

Transforming the Primary-Specialty Care Interface by Clarifying Specialists' Roles: Implications for Innovations in the Referral Process

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Contours of the US Primary-Specialty Care Interface

- **Ways to optimally allocate physician workforce is unclear**
- **Physician Supply**
- **Weak primary care**
- **High rates of direct access to specialists**
- **Primary care: role clarity**
- **Specialty care: role confusion**
- **Volume-referral relationship in primary care**

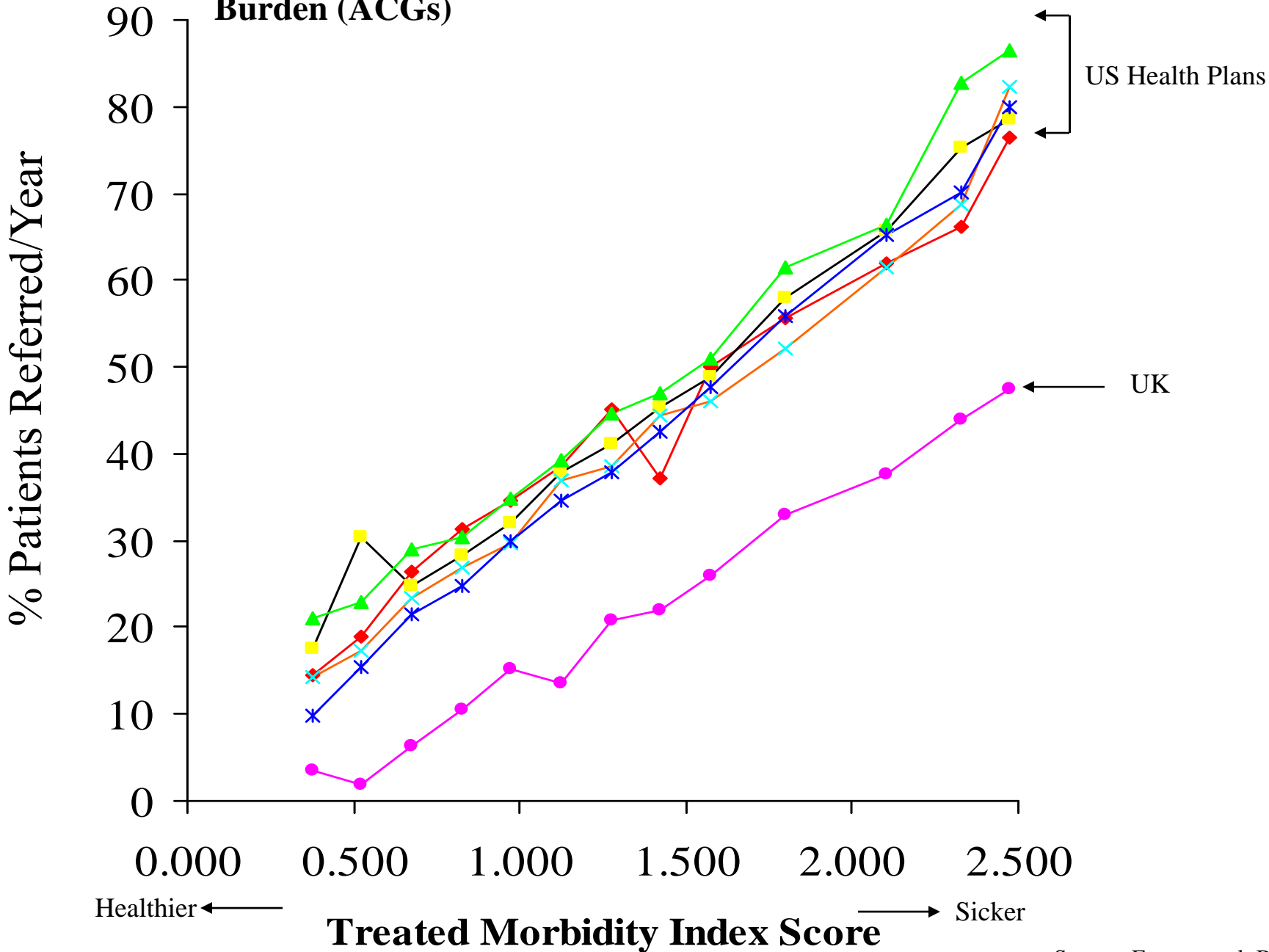
Primary Care “Exposure” in Three Countries

