Referral Management: The Good, the Bad and the Ugly!

Richard Jones,

BOS Commissioners' Day,

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About Me

- Chairman of Orthodontic Practice Committee/ Director of Clinical Practice BOS 2006-2013
- Full time Specialist Practitioner
- Chairman, Total Orthodontics Ltd. 2009-2015
- Director of Professional Development BOS 2016-2018

Learning objectives:

- Historic referral and operational models
- Issues with historic model
- Referral management: Indications and benefits
- Potential barriers and considerations for referral management
- Appraisal of current and potential Referral Management Processes
- Summary

Current/Historic Referral and Operational Model

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Where to refer:
4 providers of orthodontic care

- Specialist Practitioner
- Consultant led hospital service
- Community service
- DwSI

Current/historic referral process

GDP
Parent*

Referral- paper

Orthodontic Provider: Primary or secondary care

- Variable local policies
- Variable timeframes
- Referrer/patient choice and market forces
- No standardised care pathway
- No standardised proforma
- Multiple referrals
- Difficult to validate/ measure

Primary care treatment waiting list or treatment

Issues with current/historic model

Perceived/real issues: Commissioners

- Appropriate referrals
  - Inappropriate referrals- below IOTN threshold
  - Unsuitable for treatment
  - Wasted funding?
- Waiting times
  - 18 week challenge and existing waiting lists
  - Variable waiting list management: W/L for assessment or treatment?

Perceived/real issues: Commissioners

- Validating and tracking referrals
  - Audit trail
  - Needs assessment
- Referral to "wrong" provider?
- Multiple referrals

Perceived/real issues: Patients/parents

- Waiting times
  - Delay
  - Lack of clarity
  - Lack of informed choice?

Perceived/real issues: Providers

- Appropriate referrals
  - Inappropriate referrals- correct provider
  - Unsuitable for treatment
  - Timing
- Waiting times
  - Fixed volume contract in primary care
  - Pressure of KPI's and monitoring

Further complications:

- Primary v Secondary care
  - Different service- complexity
  - Different remuneration structures
  - Different measures and monitoring
  - Different waiting list targets and management

Commissioning guidelines 2015

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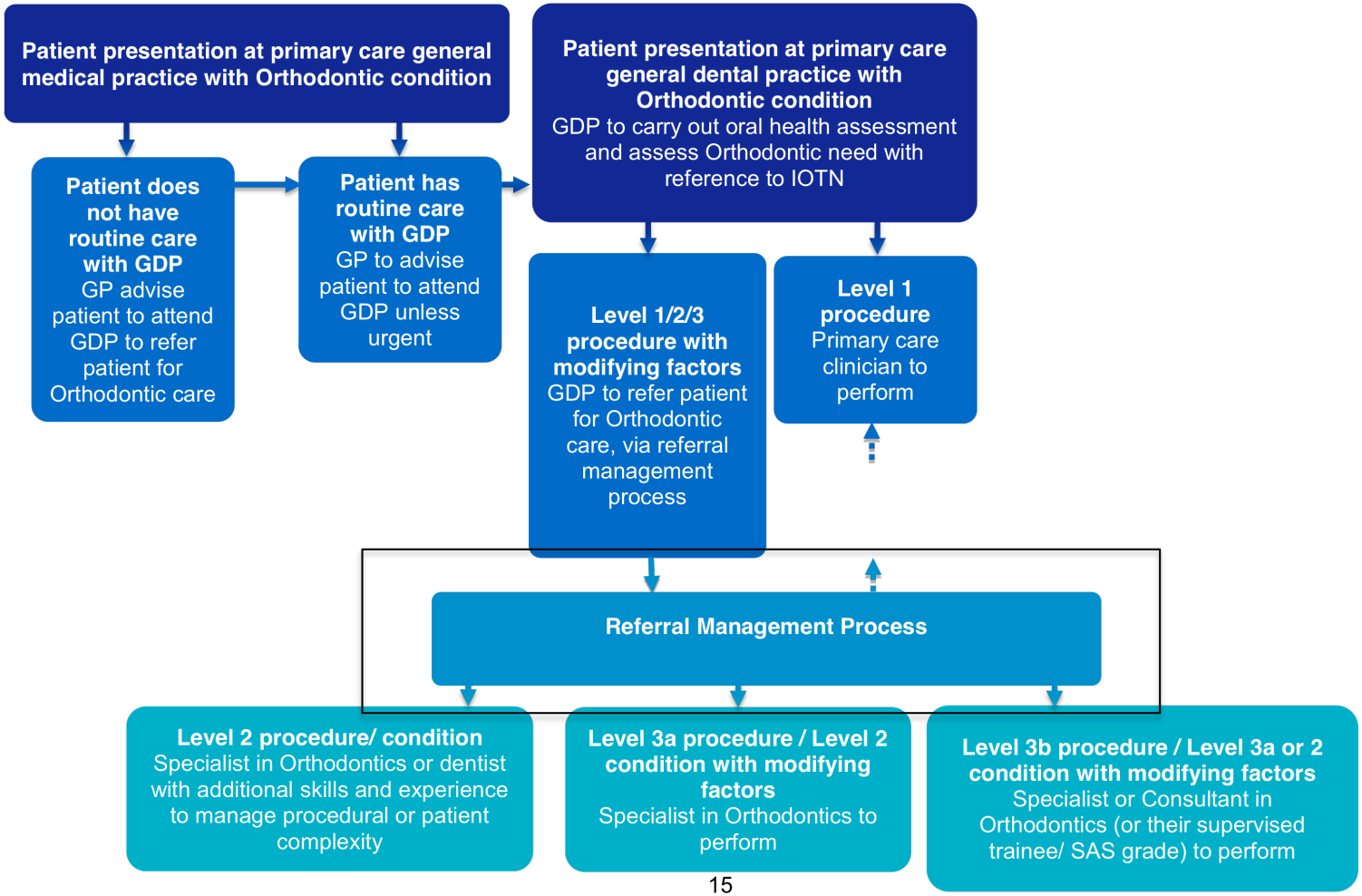
5 Summarised illustrative patient journey



