referral agreements can begin to address the problem of delays and long waiting times for appointments with referral specialists. These agreements can rationalize the referral process for patients and physicians alike. They can help family physicians be more selective about which patients they refer and more thorough in their pre-referral work-up. They can help referral specialists be more thorough and timely in communicating their findings. They can reduce demand for specialty care, thereby reducing patients' waiting times. And they can improve the relationship between family physicians and referral specialists by developing a more seamless referral process. At the same time, however, the development of referral agreements is difficult since a successful agreement requires significant process change for physicians.

Referral agreements can be implemented in four main steps:

- 1. Develop referral guidelines, which define the clinical conditions to be referred.** In my experience working with groups to develop these guidelines, this task works best when initiated by a small group of primary care physicians and referral specialists. The physicians need not work within the same organization, but they must be willing to see themselves as part of the same overall system of care. The group should work together to draft a set of guidelines that outlines the clinical conditions best managed on the primary care side and the clinical conditions best referred. Each group will draw

KEY POINTS

- Long waits and delays between primary care and specialty care are not only dissatisfying and inefficient, but also cause concerns about patients' clinical outcomes deteriorating.
- Small groups of primary care and specialty care physicians can work together to create referral agreements that rationalize the relationship.
- Referral guidelines generally result in a reduction in specialty demand, reduced waiting times for the primary care physician's patients and more timely feedback from the referral specialist.

this boundary at different places along the continuum depending on multiple factors, including local practice habits, primary care physicians' chosen scope of practice, previous patterns of referral and local availability of various referral specialists. The guidelines can be indexed either by clinical condition, diagnosis or symptoms and should include current information on how each condition should be managed, including the appropriate use of laboratory and radiological tests, the elements and sequence of the work-up, and expectations around trials of treatment prior to referral. (See an example on page 41.) These initial guidelines should then be introduced to the other primary care and specialty physicians being affected. With their input, further refinements can be made.

Of course, there are always exceptions allowed for any patient whose problem isn't covered by the guidelines, who insists on seeing a referral specialist or whose primary care physician is uneasy about the diagnosis, clinical condition or symptomatology.

Agreements such as this will generally lead to a reduction in referrals. The good news for referral specialists is that these agreements generally result in a higher surgical yield, more robust relative value units (RVUs) and an increase in the number of referrals occurring with the appropriate work-up completed, which translates into more work being done by the primary care physicians.

- 2. Determine "What's in it for me?" from the primary care physician perspective.** Referral guidelines alone are often not

Primary care and specialty care physicians must see themselves as part of the same system of care.

SAMPLE REFERRAL AGREEMENT

Women's Health and Family Medicine

The following is a collaborative service agreement between the Women's Health Clinic and the Family Medicine Clinic.

Core Services Agreements:

Women's Health will provide the following core services:

- Prenatal care and deliveries for high-risk and low-risk patients
- Postpartum care
- All gynecological surgery
- All cancerous and pre-cancerous gynecological problems
- Infertility evaluation (male and female)
- Domestic violence assessment
- Paps/pelvics and breast exams
- Male and female sterilization
- Contraception
- Gynecological procedures
- Neonatal circumcision for all non-ASU infants and for ASU infants needing procedures on weekends, holidays or after hours
- Evaluation and care for abnormal bleeding
- Incontinence (urinary & fecal)

Family Medicine will provide the following core services:

- Paps/pelvics and breast exams
- Contraception
- STD testing and counseling
- Domestic violence assessment
- Menopause care
- Menstruation care
- Low-risk prenatal care and low-risk deliveries for some patients
- Routine outpatient postpartum care
- Neonatal circumcisions for ASU patients in newborn nursery from 8 a.m. to 10 a.m. on weekdays, excluding holidays
- Selected gynecological procedures as per physician's credentialing, to include diaphragm fitting, IUD insertion and removal, Norplant insertion and removal, low-grade colposcopies and endometrial biopsy

Note: More specific information on the work-up requirements associated with the above services is detailed on subsequent pages of this agreement.

Access Agreements:

Women's Health will provide the following access:

- Same-day access for any emergency referrals from FMC
- One-week access for routine referrals from FMC
- A Women's Health physician will be available during clinic hours for emergent questions, consultations and evaluations. Monthly schedules will be sent to FMC with on-call doctors listed

Family Medicine will provide the following access:

- Same-day access for any patient referred from Women's Health

Communication Agreements:

Physicians in Women's Health and Family Medicine will use the ANMC Referral and Consultation Form to communicate requests for services between clinics. Physicians agree to respond as requested on the referral and consultation form.

Quality Assurance Agreements:

Women's Health and Family Medicine will establish standards of care for the provision of on-demand women's health care.

