



**System Study for Public Health and Community
Health Centers' Specialty Referrals**

**Final Report to the Pacific Hospital Preservation and
Development Authority
7-06-07**

Executive Summary

This study focused on evaluating the specialty referral processes for uninsured patients from numerous public health and community health centers in King County to the Pacific Medical Center (PMC) specialty clinics. This work was commissioned, organized, and financially supported by the Pacific Hospital Preservation and Development Authority (PHPDA). The PHPDA provides funding to PMC, underwriting a considerable amount of the cost of the specialty care PMC provides to the uninsured. Other important partners in this project included King County Project Access (KCPA) and the Community Health Plan (CHP). This stakeholder group (the public health department in King County, the community health centers, PMC, KCPA, and CHP) committed in advance to implementing the recommendations resulting from this project.

PMC supports a Charity Care (CC) Program to process specialty referrals and charity care applications for uninsured patients referred by providers at the public health and community health centers. In late 2005, the CC Program application review process was centralized. In the last two years PMC experienced a significant decrease in the number of uninsured specialty patients referred or seen from the public health and community health centers from a historical average of about 4,000 uninsured patients to only 968 uninsured patients seen by PMC specialty care in 2006.

The overall goals of the project were:

- To conduct a study of current eligibility determination and clinical referral processes and the CC Program practices for low income uninsured patients between public health and community health centers and PMC
- To develop recommendations for a complete and appropriate referral system, that facilitate specialty care referrals for uninsured patients from public health and community health centers to PMC

Numerous analyses and information-gathering activities were conducted by MCPP, with strong participation and support from the public health and community health centers and PMC specialty clinic leaders and staff, in completing the project. These activities included numerous analyses of the PMC CC Program referral log and sample CC Program referrals, public health and community health centers' referral logs, review of documentation from the community, public health and specialty clinics, in-person interviews, process observations, and a practitioner and staff online survey.

Major Conclusions

The major conclusions from the data analyses and qualitative findings for the system referral study are described below.

1. In the PMC CC Program sample analysis only 42% of uninsured patients referred for specialty care at PMC submitted applications for the CC Program and 58% of the specialty referrals were pended due to not having a CC Program application submitted by the patient (no application sheet for CC Program).
2. Lack of an application for the PMC CC Program was the reason for 89% of pended referrals. This means that no application form or any supporting documentation was submitted. Incomplete CC Program applications accounted for 11% of pended referrals; these applications were missing supporting documentation for proof of residency and/or verification of income.
3. Of the 42% of referrals with CC Program applications, approximately 70% were approved. When the 58% of referrals without a CC Program application were included, the overall approval rate dropped to 30% of uninsured patients referred to PMC for specialty care.
4. There was significant variation in the CC Program application process conducted at each of the public health and community health centers including:
 - Variation in referral forms, even within clinic groups,
 - Variation in processes to get CC Program applications to patients; some clinics mailed the CC Program application to the patient and some gave the CC Program application directly to the patient at the clinic,
 - Variation in the level of assistance to the patient in completing the CC Program application,
 - Variation in whether the clinic collects and holds the CC Program application and supporting documentation until the CC Program application was complete and then submitted the complete referral packet, and
 - Variation in tracking mechanisms, logs or databases for tracking the status of referrals, even within clinic groups.
5. In helping patients to prepare their CC Program application, public health and community health center staff do not use income and residency documentation previously collected for the clinics' eligibility screening processes.
6. The CC Program staff and appointment schedulers do not screen for clinical appropriateness of the referral or completeness of clinical documentation; any follow-up with the clinics regarding clinical documentation is done by the specialty practice office.