Referral Management: Potential Indications and Benefits

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- Quality of referrals
  - Treatment need
  - Suitability
  - Timing
  - Setting: Primary or secondary

- Standardised process and data set
  - Validation
  - Tracking, monitoring and audit trail
  - Commissioing decisions
  - Patient identification
  - Elimination of multiple referrals

- Waiting list management?
  - Improve access?

- Financial
  - More effective use of funding
  - Improve start: rev ratios

Financial aspects of referral management

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Primary care orthodontic budget

England: YE 14/15	% of claims	% of budget
Assess and Treat	47.8	95.05
Assess and Review	39.1	3.7
Assess and Refuse	13.1	1.24

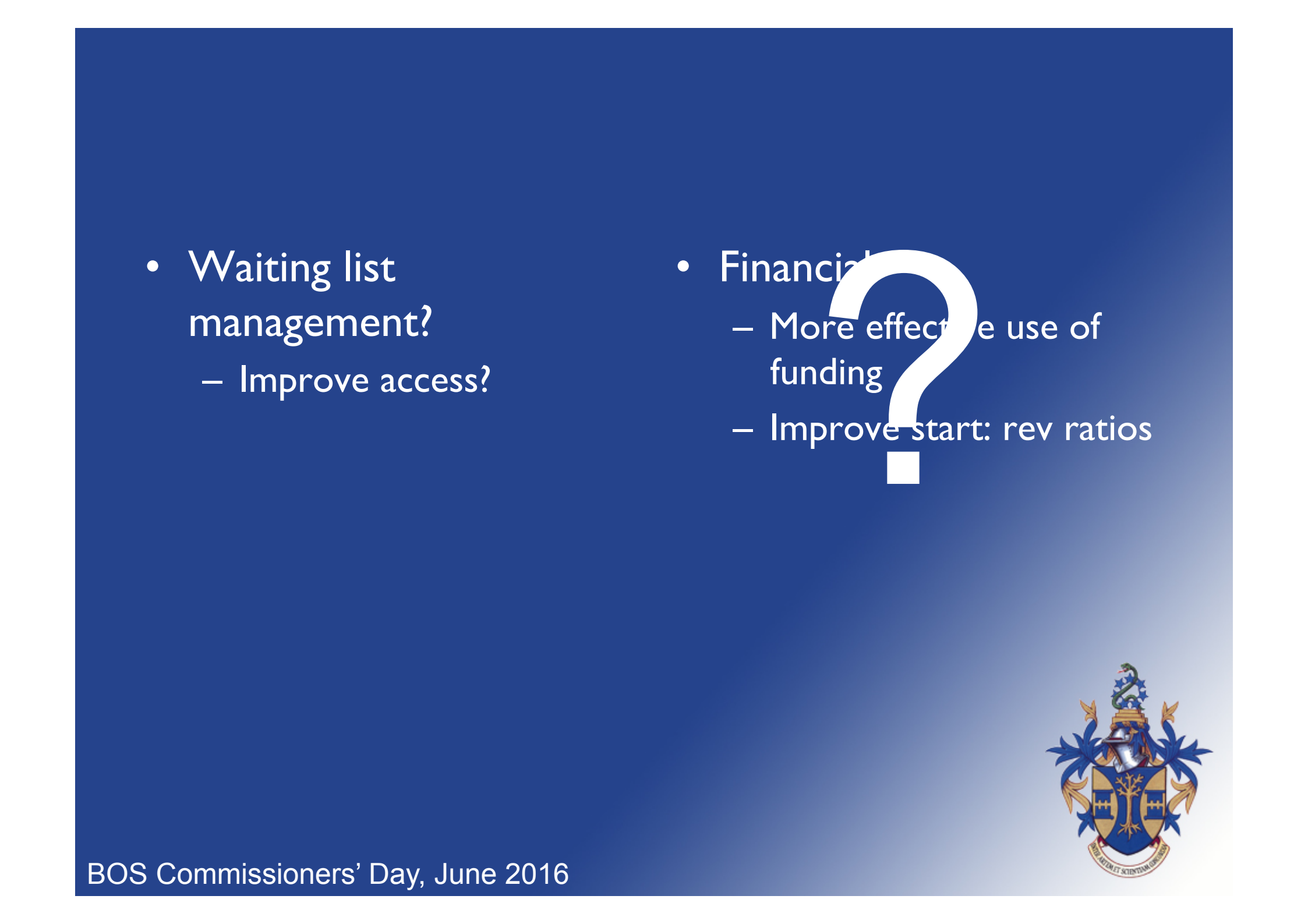
National claim trend: 12m rolling

England: June 13	% of claims	% of budget
Assess and Treat	41.3	93.6
Assess and Review	46.1	4.97
Assess and Refuse	12.6	1.36

England: Sept 14	% of claims	% of budget
Assess and Treat	44.6	94.4
Assess and Review	42.3	4.2
Assess and Refuse	13.1	1.32

England: March 16	% of claims	% of budget
Assess and Treat	51.9	95.3
Assess and Review	35.3	3.1
Assess and Refuse	12.9	1.13

- Waiting list management?
  - Improve access?
- Financial?
  - More effective use of funding
  - Improve start: rev ratios



Reasons for changing claim trend

- Referral management process?
- Changing referral pattern and gdp education?
- Changing claim submissions/kpi's

Referral Management: Barriers and Considerations

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Barriers/considerations

- Investment
- Cost v benefit
- Primary/secondary care interface
- Patient and GDP choice
- Extra bureaucratic step and delays

Referral Management: Appraisal of current and potential models

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The many faces of referral management processes:

