

# Closing-the-Loop

## Lessons Learned

### Performance Challenge

Lack of referral tracking can lead to inefficiency and frustration. Up to 50% of referrals are not completed. Of the ones that are completed, notes are often not sent back to referring practices, leaving them unaware of new diagnoses or changes. Most practices lack established processes for closing the referral loop.

### Practice Solution

Closing-the-loop requires bi-directional information sharing and communication between practices. Practices should log and track every referral request through completion. Receiving practices should also log referrals and notify requesting practices of the referral request disposition, including appointment date and time, and if referral is not appropriate or if unable to schedule. Subsequent cancellations or no-shows should also be communicated. Following a referral visit, the receiving practice should send a timely and clear response note to the referring practice.

### Change Steps

Below are key steps to establish a referral tracking system and close-the-loop workflow:

- Collect data on percent of loops closed.
- Process map the current referral tracking process; note gaps and establish clear team roles and responsibilities.
- Track no-shows, cancellations without reschedules, and referrals never scheduled.
- Develop a process to identify patients needing outreach due to no-show, cancellation or not yet scheduled.
- Develop a process for bi-directional communication after a referral appointment.
- Develop a reporting mechanism for close-the-loop metrics at the clinic and potentially, clinician levels.

*Closing-the-loop for clinical referrals improves patient safety and satisfaction, as well as clinical care coordination.*

## Practice Spotlight

Denver Health is a multi-specialty health care system that has served as Denver's safety net health system for 150 years. It receives over 151,000 unique patient visits per year from a diverse community with complex health needs. Due to the extensive range of healthcare services offered by Denver Health, 95% of referrals are made to other Denver Health clinicians, all of whom share the same EHR.

**Care Coordination Challenge:** Because of the shared EHR, Denver Health assumed that specialty practices would see new referrals in the EHR, the central scheduling center would schedule these referrals in a timely manner, and referring clinicians would know the status and outcome of their referrals. However, Denver Health identified two serious problems. First, patients often got lost in the scheduling process and never completed a referral visit. Second, even when referral visits were completed, referring clinicians were often unaware of the results and next steps, requiring the patient to serve as the communications go-between. A baseline measurement showed that post-consultation notes were sent to referring clinicians in 18% of cases.

**Assigning Close-the-Loop Roles:** Once these problems were identified, a Denver Health quality team developed a close-the-loop process for referrals and assigned new responsibilities to different groups. Previously, all notifications regarding a scheduled appointment, cancellation, or no show were sent to the clinician's inbox, where they would sit unread. Now these alerts and notifications are sent to the referring practice's care team, consisting of clerks, medical assistants, and patient navigators, who are empowered to follow up on patient no-shows, cancellations, and patients still unscheduled after 30 days to ensure that patients have every opportunity to complete a referral visit as prescribed.

The quality team then developed a modification in the EHR allowing "referred to" clinicians to send their response to the referring clinician and any other relevant clinicians with a single click, providing intentional communication capabilities without being burdensome. Several report options are available. In addition, the quality team developed accountability reports to measure on three levels—system, clinic, and clinician—along with a dashboard to track when referral responses were sent back to the referring practices. Results are part of GEMBA boards—a visual management system—clinician scorecard metrics, and newsletters.

**Patient-Centered Care Coordination:** Patients are pleased that

## Lessons Learned

### Change Tactics

Successful practice transformation tactics fall under the areas of person-and family centered care:

- Assign responsibility for care coordination and referral management.
- Establish care coordination agreements with frequently-used other practices that set expectations for documented flow of information and provider expectations between settings.
- Develop both personal and electronic relationships among medical neighborhood providers to ensure information sharing.
- Maintain a referral tracking system to help patients make and keep appointments.

### Resources

ACP’s High Value Care Coordination Curriculum provides webinars and supporting documentation to help both primary and specialty care practices improve their interactions with each other, including Closing-the-Loop. The four key steps covered include:

- ◆ *Getting Your Own House in Order* – mapping your current processes
- ◆ *Getting a High Value Referral* – referral processes and pertinent data sets
- ◆ *Ensuring Others Get What They Need* – closing the loop, patient-centered referrals
- ◆ *Creating Care Coordination Agreements*

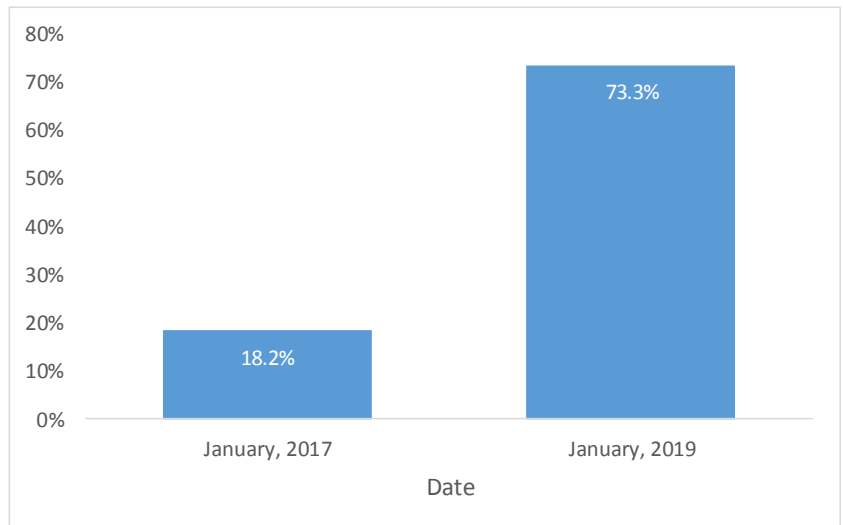
ACP Practice Advisor® modules—[Track and Coordinate Referrals](#) and [Track and Coordinate Care](#). Attention to communication between referring and referred-to practices (“closing the loop”) is a hallmark of patient-centered practices. These modules provide useful information and tools for assuring that the communication flows, whether related to a specific referral or an actual transition of care. (Login required; nominal fee may be required.)

## Practice Spotlight

they don’t fall through the cracks when referred to another clinic and happy that their doctors are communicating about their care.

**Measureable Impact on Closing-the-Loop:** In early 2017, Denver Health noted that the average rate of “closing-the-loop” for 43 specialty clinics was 18%, meaning that referral notes were sent back to

**Figure 1: Denver Health Specialty Clinics—Close-the-Loop**



the referring clinicians in only 18% of cases. Following implementation of the new processes, the average rate of referral notes rose from 18% to 73.3%, as shown in Figure 1.

It is important to note that this change is actually more impressive than the increase in the average. In 2017, while the average rate overall was 18.2%, over 72% of clinics measured had scores below 10%. Only a few better-performing clinics pulled the average up to 18.2%. However, in 2019, the 73.3% average included 79% of clinics with scores higher than 50%. Looking at the 43 clinics individually, 40 of them (93%) demonstrated improvement during the measurement period.

Patient safety improved with the implementation of a full close-the-loop process; patients complete their referrals, and visit outcomes and plans of care are received by PCPs. In addition, patients are happy to have the health system support them with care coordination and trust the reliability of the process.

The close-the loop process also improved clinician joy-in-work; primary care clinicians started calling specialty clinicians to thank them for providing referral notes and care plans. As the success of the new seamless process became known, other patient touch points, such as the emergency department, dental clinics, and behavioral health, expressed interest in implementing close-the-loop measures as well.