7. The PMC CC Program staff routinely communicate the status of the CC Program application only to the patient and not to the referring primary care clinic or primary care provider.
8. The CC Program criteria for income and residency verification are not clear to community and public health staff and providers, and numerous versions of CC Program documents (including criteria) are used across the public health and community health centers.
9. The PMC CC Program application criteria and forms are primarily written in English at a high grade level, while the uninsured population has a high percentage of non-English speaking/reading and low literacy patients needing specialty care.
10. There are no regular meetings between PMC CC Program staff and public health and community health center referral coordinators (RCs), or of the RCs within clinic groups. There are no existing orientation mechanisms for new referral coordinators at the clinics or new staff at the PMC CC Program.
11. There is no systematic mechanism for updating phone and fax numbers for all the parties involved in the specialty referral process. Many staff reported that referrals frequently needed to be re-faxed to the PMC CC Program office, sometimes more than twice.
12. Some public health and community health centers refer fewer uninsured patients to PMC than their proportion of uninsured and total users of the primary care clinics. Some do not refer to PMC for specialty care at all and others refer greater than their proportion of the uninsured and total users.
13. Among clinics providing data on insured/uninsured status, some demonstrated a higher rate of specialty referrals for the insured versus the uninsured population. While uninsured patients represented 40% of the 2006 primary care user population, they represented only 20% of the specialty referrals.
14. There is no established group to oversee or to make improvements (such as to track, analyze and address access issues, growing trends and referral patterns) across all public health and community health centers and specialty providers for the King County referral system for uninsured patients.

Recommendations

The following recommendations address the major conclusions described above and are presented by timeframe: immediate action for each party, collaborative short-term action within three months, collaborative medium-term action within six months and ongoing monitoring and system improvement. The recommendations also include the establishment of two workgroups; one short-term workgroup charged with clarification of the application of the CC Program criteria and a second mid-term workgroup to redesign the uninsured specialty referral and CC Program processes. For ongoing monitoring and improvement of these processes, it is recommended that the Oversight Committee become the referral system leadership group.

Immediate Action by Pacific Medical Center (PMC)

1. Add capacity to receive incoming CC Program applications (includes CC Program application form and documentation and specialty referral and documentation.)
 - If FAX machines are used, dedicate these machines entirely to CC Program paperwork, increase capacity and designate a back-up FAX number and machine to ensure access.
 - Investigate the possibility of using email to receive all CC Program documentation.
2. Design and implement a standard notification process to PH/CHC Referral Coordinators.
 - PMC to notify all PH/CHCs of the receipt and initial determination status of CC Program applications when the referral packet is received, including what is missing if the documentation is not complete.
 - PMC to send second notification to all PH/CHCs of the determination status 30 days after receipt of referral/CC Program packet, including what is missing if the documentation is not complete. Consider establishing a password protected website for PH/CHC staff to check the CC Program application status.
3. Establish an “aged-out” closure process for all PMC Referral/CC Program applications pended for more than 90 days. PMC will return all currently pended referral/CC Program applications dated prior to March 1, 2007.
 - Work with PH/CHC leadership to identify recipients of “aged-out” referral/CC Program applications at each PH/CHC.
 - Develop an Implementation and Communication Plan for initiating the “aged-out” closed referral/CC Program applications with instructions that includes the option to return completed CC Program applications within 30 days. (To be completed by July 31, 2007).

Immediate Action by PH/CHCs, PHPDA and PMC

1. Determine the distribution list for the Referral System Project Report.
2. Utilize the King County Project Access (KCPA) list of PH/CHC and PMC Referral Coordinator and CC Program staff names, titles, phone numbers, and FAX numbers across all PH/CHCs and PMC and assure the list is updated regularly, at least quarterly.
3. Identify the point person for each PH/CHC, for PMC and for KCPA to ensure reliable communication and implementation of referral/CC Program revisions and process updates. This may be a leadership person, not the Referral Coordinator described in number 2 above. Keep the list of point persons updated at least quarterly.

Short-Term (Next 3 months) Referral System Design Work

Establish a CC Program Eligibility Criteria and Forms Workgroup to complete the tasks outlined below by September 2007.

- Notify Workgroup members and develop charter.
- Clarify the application of the CC Program income criteria, including:
 - Documentation requirements when the unemployment office states “no wages.”
 - Eligibility boundaries for bank account balances when the individual has no income.
- Clarify the application of the CC Program residency criteria, including:
 - Whether evidence of legal residency is required and ways in which it can be documented.
 - Whether documentation of King County residency for three months is required and ways in which it can be documented.
- Clarify the application of the CC Program eligibility criteria for patients with special insurance situations, including:
 - Basic Health Plan (BHP) waiting period.
 - Pre-existing conditions for BHP patients.
 - Patients with Major Medical insurance only.
- Clarify PMC’s philosophy and intention for the CC Program to ensure that the above clarifications regarding the interpretation and application of the eligibility criteria are consistent with PMC policy.
- Determine if recent (e.g.; within 3 or 6 months) income and residency documentation previously collected by PH/CHCs will be accepted by PMC for CC Program application documentation.
- Revise the CC Program application cover letter, form and instructions to:
 - Reflect the interpretation and application of both criteria and documentation requirements,

