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Closing The Loop: Pilot Evaluation of Referral Navigator at OneWorld Community Health Centers

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Closing The Loop: Pilot Evaluation of Referral Navigator at OneWorld Community Health
Centers

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Abstract

Background. Low-income persons are subject to barriers to accessing health care and the additional complexity of the referral process, specifically for those receiving assistance from indigent care programs, contributes to those barriers. The requirements for patients receiving social assistance from indigent care programs leads to increased waiting time to be seen by specialists and contributes to health disparities.

Aim. Through a partnership with OneWorld Community Health Centers this project seeks to understand the efficacy of the implementation of a “referral navigator” at OneWorld and make recommendations to enhance the process. The proposed navigator is aimed to decrease the waiting time between the date of referral by the physician and the date on which the patient is eligible to be scheduled at a specialist’s office through HOPE.

Methods. Individual interviews were conducted with three referral care coordinators, recorded, transcribed, and coded for emergent themes. In addition, individual chart review was completed in order to determine the frequency for which referrals were being tasked or not tasked. Patient outreach was also piloted in order to assess the efficiency and feasibility of calling patients. The data were summarized using frequency tables and a SWOT analysis was conducted for easier identification of factors that impact the referral process.

Results. Interviews with referral care coordinators (RCCs) led to informative conversations that mirrored the sentiments originally presented by the Patient Voice Committee. It was identified that approximately 36% of referrals are not tasked and these non-tasked referral lead to an average initial contact time frame of roughly 24 days. Patient outreach was unproductive due to an only 8% successful patient outreach, 36% of patients were unreachable, and 20% were left a message. From this data, we were able to better understand the efficacy of the implementation of

a “referral navigator” at OneWorld and how to reduce the waiting time between the date the referral was entered and the date on which the patient is eligible for an appointment through HOPE. Recommendations of providing a communications refresher training, implementing a referral packet, and implementing a modified referral navigator position were made in order to achieve the aims of this project.

Conclusion. Through the pilot evaluation, areas of improvement were identified in order to enhance the referral process. Interventions targeting improvements in communication and follow-through between staff members have the potential for greatest impact on maximizing efficiency. Using the SWOT analysis tools to better visualize the problem, future interventions can be designed and adjusted as needed.

Introduction

OneWorld Community Health Centers (OneWorld) is a Federally Qualified Health Center (FQHC) that is dedicated to serving the under resourced communities of Omaha, Nebraska. As a healthcare organization, they are committed to providing access to the best possible care regardless of race, sex, disability, national origin, religion, sexual orientation, gender identity, immigration status or ability to pay and to that end provide a wide array of public health services. OneWorld continuously strives to be leaders in health care through the empowerment of individuals and the development of healthier communities.

In order to achieve their vision of being leaders, OneWorld endeavors to make continuous improvements to their organization to better suit the needs of their patient's and the communities they serve. For this reason, OneWorld created the Patient Voice Committee – a committee comprised of OneWorld patients that meets on a monthly basis in order to discuss areas of improvement, areas in which they excel, and other suggestions overall, they might have for the organization. Through these meetings, OneWorld learned that patients found the referral process to be particularly complex, often citing a lack of communication and follow-up between the community workers and patients.

Referrals are an operational tool through which health care organizations and providers can track patients through the continuum of care. An effective referral can help streamline the communication between a patient's primary care physician and specialists or other providers involved in the care of the patient. In an age where high healthcare costs have led to particular scrutinization of all operational processes, it is important to address inefficiencies – primarily for minimizing the cost but also for simplicity, transparency, and ease of access to patients and providers alike through a process known as closing the referral loop (Fig. 1)(Patel et al, 2018).