Standardised data set and referral proforma

Paper or electronic

TRIAGE: Paper triage or clinical screening

Centralised W/L or W/L with providers

Bristol/ Kent

GDP

Paper referral

Assessment direct with Orthodontic Provider of choice

- Agreed data set*
- Standardised proforma
- Waiting list data reported to NHS

Primary care treatment waiting list held by provider

Bristol/ Kent

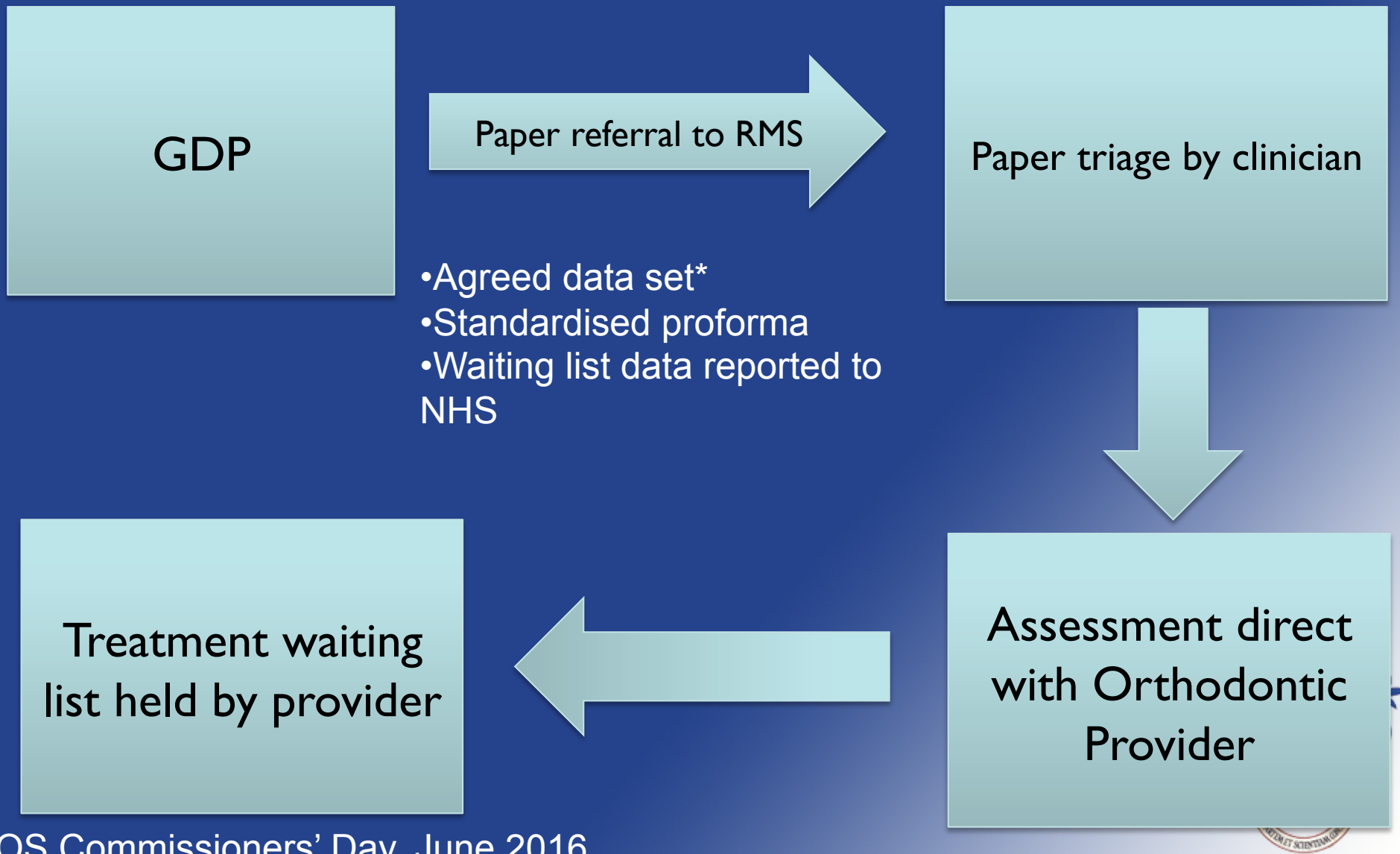
Advantages

- Cheap
- Pt and GDP make informed choice
- Improved quality of referrals
- Improved ratios
- No delays

Disadvantages

- No validation, tracking or audit trail
- No data for needs assessment
- Waiting list inconsistencies

RMS: West Sussex/Somerset



RMS: West Sussex/Somerset

Advantages

- Pt and GDP make informed choice
- Improved quality of referrals
- A degree of validation and tracking
- Potential data collection

Disadvantages

- Cost
- Bureaucratic delays/ errors
- Not universally used
- Waiting list inconsistencies

Cumbria

GDP

Central referral

- Agreed data set*
- Standardised proforma

Clinical triage by clinician at central location (cost per case approx 1 UOA)

Central waiting list

Patients drawn down by providers According to capacity

Cumbria

Advantages

- Rapid assessment
- Identifies urgent problems and secondary care need
- Validation, tracking and data collection
- 1:1 ratio of starts/ revs with providers?

