Cracking the Code on Referral Management:

Case study shows an integrated, team-based care model removes cost and improves satisfaction

By Stephen Ezeji-Okoye, MD
Chief Medical Officer, Crossover Health

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The process of managing specialist referrals has long been a source of pain for patients, providers, and payers (be they self-insured employers or health plans). Patients shoulder an unnecessary "burden of treatment" and suffer poor care experiences, including the need to courier their health data from one provider to the next. Primary care providers consistently struggle to coordinate and close the loop on downstream specialist care. Self-insured employers and other payers absorb the skyrocketing costs of specialty care without corresponding improvements in outcomes and patient satisfaction to show for it.

This picture has only grown more complex with the recent rise in adoption of virtual care. As many traditional virtual urgent care providers wade into the waters of virtual primary care they find themselves ill-equipped to handle the broader referral management challenge, with care models limited to managing episodic visits rather than longitudinal care across conditions, specialties and geographies. The resulting care is by nature limited in scope, ultimately leading to higher referral rates and more care fragmentation.

A closed loop care navigation process embedded within an integrated Primary Health model significantly reduced costs, increased referrals to quality providers, and increased patient satisfaction.

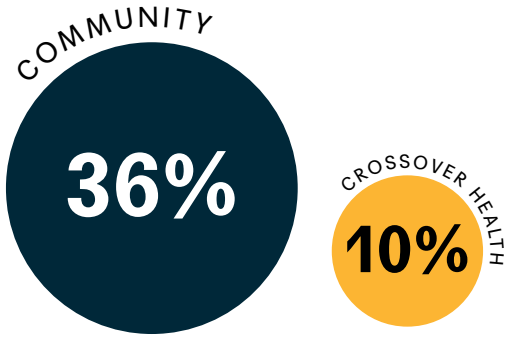
So, what's the solution? An alternative approach is to embed referral management via care navigators directly into a comprehensive, integrated Primary Health team consisting of dedicated primary care, physical medicine, mental health and health coaching providers. The construct can be effective within a hybrid offering both virtual and in-person settings.

To clearly highlight the advantages of such an approach Crossover Health conducted an in-depth case study of referral management from June 30, 2019 through June 30, 2021 (notes on methodology below). The results show that our integrated, multi-disciplinary model with embedded care navigation reduces the overall cost of care by requiring fewer outside specialist visits, and through the standardized use of care navigators, directing required referrals to high-quality, cost-effective options. Specifically, we found that Crossover's specialist costs were, on average, 30% lower than in the community—representing a significant savings for self-insured employers.

Integrated care from the Primary Health team means fewer referrals to specialists.

Referral rates from primary care to specialties such as imaging, cardiology and gastroenterology have been on the rise for years in the U.S. They constitute more than half of all outpatient visits and contribute to the skyrocketing cost of employer-based healthcare. Studies suggest that unnecessary or redundant tests and treatments contribute significantly to the estimated $760 billion in healthcare waste in this country. In sharp contrast with this status quo, we were encouraged to see in our review that patients receiving comprehensive, integrated care from Primary Health teams at Crossover were referred to specialists 26% less than patients receiving care in the community (10% compared to 36% in the community).

PERCENTAGE OF SPECIALIST REFERRALS



This lower referral rate is driven by several key factors including integrating primary care, physical medicine, mental health, and coaching in a team-based environment. Specialist referrals only occur when a patient's needs cannot be met by the Crossover Primary Health team. In a previously published study evaluating more than 300,000 visits over 18 months (2020-2021) across Crossover's Primary Health network, we found that nearly 20% of patients were seen by providers in two or more clinical disciplines. One in ten patients in primary care, for example, were diagnosed with depression or anxiety and then seen by a mental health specialist on the team. In another such example, Crossover physical medicine providers checked blood pressure in the course of the visit, resulting in a new diagnosis of hypertension for one out of five patients.