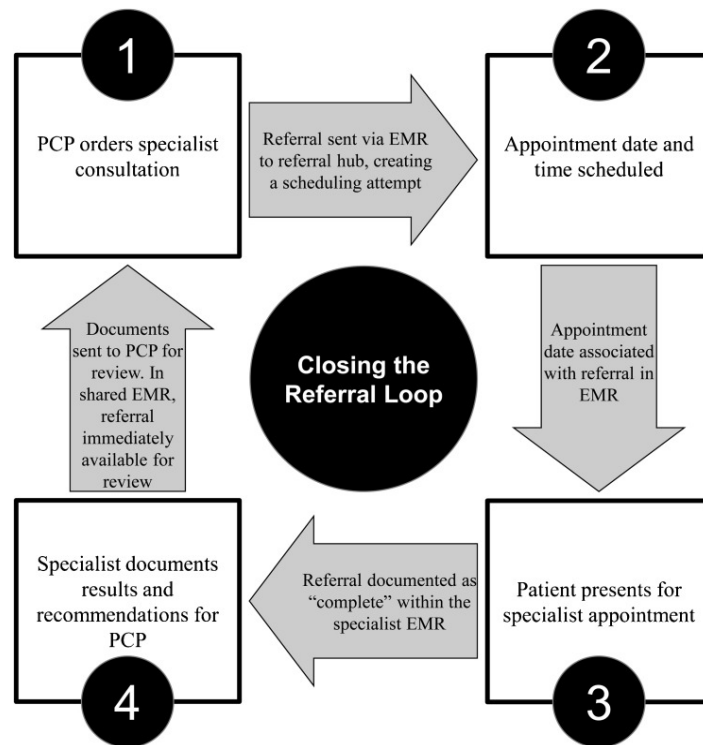


Figure 1. Closing the referral process map. Adapted from *Closing the Referral Loop: An Analysis of Primary Care Referrals to Specialists in a Large Health System* by Patel et al, 2018.

OneWorld, as a health care organization accredited by the National Committee for Quality Assurance (NCQA) has adopted the Patient-Centered Medical Home (PCMH) model of care that puts the patients at the foreground of care. While OneWorld currently follows the "referral tracking and follow up" elementⁱ stipulated by the NCQA PCMH accreditation, support staff and patients have identified the referral process (Figure 2) to be exceptionally complicated and burdensome leading to decreased, documented appointment completion (Patel et al, 2018; Ramelson et al, 2018). The level of involvement required by both patients and staff in the referral process can bring about increased lead times, decreased completion rates, and impaired utilization of healthcare services.