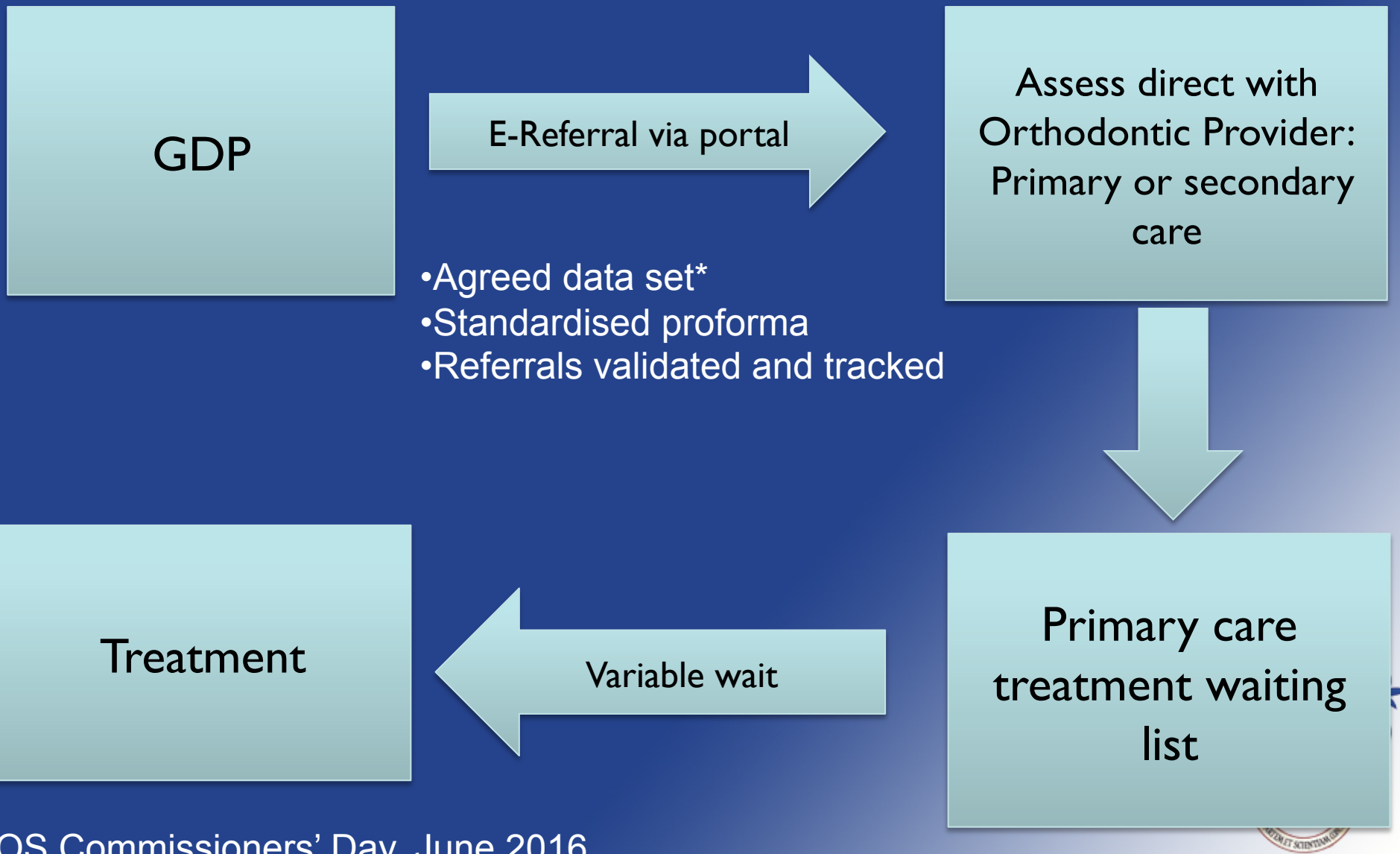
Disadvantages

- Cost- 1 uoa for assess and 21 for treatment plus operational costs
- Conflict of interest
- Clinical disagreement

Dental Electronic Referral Service (DERS)

- Being phased into Kent, Surrey and Sussex
- Operated by Vantage via Rego software
- Software installed at providers and referrers
- Referral via standardised data set over secure connection

DERS: Vantage Rego



Vantage Rego

Advantages

- Standard data set
- Improved quality of referrals
- Eliminates multiple referrals
- Allow choice
- Validation, tracking and data collection
- Ease of use*

