

# PROMISING REFERRAL PRACTICES

The promising referral approaches described below include examples of referral guidelines, pre-appointment management of referrals, referral management, and pre-visit contacts. For each approach, we provide a description and working examples.

## 1. Referral Guidelines

Referral guidelines generally define a recommended set of clinical thresholds that indicate the need for specialty care. They may also include specifications about initial diagnosis and management, ongoing management, and criteria for return to primary care. They are often developed by health plans and medical groups based on clinical standards of care and quality and utilization guidelines. As such, they may be specific to that system of care. Two referral guideline approaches are shown below - one for cerebral palsy from *Madigan Army Medical Center* in Tacoma, Washington, and

the other for otitis media from the *Institute for Clinical Systems Improvement (ICSI)* in Bloomington, Minnesota. ICSI's health care guidelines are also available for patients and families. (For more information, contact Madigan Army Medical Center's Public Affairs Office at 253-698-1902.)



### Madigan Army Medical Center

Clinical Standards

Referral Guidelines

Pharmacy Guidelines

Lab Test Information

Material Standards

Guideline Updated: 24 February 2004

Specialty: Developmental Pediatrics

## Cerebral Palsy Referral Guideline

### Diagnosis/Definition

- Cerebral Palsy describes a cluster of disorders of movement and posture resulting from a static injury to the central nervous system during the "developmental" period (0-18 years). Cerebral Palsy's diagnosis is clinical and highly dependent on a knowledge of normal developmental and its variants. It is not associated with a degeneration or regression of developmental skills.

### Initial Diagnosis and Management

- Cerebral Palsy exhibits an evolving clinical picture over time. These clinical changes may be the result of the emergence of other associated deficits. Reevaluation and monitoring is important to differentiate Cerebral Palsy from progressive neurologic disorders, metabolic conditions and hereditary degenerative diseases. Historical identification of risk factors (prematurity, perinatal infection, etc.) and physical exam findings of upper motor neuron abnormalities (hyperreflexia, spasticity, persistence of primitive reflexes, asymmetric extremity use, hypotonia) and delayed developmental milestones may all be suggestive of Cerebral Palsy. This is often a difficult diagnosis to confirm in children less than 15-18 months of age.
- Interventions and treatments for children with Cerebral Palsy should focus on their beneficial functional impact on the child and the family, both now and in the future. Interventions or therapies are not "mandated" simply by the "label" of Cerebral Palsy. A functional approach may be utilized in describing the degree of Cerebral Palsy: "mild"-consistent physical findings with no limitations on ordinary activities; "moderate"-definite difficulties in daily activities often with a need for assistive devices or bracing; "severe"-moderate to great limitations in everyday activities. Though arbitrary, their use may contribute to a common language between primary care and specialty care providers.

### Ongoing Management and Objectives

- Interventions or treatment for a particular problem cannot be developed in isolation: Their impact on the other aspects of the patient's functioning must be considered and reconsidered. Particular concerns should be for any loss of previously acquired developmental milestones.
- Findings other than the more obvious spasticity may affect management and decision making for a child with Cerebral Palsy: cognitive deficits, visual spatial deficits, poor balance, weakness, motor planning problems, impaired selective motor control, social and emotional problems, dystonia and dyskinesia.
- Initial assessments by the primary care physicians should address parental and physical concerns in each of these areas. - Evaluations of specific problems by the primary care provider (vision, hearing, seizures) and acute medical concerns should be pursued in parallel with a developmental pediatrics referral.

### Indications for Specialty Care Referral

- The complex multisystem involvement of children with this potential diagnosis supports a referral for all children (<22 years old) initially suspected of having Cerebral Palsy, especially in children less than 2 years of age, to the Developmental Pediatrics service. These children may also require multidisciplinary evaluation in the Neuromuscular Clinic (Developmental Peds, Peds Neurology, Genetics, Peds Orthopedics, Peds PT, Peds SWS)
- Children with an established diagnosis of Cerebral Palsy may also be referred for review of current needs (medical care, equipment, educational services, referral to appropriate community agencies and coordination of necessary services/case management) on a 6-12 month basis.
- All referrals for Cerebral Palsy should be reviewed by Developmental Pediatrics clinic prior to release to outside agencies.

### Criteria for Return to Primary Care

- Completed specialty care evaluation with established diagnosis and recommendations that can be accomplished at a primary care level.
- A level of involvement that can be managed by a primary care manager with ongoing monitoring by subspecialists.