Training and education processes will be developed based on these standards of care.

Quality assurance measures will be developed and monitored based on these standards of care.

Signature of WHC Medical Director

Signature of FMC Medical Director

successful because they seem to benefit specialty care only. For primary care physicians to fully embrace referral guidelines, they need to know how the guidelines will benefit them. First, because referral guidelines generally result in a reduction in specialty demand, they will bring a reduction in waiting times for the primary care physician's patients as well as more timely and thorough information from the referral specialist.

As supply and demand are brought into balance, patient waiting time for specialty care can be recalibrated at any level. Ideally,

this waiting time should be one week or less for any clinical condition, an expectation that should be written into the referral agreement. The agreement should also stipulate the amount of time primary care physicians should expect to wait for the specialists to respond to their consult questions or to provide feedback on referred patients.

As the access problem improves, both primary care and specialty care practices will realize operational efficiencies. For example, the shorter the patient waiting time, the lower the "fail to keep appointment" rate, the lower



The use of referral guidelines will ultimately bring a reduction in waiting times for the primary care physician's patients and more timely information from the referral specialist.



As part of the referral agreement, primary care and specialty care physicians need to improve their referral process so that it is timely and involves the patient.



Primary care and specialty care practices engaged in the referral agreement must measure the new process to see whether it has reduced patients' waiting times.



Family physicians should take an interest in improving access across the health care continuum because their efforts will improve care, efficiency and satisfaction.

the rework factor, and the less triage required to manage those who are waiting. With shorter waiting times into specialty care, patient satisfaction improves, physician satisfaction improves on both the primary care and specialty sides, staff satisfaction improves, adverse clinical outcomes are averted, costs are reduced and revenues are enhanced.

3. Develop a referral process. An optimum referral process needs to be timely and to involve the patient. Patients need reassurance when they leave the primary care doctor's office that their health care needs will not fall through the cracks. This means they need to know exactly how long they will

wait and who they will see. The process also needs to assist primary care physicians in getting the appropriate information to and from the specialist in a timely manner and ensure that the work-up is done appropriately.

Once the primary care physician has decided to refer a patient, a number of components need to be put into play. The patient needs to be involved in the process, either by being informed about or actually choosing the referral specialist he or she will see. The patient also needs to make the decision before leaving the primary care physician's office about when he or she will be seen by the referral specialist. Immediately, the primary care physician's practice needs to complete the required work-up, including any lab tests or other required services detailed in the referral guidelines, and forward the patient's information to the referral specialist. Ideally, this process is carried out electronically.

The best referral processes include an inspection step as part of the process, where the primary care physician's office reviews the appropriateness and completeness of the work-up. For example, some organizations with an electronic referral process have disease-specific referral forms indexed electronically with the appropriate work-up outlined. The patient cannot successfully be referred unless the appropriate work-up has been arranged *and will be completed* prior to the referral date. A referral process structured in this way relieves the referral specialist from seeing a patient with an incomplete work-up, sending the patient back out for tests, and then seeing the patient back again, which results in more waits and delays in care.

With shorter waiting times, adverse clinical outcomes are averted.

For those patients whose problems do not completely fall into the referral guidelines or for whom the primary care physician has a question, a further enhanced process is necessary. In optimum systems, these questions from primary care physician to specialty physician are answered immediately (e.g., the referral specialist has agreed to immediate consults when contacted at a dedicated cell phone or pager number); in other systems, the consults can occur within 24 hours via

e-mail. In any case, the patient should be informed and involved in the process and reassured that the primary care doctor has indeed spoken with the referral

specialist. The result of the consult could be that further work-up is pursued, a referral is made or a referral is avoided altogether.

4. Conduct an audit to determine whether the changes have actually improved the system. The primary care and specialty practices engaged in the referral agreement must develop a set of measures to assess whether their objectives have been achieved. The primary objective in a referral agreement is to reduce the patient's waiting time between primary care and specialty care. Thus, the key measure is waiting time for an appointment to the referral specialist. Other corollary measures include the measurement of physician compliance with the referral guidelines or with other elements of the improved referral process, such as patient satisfaction with their involvement in the referral process or the percentage of referrals occurring with the completed work-up.

Conclusion

Primary care-specialty care referral agreements are valuable tools in the quest for improved access to care across the health care continuum. Family physicians should take an interest in improving access to specialty care because their efforts will result in improved care, efficiency and satisfaction. **FPM**

Editor's note: Do you have ideas for operationalizing the principles described in this article? Send comments to fpm@aaafp.org.

1. Murray M, Tantau C. Same-day appointments: exploding the access paradigm. *Fam Pract Manage.* September 2000;45-50.