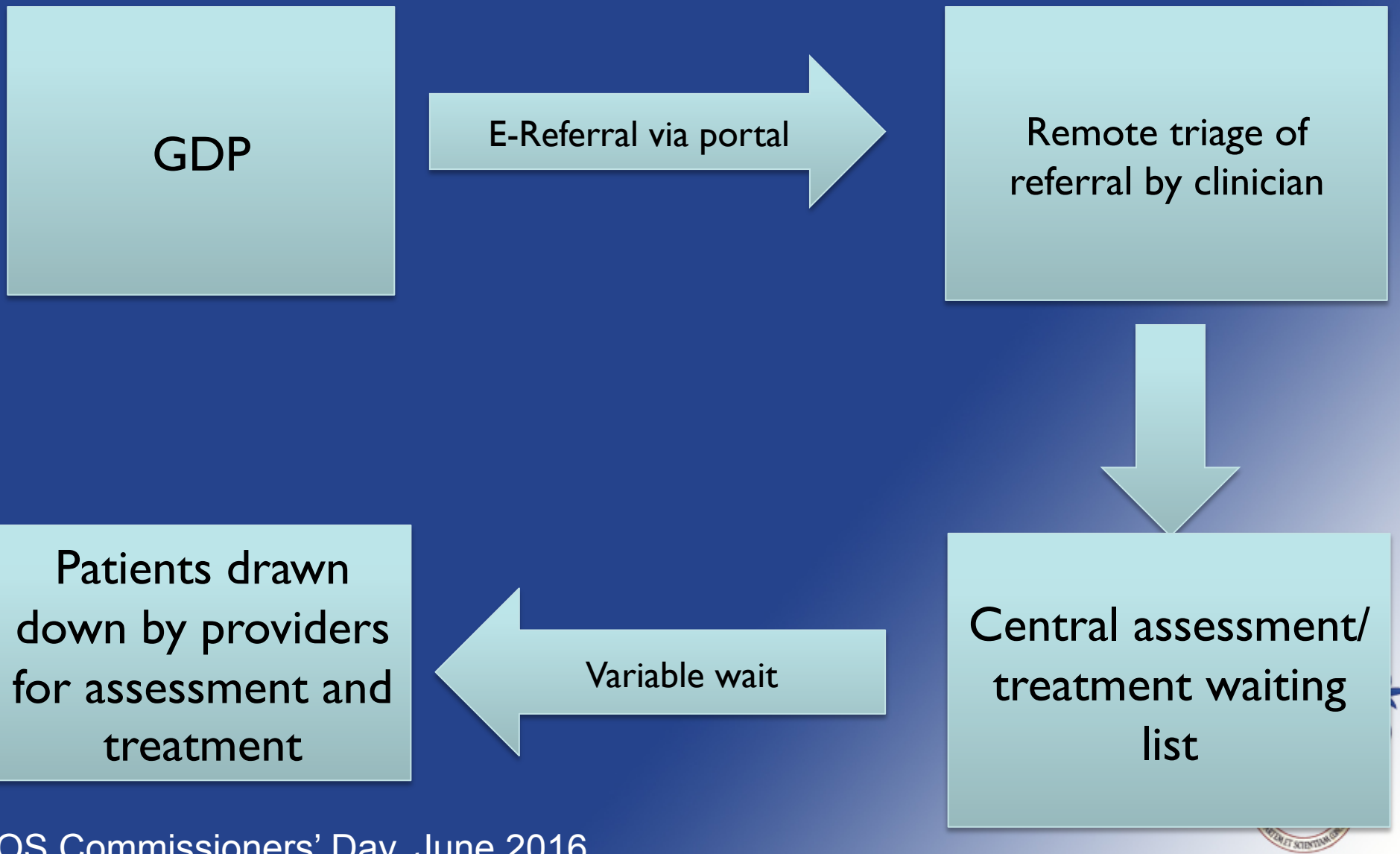
Disadvantages

- Investment
- Cost- Still 22 uoa's per case with 2:1 ratio
- No consistency of waiting list management
- Referral of IOTN 3 cases

Greater Manchester

- Evolution over time
  - Clinical triage, paper triage, electronic triage

Greater Manchester



Greater Manchester

Advantages

- Improved quality of referrals
- Validation, tracking and data collection
- Improved start/rev ratios and more funding for treatment?