Country	Annual PC Visits Per Person	Mean Duration of a Primary Care Visit	Annual Primary Care Exposure per Person
Australia	6	15 minutes	90 minutes
New Zealand	5	15 minutes	75 minutes
United States	2	17 minutes	34 minutes

Data Sources: Australia—BEACH study; New Zealand—NatMedCa Study; US—NAMCS, NHAMCS, CHC visit survey; Data are from 2001; Visits per person and duration of visits have been rounded up to the nearest integer.

See Bindman, Forrest, Britt et al., BMJ 2007.

Specialty Referral Rates in the US versus UK, Controlling for Morbidity Burden (ACGs)



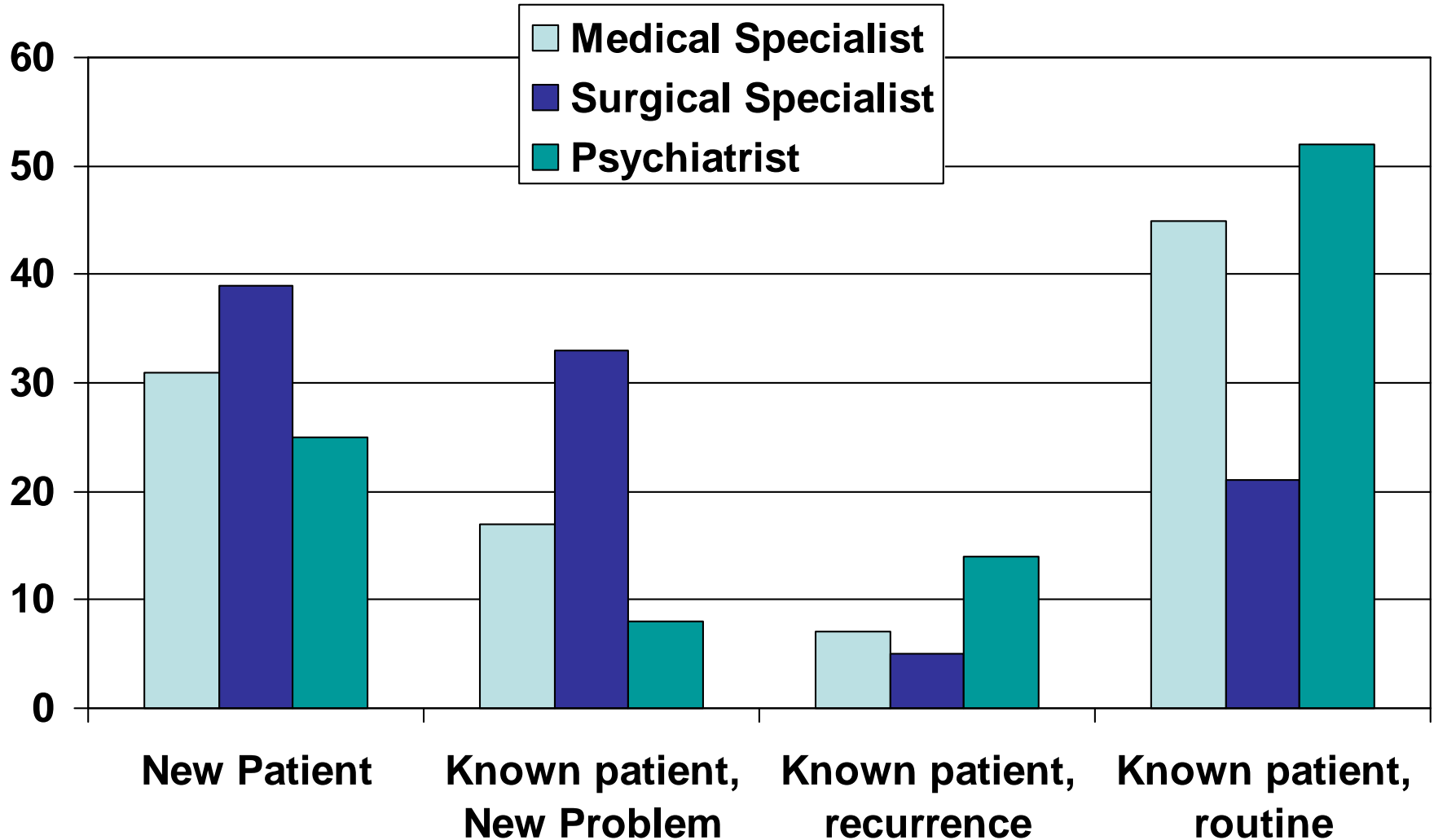
Generalists and Specialists: Perspective is Everything