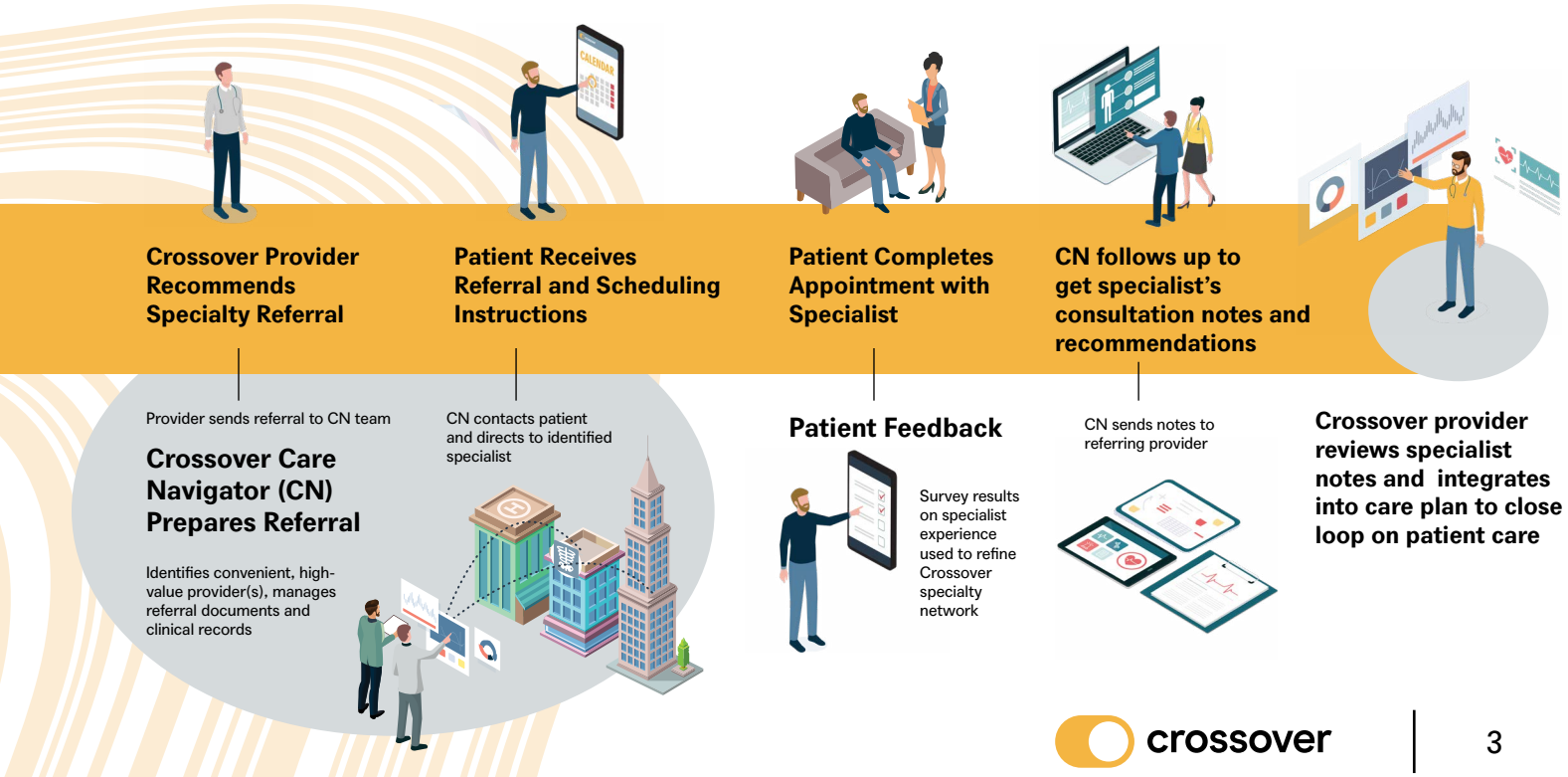
What are the key factors driving success here? In Crossover's Primary Health model, care is established with a designated care team, longer appointments allow for the development of a meaningful relationship, and shared decision-making is at the core of the treatment philosophy. All of these elements combine to ensure that every specialist referral is thoughtfully considered and evidence-based where possible—not simply the default choice. This approach to referral management is further reinforced by Crossover's outcomes-based payment model which compensates providers not for visit volume but for doing what's right for the patient.

High-value care navigation drives lower costs and a better patient experience.

When patient needs cannot be met within the Crossover Primary Health team and a specialist referral is required, expert navigation is another key factor in lowering costs and boosting patient satisfaction. Traditionally in healthcare, specialist referrals are initiated by the ordering clinicians and based on established networks and prior relationships. However, clinicians often lack the resources to maintain up-to-date knowledge of high-quality providers across various specialties and geographies.

Crossover addresses this challenge by centralizing the referral function within a team of dedicated care navigators who combine regional expertise, data-backed navigation tools, knowledge of community resources to address social determinants of health, and high-touch support for patients when they need it most. Our care navigators continuously vet specialists and community resources in their geographies against a set of rigorous criteria, including quality of care, timely access, and ease of getting records back. This allows for real-time and constant iterative feedback and improvement. Quality of provider and patient experience are always prioritized. Cost of care for patient and employers is managed by care navigators who direct patients to convenient, high-value outpatient providers such as independent ambulatory surgery centers and imaging centers.

These care navigators also remove frustration and unnecessary administrative burden for both patients and providers, managing all the required referral documentation—including clinical records—so the specialist knows why they are seeing the patient and has a complete, up-to-date patient history. Following the specialist visit, care navigators then manage the process of returning the specialist's consultation notes and recommendations to the referring clinician, thus closing the loop on patient care.



As a result of our Primary Health model, Crossover's specialist costs were 30% lower than in the community.