Disadvantages

- Costs?
- Wait for assessment?
- Transition from local waiting list to centralised waiting list

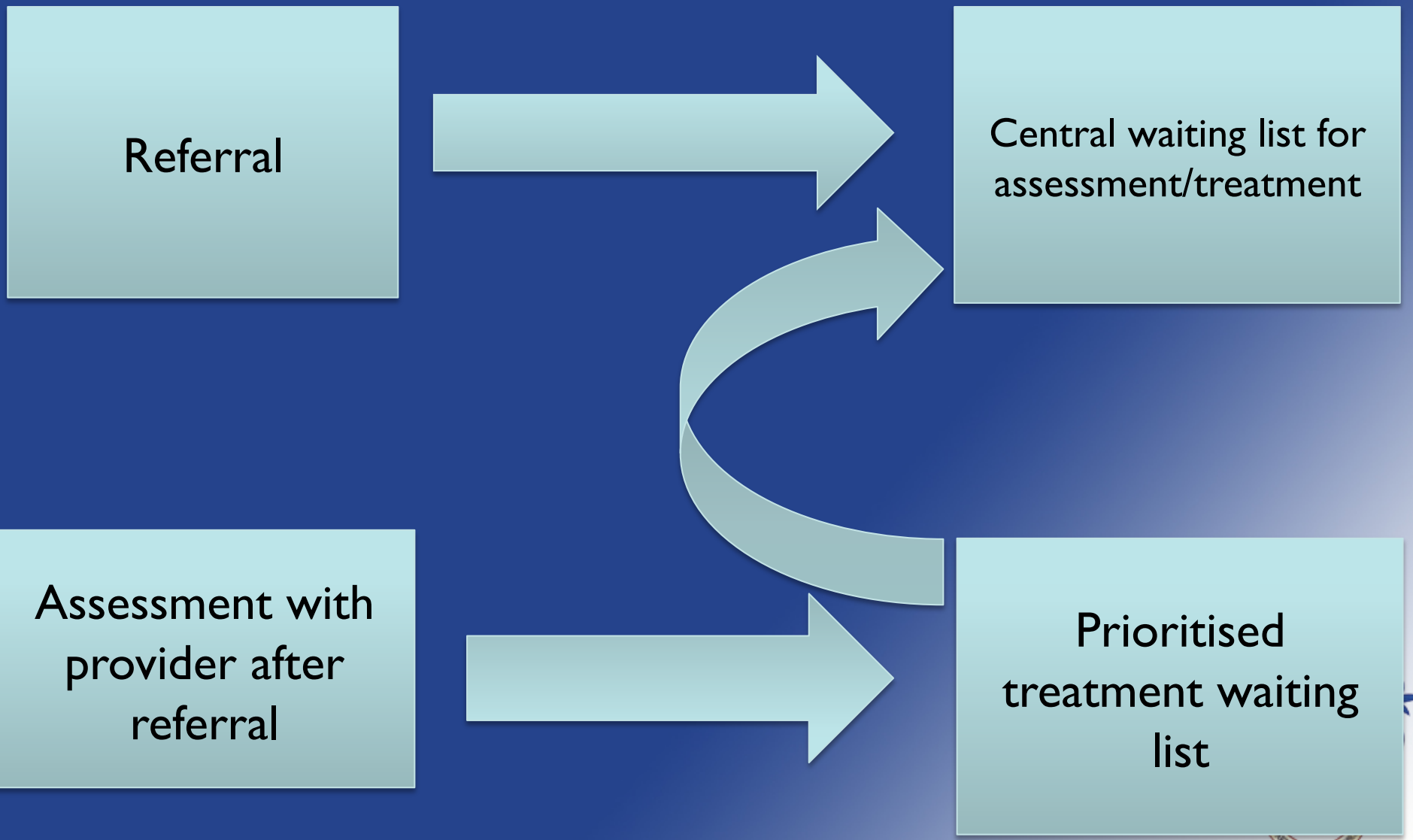
GM v England claim pattern

England: YE 14/15	% of claims	% of budget
Assess and Treat	47.8	95.05
Assess and Review	39.1	3.7
Assess and Refuse	13.1	1.24

GM: Sept 14	% of claims	% of budget
Assess and Treat	66.2	97.6
Assess and Review	22.9	1.6
Assess and Refuse	10.8	0.75

2.5% increase in treatment funding in same period

Greater Manchester



Waiting list for assessment or waiting list for treatment- which is better?

In conclusion

Referral Management Process

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In conclusion:

- Demonstrable benefits of referral management process
- BUT CONSIDER…
- Cost-benefit
- Waiting list consideration-central or local
- Unnecessary bureaucracy
- Primary and secondary care integration

Thank you for listening

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