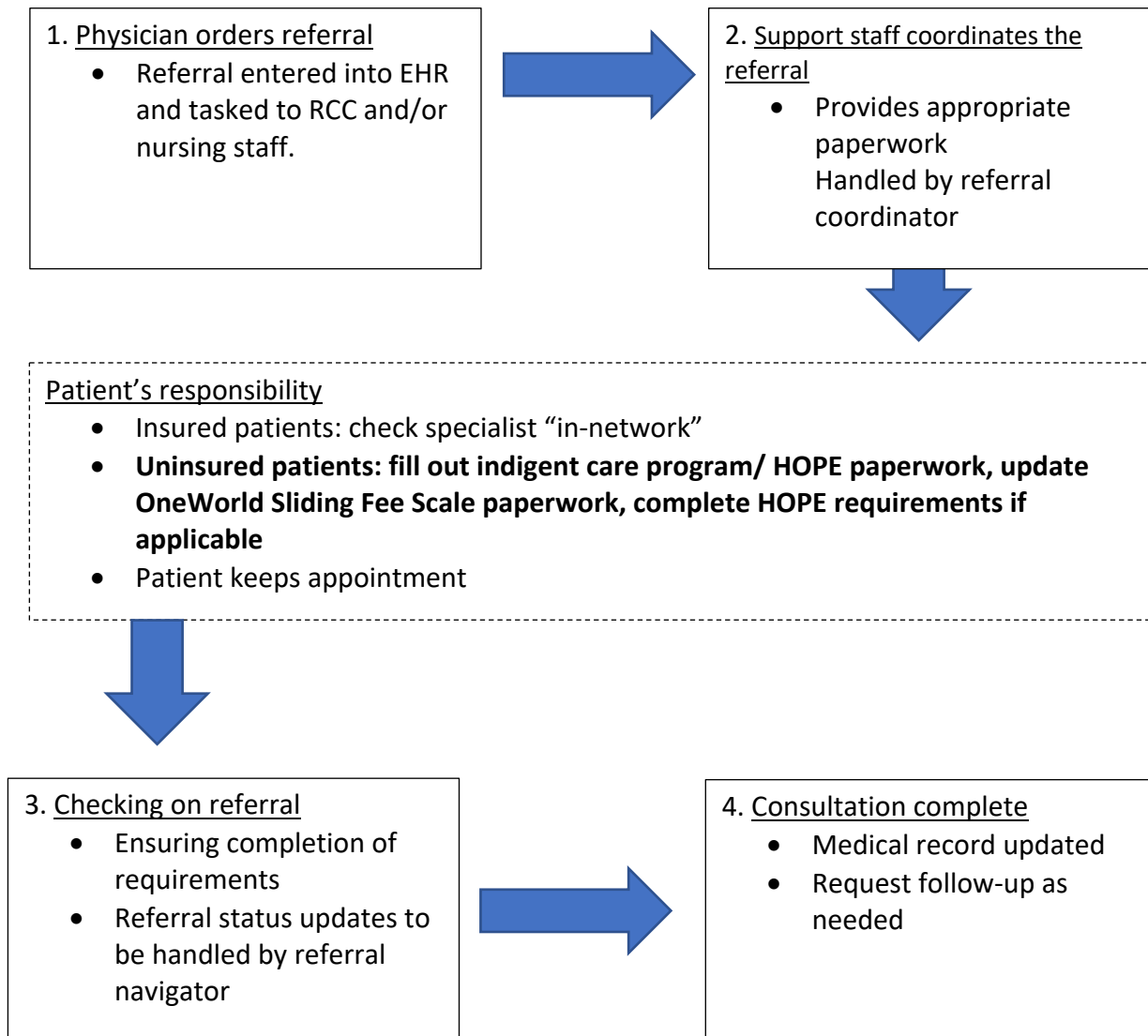


Figure 2. Visual referral process map.

A large portion of the complexity for the referral process comes from the requirements for financial assistance. The Hope Medical Outreach Coalition (HOPE) process, one of the main forms of financial assistance available for referrals, is dictated by the availability of resources which can lead to wait times ranging from a few weeks to a couple of months, so OneWorld’s focus is on trying to get the patient eligible for an appointment as quickly as possible to help

reduce their wait time. OneWorld as an organization has no influence on how long it takes for patients to be seen after being approved for assistance.

When a referral is initiated by a primary care provider, that referral is tasked to the appropriate referral care coordinators (RCC) who then either goes over requirements with the patient or tasks the nursing staff to explain the medical necessity of the referral. Once the patient is in agreement with the referral plan, they are given a list of requirements which need to be completed prior to screening for HOPE eligibility such as proof of income, proof of Nebraska residency, letter of rejection from Medicaid, and proof of ineligibility for private marketplace insurance to name a few. These requirements take time to be gathered and can be difficult to gather due to language, cultural, and immigration status barriers that exists for OneWorld patients. It is only after these requirements are complete that the referral can be entered into the HOPE portal for processing and scheduling.

OneWorld currently employs six teams of RCCs which work directly with patients to ensure understanding of the referral process and agreement with next steps for the completion of the referral. The role of an RCC can include but is not limited to in-room consultations, walk-ins, coordination of referral appointments between patients and clinics, and patient follow-up to ensure prompt completion of referral requirements and appointment completion. Presently, the Chief Medical Officer and Operation's Director at OneWorld plan to implement a referral navigator to address this issue through patient follow-up, in addition to their referral coordinator that handles the initial patient interaction. The referral navigator will serve to follow-up with patients to gauge their understanding of the process, provide support with regard to next steps they need to take to continue with the referral process, and ensure that their pre-requisites are kept up-to-date on a yearly basis (i.e. ensuring validity of HOPE agreement, sliding scale, and

insurance marketplace paperwork). As it currently stands, referral coordinators do not have sufficient time with their current workload to complete the tasks proposed for the referral navigator.