SPECIALIST	AVERAGE COST OF SPECIALIST VISIT INITIATED IN THE CROSSOVER CLINIC COHORT	AVERAGE COST OF SPECIALIST VISIT INITIATED IN THE COMMUNITY COHORT
Imaging	$171	$215
Obstetrics & Gynecology	$171	$195
Otolaryngology/ENT	$210	$276
Gastroenterology	$210	$430
Allergy, Asthma, and Immunology	$229	$263
Cardiology	$177	$199
Dermatology	$190	$256
Urology	$178	$196
Orthopedics	$148	$188
Sleep Medicine	$210	$244
OVERALL	**$188**	**$255**

Costs for gastroenterology visits, for example, were a significant 69% lower than in the community. Additionally, Crossover patients were highly satisfied with their specialist visits, rating them, on average, 4.33 on a scale of 5. Moreover, nearly half of referred patients reported a wait time of less than 5 minutes before being seen by their specialist upon arrival. In a disconnected healthcare system where patients consistently report frustration with the care experience, our high satisfaction scores reinforce that our Primary Health model is working better for everyone.

This paper shows how Crossover's integrated, team-based care model effectively cracks the code on referral management, significantly reducing referral costs for payers and creating better outcomes and a better care experience for members.

By simplifying the healthcare experience and providing team-based care in a tightly integrated, multi-disciplinary setting, Crossover is able to address member health comprehensively and proactively, thus reducing unnecessary referrals. Our embedded care navigation model—which combines a high-touch service with a regional repository of high quality providers—ensures the referrals we do send are more cost-effective, clinically efficient, and yield consistently higher satisfaction. Furthermore, by embedding care navigation into Primary Health, we're able to radically simplify referral management for employers, reducing the number and complexity of vendors needed to do the work. Ultimately, our results speak to the success of our model: 30% lower overall costs for secondary care and higher member and provider satisfaction.

Furthermore, in a future where we will continue to see steady, if not increased, rates in the use of virtual urgent care it's more important than ever for self-insured employers to have a smartly-orchestrated, simplified approach to longitudinal care—one that can ultimately achieve better results with fewer vendors and less complexity. For the future-ready employer, the message of this paper is clear: Implementing a hybrid Primary Health model such as Crossover's not only ensures great access to foundational primary care, but also ensures that speciality referrals are well-managed, cost-effective, and lead to better outcomes for members.

Note on Methodology: For the study, the Crossover research team identified a cohort of 680 patients who received most of their primary care (75%+) in a Crossover employer-sponsored clinic between June 30, 2019 and June 30, 2021 and received a specialty referral as part of their care. A cohort of 1,360 patients with characteristics similar to those seen in the clinic was identified from the total population of patients eligible for employer-sponsored services who received a specialist referral in the community during the same time period. Our researchers then compared referral rates, referral costs, and patient satisfaction for the two populations.

About Stephen Ezeji-Okoye, MD

As Chief Medical Officer, Dr. Stephen Ezeji-Okoye oversees the company's national medical group, which consists of in-person and virtual care teams and spans primary care, physical medicine, mental health, health coaching and care navigation. He is instrumental in the design of Crossover's interdisciplinary, team-based care model, as well as the company's hybrid, surround-sound approach to care delivery. He also plays a lead role in scaling the national medical group across new markets and partnerships. Prior to his promotion to Chief Medical Officer in July 2019, Dr. Ezeji-Okoye served as the Medical Director at Life @Wellness (Crossover's clinic at Meta).

Dr. Ezeji-Okoye joins Crossover from VA Palo Alto Health Care System (VAPAHCS). His success at the VA can be attributed to several cutting-edge initiatives he spearheaded that continue to enable the organization to support the health and wellbeing of veterans, including redesigning systems from the ground up to abide by the Principles of Lean Manufacturing in which he is an expert. His innovative use of disease prevention, chronic disease management, social determinants of health, and complementary and integrative health practices to promote self care among veterans led to his appointment as a national consultant to the VA on the use of Integrative Medicine and an Advisory Council member to the National Institution of Health's National Center of Complementary and Integrative Health.

Dr. Ezeji-Okoye graduated magna cum laude from Harvard College, and completed his internship, residency, and chief residency in Internal Medicine at Stanford University. He has also served as a Clinical Professor (Affiliated) at Stanford University School of Medicine.

About Crossover Health:

Crossover Health is the leader in delivering value-based hybrid care. The company's national medical group delivers at scale, Primary Health, a proven care model driven by an interdisciplinary team inclusive of primary care, physical medicine, mental health, health coaching, and care navigation. With a focus on wellbeing and prevention that extends beyond traditional sick care, Crossover builds trusted relationships with its members and flexibly surrounds them with care—in-person, online, and anytime—based on the member preference. Combining a sophisticated approach to data analytics that incorporates Social Determinants of Health, Crossover delivers concrete results and measurable value for employers, payers, and most importantly, members. Together we are building health as it should be and engaging a community of members to live their best health.

Are you interested in learning more about Crossover Health's innovative Primary Health model that brings together virtual and in-person healthcare?

Visit **crossoverhealth.com**,
follow us on social media **@crossoverhealth**,
or contact us at **connect@crossoverhealth.com**
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