Referral Management

Risk: Unreconciled specialist opinion/recommendation

Lack of follow up with patient due to inadequate office practice system to reconcile record from specialist visits.

CLOSED MALPRACTICE CASE

A 74-year-old male was advised, during a hospital stay, to see a pulmonologist for a specific opacity in his right upper lobe suspicious for carcinoma seen on a CT scan. The patient was seen shortly thereafter by his PCP, who made a referral to a pulmonologist. The PCP saw the patient for regular visits for the next four years, but was not aware of the pulmonologist's recommendation for additional follow up regarding the lung concern. At age 78, the patient was diagnosed with stage IV lung cancer and died three months later.

DIAGNOSTIC PROCESS OF CARE IN AMBULATORY DIAGNOSIS CASES, 2009–2013

A mismanaged referral is a contributing factor in 11% of CRICO (19% of CBS) ambulatory cases alleging a missed or delayed diagnosis.

	PERCENT OF CASES*	
STEP	CRICO (N=194)	CBS† (N=2,685)
1. Patient notes problem and seeks care	2%	1%
2. History and physical	8%	7%
3. Patient assessment/evaluation of symptoms	39%	26%
4. Diagnostic processing	45%	34%
5. Order of diagnostic/lab test	43%	31%
6. Performance of tests	6%	3%
7. Interpretation of tests	32%	23%
8. Receipt/transmittal of test results to provider	3%	5%
9. Physician follow up with patient	26%	18%
10. Referral management	11%	19%
11. Provider-to-provider communication	13%	12%
12. Patient compliance with follow-up plan	8%	15%

*A case will often have multiple factors identified.
†CBS is CRICO's Comparative Benchmarking System.

PATIENT SAFETY VULNERABILITIES

1. If referrals fail to reach the office, patients, or specialists, or if the information is not integrated into the care plan, patients may be at risk.

   SAFER CARE: To avoid a "person specific" referral management process, develop reliable processes to ensure 1) patients are referred to specialists in a consistent manner, 2) outstanding visits are followed up, and 3) specialist reports are brought to the attention of the patient and the care team.

2. Communicate clearly with patients your clinical reasons for referrals and their urgency. Breakdowns in communication with the patient regarding test results, change in medical status, and when to return for unresolved concerns can lead to poor patient outcomes.

   SAFER CARE: When all parties are involved in referral transactions they reduce the opportunities for patients (or reports) to fall through the cracks. Inadequate systems for closed loop communications of referrals can lead to gaps in patient care. Build a redundant system incorporating all members of the care team, including the patient.

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Referral Management, continued

Risk: Unreconciled specialist opinion/recommendation

QUICK ASSESSMENT

1. Has this type of event happened at our practice?
2. What did the providers in this case do well? Where did communication breakdown (or where did things go wrong)?
3. What is our system for referral management? What role does each team member (including the patient) play?
4. How do we communicate high-priority referrals to the clinical team and patient?
5. Do we document all patient communication in the medical record?

IMPROVEMENT OPPORTUNITIES

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
1. Referrals are ordered and documented in the EHR		
2. The reason and urgency for the referral is communicated to the patient and specialist, and an appointment is made for the patient prior to leaving the office		
3. A procedure to identify which referrals are outstanding		
4. A system to track and log completed referrals		
5. Provider review of all incoming referrals is tracked		

CRICO Safer Care **materials are designed to help all members of a multidisciplinary team reduce the risk of patient harm in the course of diagnosis and treatment. Office-based events that trigger malpractice cases present valuable opportunities to identify vulnerabilities in communication, clinical judgment, and patient care systems. Successful practices shared by local and national peers inform the Safer Care recommendations. CRICO works closely with your organization's Patient Safety and Risk Management staff to build expert resources for individual and team-based education and training.**

Email comments, resources, or questions to safercare@rmf.harvard.edu.

Additional Resources

www.rmf.harvard.edu/safercare

Please visit the CRICO website for related:

- CME Bundles
- Podcasts
- Clinical Decision Support
- Slideshow presentations to share with your team
  Open Presentation PDF
- Plus, additional topics in the *Safer Care* series

How to Earn Category 2 Risk Management Credits

This *Safer Care in the Office Setting* module is suitable for 0.25 Category 2 risk management credit for MA physicians. Risk Management Study is self-claimed; complete, date, and keep this page for your record keeping.

About CRICO

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest health care in the world. CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard medical community.

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