This project seeks to complete a pilot evaluation of the referral navigator position to identify its impact on completion of referral requirements. For the evaluation, a logic model (Figure 3) was created in order to visualize inputs, outputs, and expected outcomes. This model will be useful for organization and the design of an intervention in order to achieve desired outcomes.

Inputs	Activities	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
Trained staff on referral operational process	Referral consultations	Number of referrals entered	Appropriate staff are more knowledgeable about referral processes	Faster completion of referral requirements	Complete or near-complete elimination of referral backlog
Nursing staff	Financial aid/marketplace consults	Number of referrals completed	Patients are more knowledgeable about referral processes	Increased completion of referral appointments	Ability to serve more patients in timely manner
Funds and resource availability	Patient follow-up				
Clear and informative referral materials					

Figure 3. Logic model.

Methods

Project Design

The primary objective of this project was to identify areas of improvement for the patient referral process at OneWorld Community Health Centers through semi-structured interviews. Semi-structured interviews were conducted with three RCCs at OneWorld to inform continuous improvement of the referral process. The objective of this aim was to determine the root cause of the inefficiencies in the patient portion (i.e. filling out of application, gathering of HOPE requirements, etc.) and operational processes of the referral process.

Three RCCs were invited to participate in an audio-recorded, semi-structured interview (Appendix A), during their regular work hours. This allowed participants to share their experiences and feedback regarding the referral process (e.g., understanding of the referral process, length of patient interaction, potential areas of improvement, and their thoughts on the addition of a referral navigator position). The purpose of the semi-structured interviews was to identify barriers to the completion of HOPE requirements through the free exchange of ideas. The 45-60-minute interviews were conducted with three RCCs, each of whom were part of different referral teams serving different patient populations (e.g. women's health, high-risk, pediatrics, etc.).

The secondary objective was to evaluate the feasibility of the proposed "referral navigator" intervention in reducing patient waiting time between referral initiation and eligibility for appointment. A pilot evaluation of the referral navigator will be implemented at OneWorld Community Health Centers to address the patient follow-up issues identified by the Patient Voice Committee with the referral process. The objective of this aim, as established by OneWorld's Chief Medical Officer, is to track timeliness of HOPE requirement completion and

feasibility of implementing a referral navigator. To attain the objective of this section, a patient referral backlog was generated by the Patient Support Supervisor which was used to contact patients using a phone script and extensive field notes were taken which included monitoring patient's understanding and the length of the conversation. The phone script was translated from English to Spanish when appropriate to communicate with patients.