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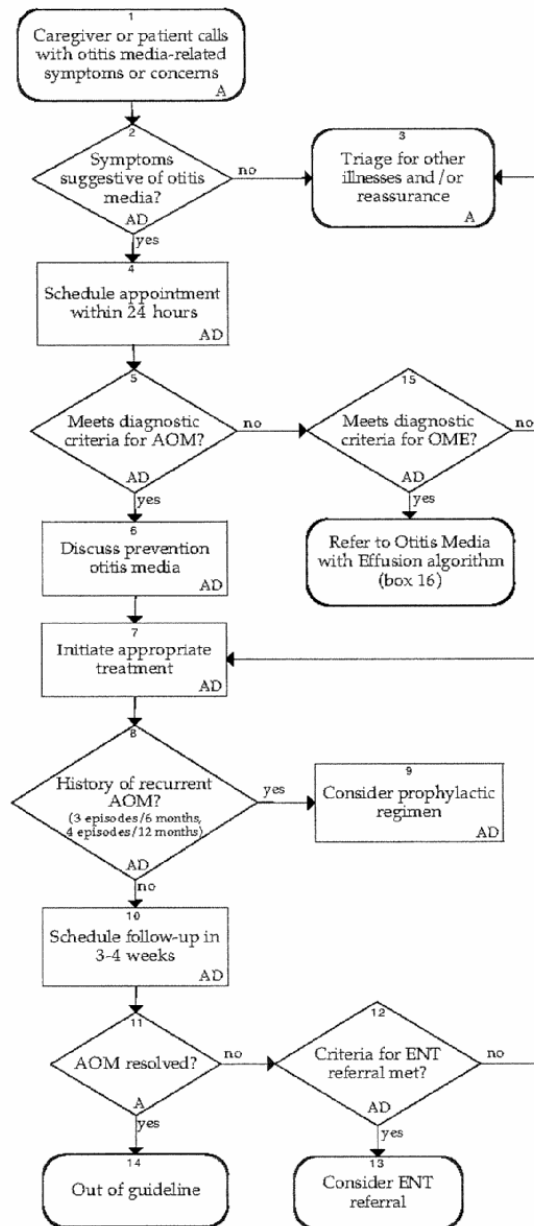
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These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.



A = Annotation  
D = Discussion

**2**  
**Symptoms Suggestive of Otitis Media**

**Children < 3 Years**

- irritability
- fever
- night waking
- poor feeding
- coryza
- conjunctivitis
- balance problems
- hearing loss
- otalgia

**Children 3 Years and Older**

- otalgia
- otorrhea
- hearing loss
- ear popping
- ear fullness
- dizziness

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**Diagnostic Criteria for Acute Otitis Media (AOM)**

- Middle ear effusion (seen on exam and/or confirmed by pneumatic otoscopy) with either:
  - local signs of inflammation; or
  - otalgia, otorrhea, irritability, restlessness, or poor feeding.

**Diagnostic Criteria for Otitis Media with Effusion (OME)**

- Middle ear effusion (seen on exam and/or confirmed by pneumatic otoscopy) or abnormal tympanometry without signs or symptoms of AOM.

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**Appropriate Treatment**

- Antibiotic regimen using criteria for first vs. second line antibiotics
- or
- Observation for mildly symptomatic children

## 2. Pre-Appointment Management of Referrals

Pre-appointment management of patient referrals involves review of prior medical records and other pertinent information before a specialty appointment is scheduled in order to determine the most appropriate care. In the approach we selected, developed by the Rheumatology Department at the *University of Wisconsin Medical Foundation*, the rheumatologist reviews each newly referred patient's records prior to scheduling an appointment. Using a pre-appointment management intake form, office staff collect patient and referring provider information, reason for consultation, and location of pertinent records. This is supplemented with medical records, obtained via email or fax, and lab and x-rays, when necessary. The specialist reviews this information and selects one of the following options: 1) patient with appropriate indication is scheduled and appointments are classified as urgent or routine, and also as brief, usual, or extended time; 2) further information may be requested before making a decision to schedule an appointment usually through discussion with referring physician; 3) care may be continued with referring physician without specialty consultation typically through conversation with the patient and referring physician to provide coordinated care; 4) other more appropriate consultation may be arranged; and 5) appointment is not provided when a referral is inappropriate or records are not provided.

Evaluation results of pre-appointment management found that only 59% of new patients

**University of Wisconsin Medical Foundation**

**Rheumatology Pre Appointment Management**

Patient Name \_\_\_\_\_ Contact Date \_\_\_\_\_

Medical Record Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Insurance \_\_\_\_\_

Name of person requesting appointment if other than patient \_\_\_\_\_

Referring Provider \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

PCP \_\_\_\_\_

Has patient seen a Rheumatologist before? Yes No  
 Who was the Rheumatologist? \_\_\_\_\_  
 When was patient seen? \_\_\_\_\_  
 Ask records to be faxed if Rheumatologist is outside UWMF or UWHC

Reason for appointment \_\_\_\_\_

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Bone Density: Yes No Where was BD done? \_\_\_\_\_  
 X-rays: Yes No  
 What type of x-ray? \_\_\_\_\_ Where were x-rays done? \_\_\_\_\_

Date films ordered \_\_\_\_\_  
 Date(s) Records requested \_\_\_\_\_  
 Additional records needed \_\_\_\_\_

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Date: \_\_\_\_\_

**Appointment request approved.**  
 Please obtain the following information prior to the appointment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Appointment request denied.**  
 Records from the referring physician are needed.  
 Patient needs to see their PCP  
 We suggest the following:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

referred actually required a specialty appointment. Practice access and efficiency were improved. An estimated 45 minutes was initially spent each week by each of three specialists to complete pre-appointment management of more than 100 patients referred. Only about a third of the referrals required more than three minutes to review.<sup>1</sup> (For more information, contact Tim Harrington, MD at [tim.harrington@uwmf.wisc.edu](mailto:tim.harrington@uwmf.wisc.edu)).