- **Generalists versus Specialists**
 - Domain expertise: Specialists > Generalists
 - Primary care quality: Generalists > Specialists

- **Generalists with Specialists**
 - Cardiovascular quality and outcomes
 - Comanaged > Specialist only

We need to define roles and responsibilities of specialists to enhance the “with” model.

Among Referred Patients, Type of Work Done by Specialists in the US (Data are from the 2002-2004 NAMCS)



Conceptual Basis of Specialty Care

Stimulus	Implication
Growth in knowledge	<ul style="list-style-type: none">• Master narrowly defined knowledge bases• Reduce cognitive uncertainty• Educate
Expansion of technology	<ul style="list-style-type: none">• Expertise in sub-set of procedures
Volume-outcome	<ul style="list-style-type: none">• Care for uncommon problems

Reasons for Referral: Advice

Advice: *To obtain specialist's opinion on a patient's diagnosis, abnormal laboratory or imaging study result, treatment, or prognosis*

- For unusual, uncommon, and uncertain problems
- For common problems with unusual manifestations
- For problems that have failed conventional treatment
- Evaluate need for a new medication or treatment
- Get reassurance that the diagnosis is correct and/or the most effective treatments are being applied
- Patient request
- Medicolegal concerns

Reasons for Referral: Technical Procedure

Technical Procedure: *To obtain a technical procedure for diagnostic, therapeutic, or palliative purposes*

- Minor surgery, such as excision of masses
- Major surgical procedures that require general anesthesia
- Invasive procedures, such as endoscopy, cardiac catheterization, and imaging
- Procedures for common problems that require use of complex equipment (e.g., optical refraction)
- Pathological evaluations
- Anesthetic interventions

Reasons for Referral: Co-Management

Co-Management: *To share the ongoing management of a patient's unstable health condition.*

- Long-term medical disorders that require frequent alterations in a treatment plan
- Complex anatomical problems that need multiple surgical procedures to correct congenital or acquired anomalies

Typology of Specialist's Clinical Roles

- **Cognitive Consultation**
- **Procedural Consultation**
- **Comanager with Shared Care**
- **Comanager with Principal Care**
- **Primary Care Physician**

Cognitive Consultation

Provide diagnostic or therapeutic advice to reduce clinical uncertainty

Responsibilities

- Gather and interpret clinical information
- Perform necessary testing and imaging
- Interpret new data
- Make recommendations
- Timely communication of opinion

Procedural Consultation

Perform a technical procedure to aid diagnosis, cure a condition, identify and prevent new conditions, or palliate symptoms

Responsibilities

- Evaluate need for procedure
- Assess risks and benefits
- Ensure that patient provides informed consent
- Perform procedure safely
- Timely communication of procedure findings

Comanager with Shared Care

Share long-term management with a primary care physician for patient's referred health problem

Responsibilities

- **Provide evidence-based management**
- **Clarify accountability with primary care physician for management tasks related to referred health problem**
- **Timely communication of recommendations and changes in management**

Comanager with Principal Care

Assume total responsibility for long-term management of a referred health problem

Responsibilities

- **Provide evidence-based management**
- **Assume full accountability for management tasks related to referred health problem**
- **Timely communication of recommendations and changes in management**