- Meet a lower literacy level (recommend 6th grade),
- Translate the forms and instructions into multiple languages, and
- Develop a CC Program description to introduce the program to uninsured patients and include as regular part of CC Program application. (See example from CHCKC)

Medium-Term (Next 3-6 months) Referral System Design Work

1. Develop and implement an ongoing monitoring system for PMC CC Program applications for consistency of the interpretation and application of the CC Program criteria such as a sample audit of CC Program applications, using a standard template with a summary report to go to the Referral System Implementation Workgroup.
2. Develop and implement a single, shared web-based referral database that every PH/CHC and referral source uses, which standardizes the methodology and makes it possible to unduplicate the specialty demand.
 - Review the Service Point tracking system piloted by Project Access NOW, Oregon.
 - Agree on the methodology for the database (fields, nomenclature, etc) to be implemented in every site
 - Collect, analyze and report data at least annually to monitor utilization by PH/CHC and specialty source
3. Establish regular meetings for referral staff
 - Establish regular meetings for Referral Coordinators at each PH/CHC.
 - Orient PH/CHCs to successfully implement the results of the CC Program Eligibility Criteria and Forms Workgroup.
 - Conduct periodic meetings of the PH/CHC/PMC referral staff convened by the Referral System Implementation Workgroup (*See Ongoing Monitoring Recommendation #1*) to problem-solve uninsured patient referral and CC Program issues.
4. Develop a PMC website to post all CC Program related material, (e.g. process instructions, updates and general information).
 - Create a direct link from the PMC/CC Program website to the KCPA website and the Referral Coordinator list.
 - Consider a password protected website for PH/CHC staff to check on CC Program application status.
5. Charter the Oversight Committee as the Referral/CC Program Re-Design Workgroup to complete the following tasks by December 2007.
 - Create one county-wide specialty referral and CC Program application process for uninsured patients with one set of clinical specialty criteria, referral forms and CC Program application forms that are used across all PH/CHC sites.
 - Review, improve, and implement the recommended Referral and CC Program Work Flow (*See Attachment E*)

- Use Milliman Referral Management Guidelines for specialty referrals.
- Use standard referral form (review CHP form).
- Work with PH/CHCs to ensure that all PH/CHCs complete the CC Program application with all needed documentation before it is sent with the completed specialty referral and documentation to PMC, to match the existing KCPA process.
- Work with PH/CHCs to ensure that all PH/CHCs Referral Coordinators meet with patients whenever possible to assist in completing the CC Program application and collecting all needed documentation.
- Once the literacy and translation revisions to the CC Program application and supporting documents have been fully implemented, investigate reasons that uninsured PH/CHC patients do not submit the CC Program application.
 - Based on findings, design interventions to increase the percent of eligible uninsured patients submitting completed CC Program applications for specialty care.
- Once improved email/fax capacity is in place at PMC, monitor the sites and circumstances of failed email/fax attempts and duplicate requests between individual PH/CHC Referral Coordinators and PMC. Based on findings, design and implement strategies to decrease/eliminate rework.

Ongoing Monitoring and Systems Improvement

1. Charter the Oversight Committee to become the Referral System Implementation Workgroup to oversee and direct the work plan development and implementation of the re-designed referral and CC Program application process improvements across all PH/CHCs, KCPA, and PMC.
2. Establish ongoing mechanisms for resolving problems and concerns regarding the uninsured specialty referral/CC Program processes.
 - Regularly review data regarding the incidence of concerns and ensure the timeliness of resolution.
 - Ensure that current information is available regarding the capacity and availability of specialty services.
3. Monitor and document the improvements in the referral and CC Program processes and track referral patterns to determine impact of numbers of patients referred and seen at PMC.
4. Expand the uninsured specialty referral database (*See Medium Term Recommendation #2*) to include both uninsured and insured patients.
 - Monitor the percentage of uninsured patients receiving needed specialty care, and analyze referral patterns to identify disparities in referral patterns between insured and uninsured patients.
 - Make use of available CHC EMR data for ongoing monitoring and measurement of outcomes.
 - Target further opportunities for improvement in referral and CC Program processes.