### 3. Referral Management Initiative

The *Referral Management Initiative* (RMI) at *New York's Children's Health Project* (and also at the Children's Health Project in Washington, DC, Dallas, South Florida, and Los Angeles) is designed to assure that children in medically underserved communities have the necessary supports to access and complete a specialty referral. When a referral to a subspecialist is made, the primary care provider rates the severity of the referral problem on a three-point scale so that immediate needs can be addressed within 24 hours, urgent needs within two weeks, and routine needs as soon as is possible given the availability of specialists. RMI case managers make the appointment with the specialist, and if a child with an urgent need is not able to receive an appointment quickly enough, the primary care provider contacts the specialist. Families also receive appointment reminders by phone, through the mail, or in-person by shelter staff. Prior to the visit, RMI staff ensure that there are no insurance obstacles. RMI covers the costs of transportation to the specialist or provides transportation when public transportation is unavailable, and an RMI staff person is available at the medical center to assist with navigation to the specialist's office. After the specialist visit, an RMI staff person obtains the notes and gives them to the primary care provider. Translation services are also made available to families, if necessary, to ensure that they understand the results of the specialist visit.

Evaluation of RMI found that adherence to medical specialty appointments among homeless families with children increased dramatically from 7% to 61%. Many children who had previously foregone care were able to receive services, and serious health consequences were averted. In addition, RMI resulted in reduced time between referral and appointment

dates; fewer transportation, language, and insurance barriers; and fewer communication difficulties between primary and specialty providers.<sup>2</sup> (For information, contact Irwin Redlener, MD.)

#### 4. Pre-Visit Contacts

Pre-visit contacts are intended to prepare providers in advance of a scheduled preventive or chronic care visit so that the visit is used to plan for the future, not to review past events. In the model we selected, used by *Chapel Hill Pediatrics and Adolescents* in North Carolina, children with special health care needs are first identified and assigned a complexity

have and their severity. (1= a well-controlled chronic condition; 2= an evolving, unstable chronic condition or 2 well-controlled chronic conditions; 3= 2 or more chronic conditions, one of which is unstable; 4= any technology-dependent patient or patient with moderate/severe cognitive delays; +1 for language barrier; +1 for behavioral disorder; +1 for family/social complications).

#### Chapel Hill Pediatrics and Adolescents Pre-Visit Contact

Date of contact: \_\_\_\_\_

Patient \_\_\_\_\_ Chart \_\_\_\_\_

Phone where reached \_\_\_\_\_

In order to be best prepared for your child's upcoming visit, we'd like to know:

1. Has your child been to the Emergency Room since your last CHP visit?  Yes  No

If yes, where? \_\_\_\_\_

For what reason? \_\_\_\_\_

Records of hospital stay? \_\_\_\_\_

Ourcome/Recommendations? \_\_\_\_\_

2. Has your child been hospitalized since your last CHP visit?  Yes  No

If yes, where? \_\_\_\_\_

For what reason? \_\_\_\_\_

Records of hospital stay? \_\_\_\_\_

Ourcome/Recommendations? \_\_\_\_\_

3. Has your child seen any specialists since your last CHP visit?  Yes  No

Who? \_\_\_\_\_

Where? \_\_\_\_\_

Specialist note is in chart  Yes  No

4. Has your child had any lab data obtained or Xrays performed since last CHP visit?

What? \_\_\_\_\_

Where? \_\_\_\_\_

Results on chart  Yes  No

5. Are there any forms or letters you'll need to completed during this visit?  Yes  No

6. Do you anticipate your child needing lab work at your upcoming visit?  Yes  No

7. What are your three major areas of concern or topics you need addressed at this visit?

1.

2.

3.

Check Scheduling to be sure has adequate time!!!

The child's physician then decides if a pre-visit contact with the family would be helpful, taking into account the complexity score and the stability of the child's condition. If so, a care coordinator contacts the family prior to the visit to obtain information on any emergency room or specialist visits, hospital stays, lab tests or x-rays that occurred since the last visit and to ask if lab tests are likely to be required during the upcoming visit. The care coordinator completes the pre-visit contact form by asking about issues the family would like to see discussed during the visit. The physician is given the form as well as any consultation notes, lab results, or x-ray reports from other visits prior to the appointment. If lab work is

score based on how many chronic conditions they

required, appropriate lab slips are prepared, and the child/parent is given the option of application of anesthetic cream to the arm prior to the visit and blood draw.

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<sup>1</sup> Information based on an interview with Dr. Timothy Harrington, July 2005. Also, Harrington JT, Walsh MB. Pre-appointment management of new patient referrals in rheumatology: a key strategy for improving health care delivery. *Arthritis and Rheumatism*. 2001;45,295-300.

<sup>2</sup> Information based on Redlener I, Grant R, Krol DM. Beyond primary care: ensuring access to subspecialists, special services, and health care systems for medically underserved children. *Advances in Pediatrics*. 2005; 52, 9-22.