# Gastroenterology

# CASE STUDY FACILITATOR COPY

**Describe the Practice:**

Gastroenterology Practice is finding they have limited access for referrals. They have a back log of patients needed to be seen for such diagnosis of Crohn's disease, ulcerative colitis, or irritable bowel syndrome. The physicians are experiencing an uptick in phone calls directly from Primary Care Physicians trying to get their patients seen sooner. The PCP's feel their patients are frequenting the ED, have been prescribed poly pharmaceuticals and frequent labs/radiology studies providing no relief to frustrated patients and their families.

**Current State:**

The practice is unsure where to start in addressing the referral backlog, and they are concerned about the frustration they are hearing from their referring primary care providers. When asked if they are able to identify any areas of waste in their system, the practice manager noted that they have been discussing how to better handle many referrals for patients with heartburn who are being referred for diagnostics of gastro-esophageal reflux disease using endoscopy. They are concerned that many of these referrals are unnecessary based on the evidence, but unsure how to approach this given the frequency of referrals and the patient expectations that endoscopy will be beneficial to them. Their Referral Specialist is concerned that there are inefficiencies in their referral process, but is not sure how to tackle it.

**TCPi Change Package and Goal Alignment:**

Define specialty-primary care roles: Jointly implement criteria and processes for specialty referrals for episodic care, co-management, or transfer of care, as well as graduation back to primary care, as appropriate; communicate to the patient and family:

1. Develop compacts between primary care and specialist practices that include defined referral criteria
2. Educate patients on resources and appropriate use of specialists
3. Assign responsibility for care coordination and referral management
4. Use structured referral notes to ensure referrals are appropriate
5. Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings
6. Systematically integrate information from referrals into the plan of care
7. Have a shared care plan used by primary care and specialist practices for co-managed patients
8. Have a reference list for use by specialist's front desk staff so that they can screen for "appropriate" referrals, or those that are usually urgent or non-urgent

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9. Develop a system for handling "rebounds" of patients who are determined not to be appropriate for referral or transition

**Target Ideal State:**

Describe this practice's ideal state for a process they are working to change.
What is most important to the practice? What would success look and feel like?

Consider how to address concerns about the referral process – how could the practice begin to have visibility of improvements they could make in the referral process? How could patients be better prepared for referrals?

Hint: consider pre-consultation

Hint: consider how to 'close the loop' in the referral process

Does this practice know when their patients are landing in the ED?

How could they work better with their patients' Primary Care Providers?

**Recent Changes to your Process:**

Add bullet(s) to describe changes the practice could make – where could they start?

Note available data used to track changes such as current state and change in key processes:

What areas still need improvement?

**Barriers to Beginning Change:**

Describe barriers to starting key changes: