The Referral Process from an Operational Viewpoint

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The Referral Process – Potential for everyone involved

The hospital CFO, new to the organization, wanted to know the referral impact of the owned physician practice on the outpatient business. The hospital data indicated a volume much less than what he expected given the practice's size. When the

physician organization presented their referral data, the volume was over 30% greater than the hospital's report.

A review of the physician practice's current referral list to the hospital outpatient services indicated that approximately 40% of the patients had no referral or authorization source restriction. They could go anywhere in a highly competitive marketplace saturated with advertising and very accommodating service accessibility. The physician practice had no aggregate referral completion information thus did not know where patients went for referred outpatient service.

What they did know is that obtaining results from the multiple non-hospital providers was both labor intensive and interfered with follow up visits via missing information. The physician scheduling center experienced 12% No Show and 17% Reschedule rates in return visits; many of which involved referral work to be completed. This translated into significant increased operating costs, revenue loss and ultimately poor access for other patients who could have used those missed appointment slots.

In our work with many hospital scheduling operations, not one ever asked when the patient was scheduled for the physician's return visit yet alone account for it in scheduling. Only <u>one hospital</u> scheduling system we have encountered accommodated the return visit date in a field but it did not automatically trigger an event if the return date was exceeded.

Is it any wonder why independent physician offices would allow patients to make the decision where to complete referral work and not schedule return visits until the patient completes? The patient then must call them to schedule the return visit which just adds costs for the practice and inconvenience for the patient.

Structural Impediments to good information

Reconciling referral information with the physician practice can be a tricky act. The hospital referral measurement system typically represents patients actually treated; not the total referred by a practice. The practice's information may provide quite a different picture as they measure referrals even if not completed. Regardless, when patients have unlimited options for outpatient providers both systems can be inaccurate or useless.

Most administrations don't reconcile contacts to service departments with ultimate services delivered. So how many times are voicemails not returned or connected with and patients go elsewhere? We've observed (scheduling/service area) voicemail return practices in which only one return call is made to a patient and if not available expecting the patient to call again. The message list is never reconciled to ensure all inquiries were ultimately personally contacted and serviced. No wonder studies of automatic referral systems indicate an increase in referrals but not necessarily increased enrollment rates.

The one position, physician liaison, which can view the traverse between referral source and the hospital typically, has no authority to rectify the situation. We actually had a Business Development manager tell us he would be better off focusing on other marketing efforts than attempting to address a poor performing scheduling department of which he was well aware.

Attracting Referrals

So, unless your clinical offerings are so outstanding to attract the business volume desired without any extra effort (such as liaisons and business development) what has to be addressed in the "mechanics" of the referral process includes:

1. Identify the referral and reach out to them vs. waiting for them to call you*

2. Ensure the correct resource is connected with the patient and scheduling occurs in accordance with any return visit schedule*

3. Provide the referring source the schedule status of the referral compared to the return visit so they can adjust if necessary*

4. Improve those services not meeting the referral scheduling needs

* Instant information exchange preferred

No doubt these steps may be different than what is in place now but don't forget the cost associated with the current process for everyone involved. It may require a new type of referral system and providing operations with technical assistance to meet the referral expectations, especially if volume increases. However, the liaison that is charged with building referrals will have a competitive edge and the patient will have a more seamless experience.