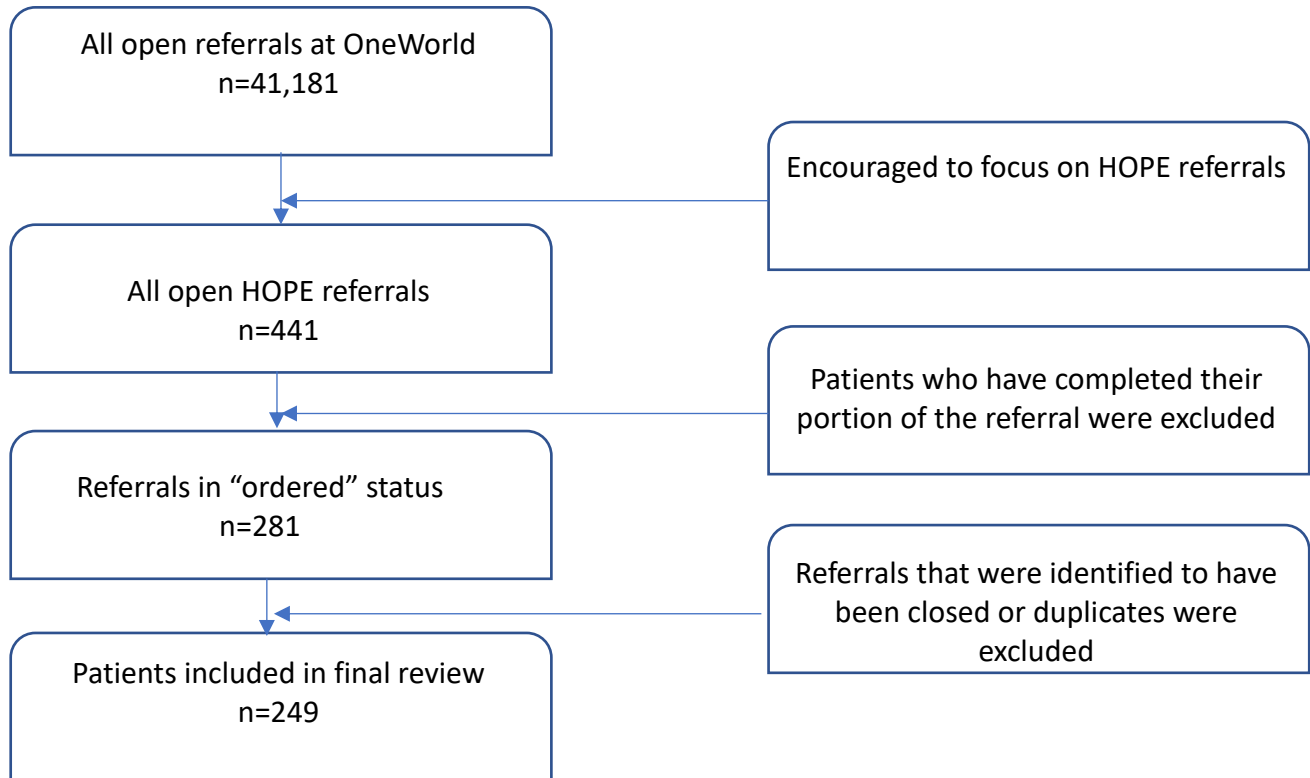
In addition, using the referral backlog, HOPE requirement completion data will be tracked through the electronic health record (EHR). Data gathered from EHR includes whether or not the referral was tasked to RCCs and the time between creation of the referral and the initial contact with patient. The information gathered from the patient interaction will be used track ability to reach patient (phone conversation/ voicemail), patient understanding, patient's desire to continue process (patient will continue with referral or will not), date of initial patient contact, length between initial contact and follow-up, referral status (urgent/non-urgent), length of conversation, number of patients contacted, and any other criteria deemed of interest during conversations. This will then be used to further identify any inefficiencies in the referral process based on patient interaction/suggestions and help make recommendations to OneWorld Community Health Centers to further improve their referral operational processes.

Research Site

The project was conducted between the buildings at OneWorld's main campus in South Omaha - the Livestock Exchange Building (LSX), Women's Health Building, and their administrative building. Interviews were conducted in the RCCs respective work areas during their regularly scheduled shifts. Patient outreach and individual chart review were completed wherever workspace in LSX or the administrative building.

Sample

Sample for patient outreach and individual chart review was taken from all open referrals at OneWorld. Convenience sampling was used to narrow down the open referrals to those specifically going through HOPE.



Data Analysis

Individual interviews with RCCs were audio recorded with the permission of participants. All interviews were transcribed verbatim and coded for emergent themes and subthemes mentioned by participants. A narrative analysis was used in order to highlight critical areas that resonate with findings from the pilot evaluation and the sentiments expressed by the Patient Voice committee. Certain portions of the interviews were translated from Spanish to English for simplicity of analysis and presentation. Frequencies were collected from the individual patient chart review and patient outreach and presented in tables.

Results

Individual Interviews with RCCs

During the individual interviews, RCCs were given the opportunity to share more about their position within OneWorld. They were encouraged to share aspects of their position they felt were not conducive to patient's completing the referral process. They mirrored what the Patient Voice Committee had stated that there was a lack of follow-through.

There's nobody really that follows through, like nobody calls the next day to find out, 'Hey, how was your appointment? Did you attend?' So, we won't find out about this stuff 'till later.

When asked to identify areas in which operational processes could be improved to better serve patients, tasking was brought up.

Today I even pulled up a referral and it was urgent, and it had been a week later, and no one had even talked to them yet.

I'll task [the doctor], 'can you please enter referral for MRI diagnosis?' They won't task me back. They'll task [their RCC] so I have to make sure that I can keep track of what I need entered for patient so I can go back and fill in the details so the [RCCs] are not entering that referral into the whole tracker again.

A lot of times [RCCs] won't see referrals until they look at their backlog and they're like, well this was never tasked to anybody and so no one saw, no one even - no one's even talked to the patient it's been like you know two weeks or something.

We were able to identify that the tasking issues were not necessarily limited to the initial tasking done by providers when entering the referrals into the EHR. Some RCCs mentioned that there were problems with tasking the nursing staff.

We don't exactly get tasked once [nurses] find out. The nurses don't task us back 'cause I run into that problem to where a patient hasn't exactly been told her diagnosis or they don't know exactly know why their requiring to have why they're needing to see the specialist. I'm not a nurse so they have to read over [...] and tell the patient the reason why in case they have any other medical questions and they don't exactly task back on, so I do have to keep track on my own to make sure.

We're just never notified [sometimes] and then we don't see it until back what comes in and then it's like oh when did they put this, does the patient know even though it's in there so that we have to wait and find out if the patient knows 'cause we can't contact them unless they know.

The RCCs continued to express that the tasking processes tended to get complicated and lost when multiple staff were involved and particularly during night clinics.

It's like a big thing especially for night clinic, so little issues there. So, we have night clinic on Tuesdays. [They] stay until I don't know eight or something and the referrals that [they] put in that night we don't get notified.

I want to make sure they get back to the person that initially tasked them because sometimes I'll task the provider, the provider will task the nurse and nurse will task the patient support when I was the one that needed [to be tasked] to begin with.

When questioned how they felt that affected workflow and patient follow-through they expressed their frustration and the measures they took to go above and beyond to serve their patient population.

I've stayed here from 5 to 8 sometimes just to... around the weekend. Getting ahold of them on Saturday. Not Saturday mornings, like in-between like ten to two, I always find it great to get ahold of patients.

The Hispanic community they have like jobs where they don't get off till 5:00 o'clock so I found that the best time to reach patients sometimes is after five o'clock. Like I am surprised by the volume of patients that answer after five.

We are the clinic. We are the ones that put in the referral. So, we are the ones that need to reach out to the patient, and I think it's especially important to reach out to that patient within that week.

Our goal is to schedule while they're in the room, leave with an appointment.

The complexity of the referral process had been brought up during the Patient Voice Committee meeting, so the next question inquired over the patient's requirements of the HOPE process. RCCs mostly agreed that the process was relatively easy for patients.

[RCCs] walk [patient's] through everything. Like the biggest part is they just need to go get like pay stubs and stuff for like the sliding fee, but even then in order to be a OneWorld patient they're required to have an active slide, so I can see doctors sort of point of view but I don't think these steps are complicated at all.

RCCs, however, did express the difficulty of getting patients to complete their portion of the referral process if they were not communicated the same day of their appointment.

I found it good to call the patient throughout that week, so if their appointment was on Monday try to call them during that week 'cause if you call them like 2 weeks after they probably

sometimes they didn't even remember what the referral was about so it was like having to task the nurse to call the patient to tell him what that referral was about. It took the nurses a couple of days to do that sometimes not because of them but sometimes it can get hard to get ahold of the patients once they leave the clinic.

[Patient] didn't exactly get a number or a card from the [RCC] to help her, so she has to call the main line, so the main line has to try to find who helped that patient.

Sometimes we can't get ahold of [patients] and then they just sit there and sit there and sit there and we just couldn't get ahold of them.

Individual Patient Chart Review

As part of the chart review, I sought to find the differences between those referrals that were tasked and those that were not (Figure 4). The chart review revealed that approximately 64% of referrals were being tasked and 36% were not being tasked (this included both referrals not being tasked by providers and those tasked to nursing and not tasked back to the RCCs). Additionally, of the 11 referrals created after 4pm – none of them were tasked to the RCCs. On average the referrals tasked were communicated to patients in less than a day (day of appointment); meanwhile those not tasked, were on average communicated to patients 24 days after being entered.

	Referral Tasked	Referral Not Tasked*
Total Referrals (n=246)	157 (64%)	89 (36%)
Referrals after 4pm (n=11)	0	1.0

Avg. time for initial patient contact (days)	<1	24.58
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Figure 4. Frequency table comparing referrals tasked and not tasked.
**this includes both referrals not tasked by providers and those not tasked back to RCCs by nursing staff*

Patient Outreach

Due to time constraints and workspace limitations, and the guidelines brought on by the COVID-19 outbreak, only 50 patients were called to complete the patient outreach portion of this project. Of the patients called only 11 patients answered their phone, 18 patients had no voicemail set up or full mailboxes, and 3 patients were sent to voicemail. Of the 11 phone calls that were answered, 7 were answered by family members that expressed intent to pass on a message to the patient, 3 patients expressed understanding of the referral and intent to return to OneWorld to speak to an RCC and complete referral requirements, and 1 patient was not aware of a referral being entered for them.

Discussion

This preliminary evaluation of the referral navigator can be used to inform the next steps for OneWorld with regard to closing the referral loop. The results of this evaluation have demonstrated the strengths of the RCCs and current referral process, however the weaknesses have also become apparent with regard to communication. The information gathered will be useful in assessing the impact of introducing a referral navigator and help OneWorld improve how they guide patients through the referral process.

Current RCCs have reflected on their current positions at OneWorld and helped identify some issues that could help maximize the efficiency of their operational processes. Although the referral backlog has ensured that patients are being reached to complete the referral

requirements, RCCs expressed the difficulty in continuously working off of the backlog in addition to serving patients in clinic. The coordinators additionally felt that certain aspects of their workflow were not always culturally tailored to the community, particularly with regard to hours that patients are available, and the level of hands-on work required for patients to follow-through with their requirements.

Through the chart review, communication was found to be a problem between the members of the healthcare team. On average, referrals that were not tasked stayed on the backlog for approximately 24 days before the initial contact between patients and RCCs. Several of the referrals that were not tasked were listed as urgent further underlining the importance of clear and effective communication.

The final concern brought up from the evaluation was during the patient outreach portion. Of the 50 phone calls made, only 8% of the phone calls resulted in a conversation with the actual patient regarding their pending referral lasting on average approximately 7 minutes per phone call. This is a low rate of successful outreach and while the sample is limited, this might be fairly representative of actual outreach at a larger level based off of previous concerns expressed by RCCs (e.g. patients working during the days, not answering unknown phone calls, etc.).

The findings from the pilot evaluation for the referral navigator were organized into a strength, weaknesses, opportunities, threats (SWOT) analysis tool (Figure 5) to better visualize the intervention. Interventions implemented and adjustments made can be based off of this tool using it as a baseline.

<p><u>Strengths</u></p> <ul style="list-style-type: none"> • Well-trained team • Ease of accessibility to RCC • Ease of accessibility to other services (finance, marketplace, etc.) 	<p><u>Weaknesses</u></p> <ul style="list-style-type: none"> • Lack of communication • Lack of follow-up • Limited RCC schedule
<p><u>Opportunities</u></p>	<p><u>Threats</u></p>

<ul style="list-style-type: none"> • Further collaboration between teams (providers, nursing, support staff, etc.) • Improved service to the patient 	<ul style="list-style-type: none"> • Time pressure • Lack of clarity between team members and patients • Lack of motivation and resources for patients
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Figure 5. Referral navigator SWOT analysis.

Recommendations

Communication training refresher

The principal issue that should be addressed is tasking and communication between all members of the healthcare team. Improving communication between the members of the healthcare team will serve to maximize efficiency of operational process and improve the service being provided to the patient. This could include retraining, or an operations training memo (Appendix B) sent out to all employees in order to refresh their training and ensure everyone is on the same page. This has the potential to have a high impact on the referral process with virtually no additional cost to OneWorld.

Implementation of referral packet

In an effort to improve service to the patient through the inclusion of family members and an improvement in the ease of access to information, the implementation of a referral packet would be recommended. This referral packet would essentially be comprised of a folder which included information regarding next steps, clinic visit summary, reason for referral, and include the contact information for their RCC. The patient voice committee expressed difficulty in reaching members of the referral team and cited a lack of follow-through. The implementation of a packet would give patients easier to access to information and their RCC while avoiding the multiple prompts of the telephone system which can be confusing to patients. The implementation of a packet if executed properly could have a medium impact with a relatively low cost.

Branded Folders (10,000)	\$8,415
Printing Costs (assuming 7.5 cents per black & white page and avg. 5pgs per packet)	\$750
Business Cards (10,000)	\$257
Total	\$9422

Figure 6. Sample yearly Referral Packet budget.

Implementation of referral navigator/rotating referral coordinator

Due to the low percentage of patients reached, a referral navigator whose sole job is to contact patients over the phone and postcards, it is difficult to justify the position in and of itself. An alternative, however, could include hiring additional referral coordinators that would serve to “float” or rotate contacting patients as their primary role, working alongside regular RCCs helping patients in-clinic as a secondary role, and rotating shifts in order to contact patients in the evenings (during night clinics) as determined by the needs of the clinic. The creation of this position would be more justifiable in terms of efficacy and feasibility. The implementation of a new position has the potential to have a high impact on the referral process at a higher cost.

Employee Salary (FTE 1, \$15/hr)	\$31,200
Employee Benefits (based on avg. cost 2018)	\$24,128
# of employees to hire	X2-3
Total	\$110,656 - \$165,984

Figure 7. Yearly referral navigator budget.

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First and foremost, I would like to express my gratitude to OneWorld Community Health Centers for allowing me the opportunity to working with such a wonderful team and community. This project would not have been possible without the help of Jennifer Mayhew and the operations team at OneWorld. I also wanted to extend a special thanks to my committee chair Dr. Dejun Su and faculty committee member Dr. Regina Idoate for all their guidance and help with putting together and completing this project. This project would not have been achievable without you.

Appendix A

Survey Questions

Do I have your consent to record this interview?

Can you tell me about yourself and what your role is at OneWorld?

Can you walk me through a typical interaction with a patient in-room?

-How about phone interactions?

Can you walk me through typical interactions with providers?

-Ho about with nursing staff?

Are there any issues you have identified with the patient portion of the referral process?

Are there any issues you have identified with the role of RCCs or other staff in the referral process?

If there was something that could make your job easier what would that be?

What aspects of your job, if any, would you like to see changed?

Why?

Is there anything else you would like to share?

Appendix B

Operations Training Memo

Effective date: MM/DD/YYYY

Re: Referral Tasking

To guarantee that we continue providing the best care possible and ensure prompt communication and completion of tasks, we are sending this reminder to refocus our goal of meeting the community's needs.

- Providers should task or radio for an RCC any time that a referral is entered. Patients should be reminded to stay in their room until an RCC speaks with them in order to maximize the efficiency of their time spent at OneWorld.
- Nursing staff tasked by an RCC to contact a patient should task back the exact person that issued the initial task after its completion in order to prevent any disruption in the continuum of care.
- RCC's should review patient chart prior to entering a task to ensure there is no duplication of referrals.

ⁱThe practice coordinates referrals by providing a reason for referral and relevant clinical information, tracking referral status, following up to obtain specialist's report, documenting agreements with specialists for co-management, providing an electronic exchange of patient information.