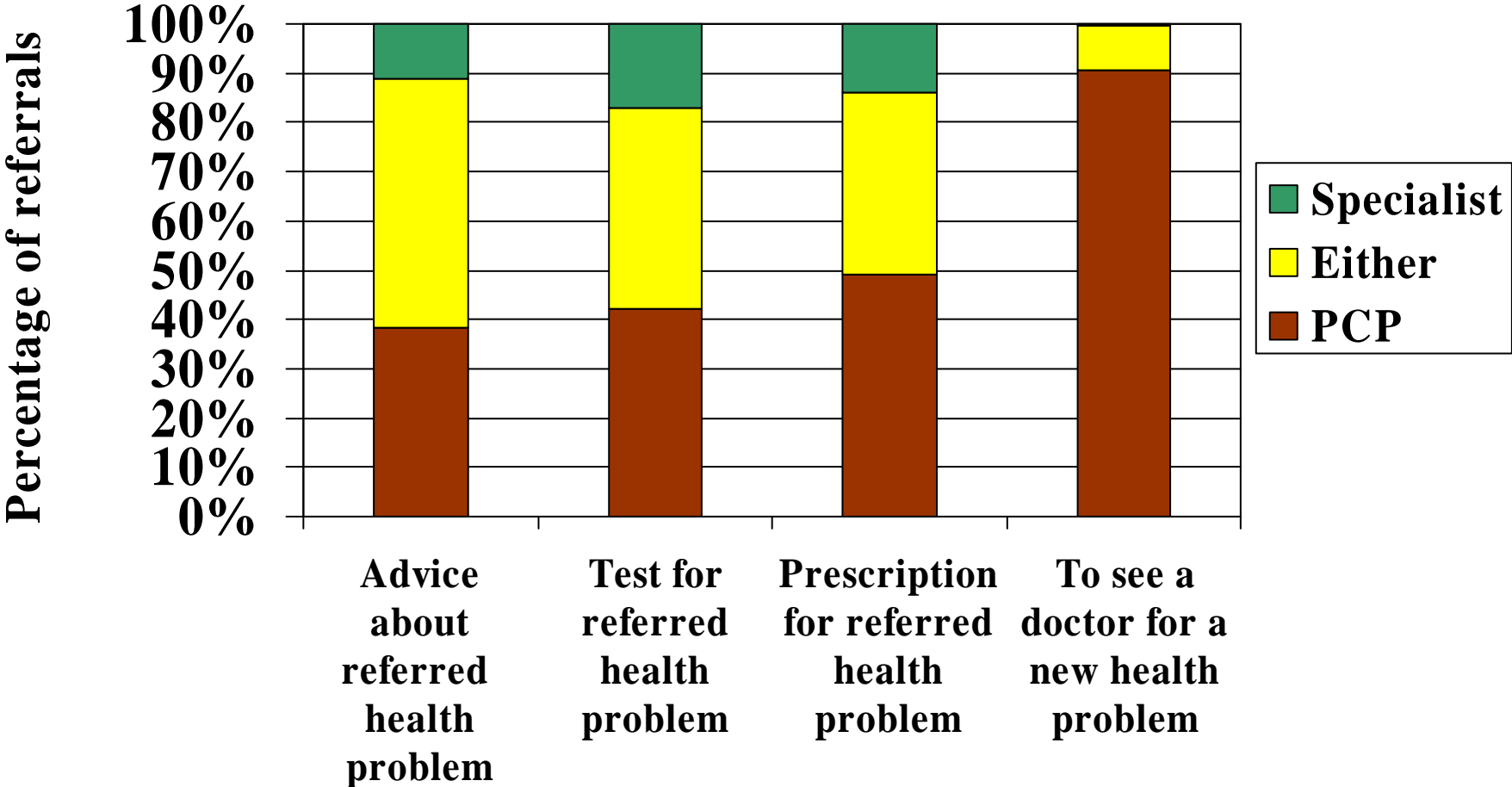
□ Primary Care Physician

Provides a medical home for a group of patients

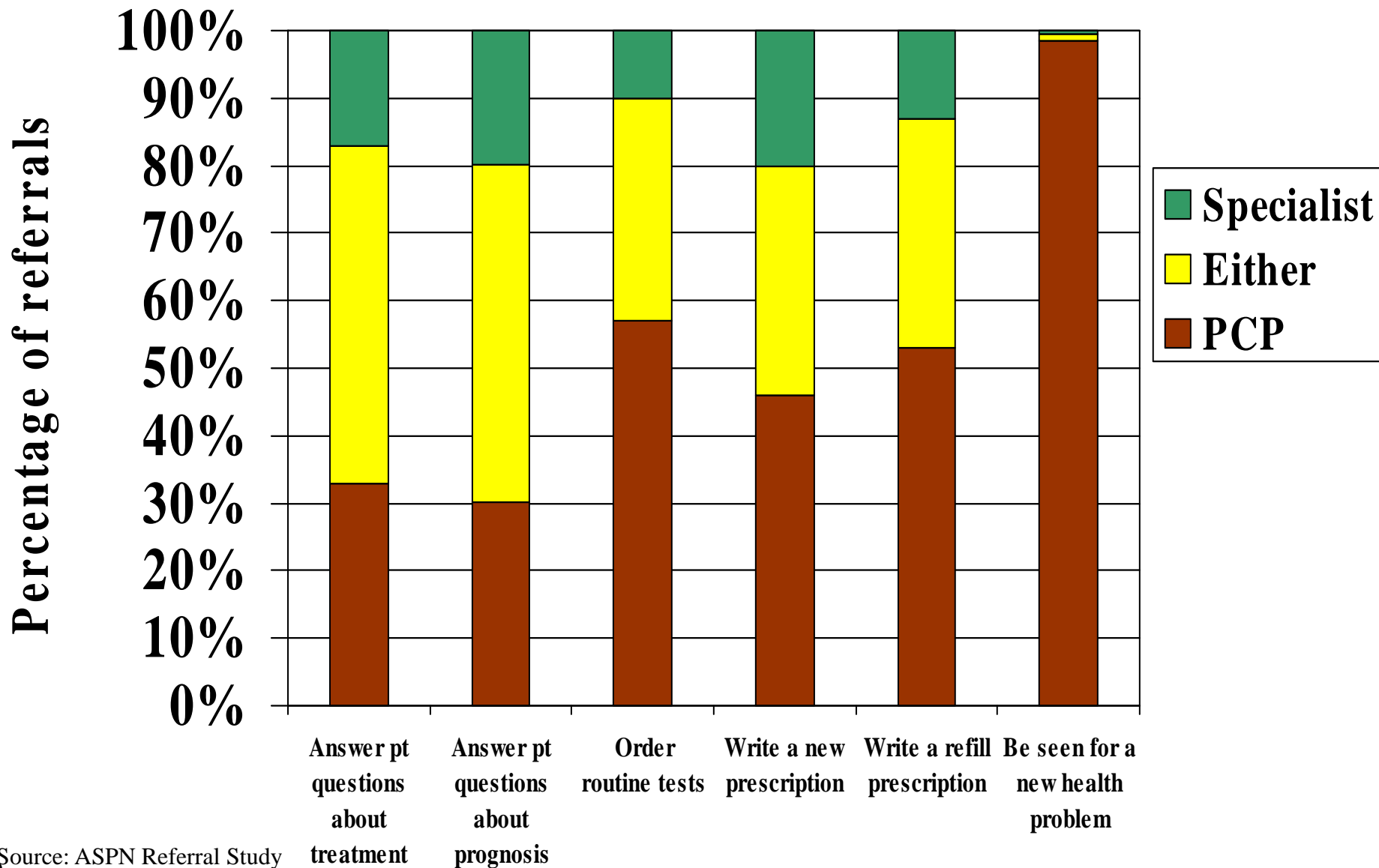
Responsibilities

- Ready access to medical home
- Continuous care over time
- Comprehensive service package that meets most needs of population served
- Integrate care across providers and time
- Facilitate linkages with community resources

Patients in Referral Arrangements Reported Who They Would Prefer to Talk With When They Need:



Among these same patients, their PCPs reported who should:



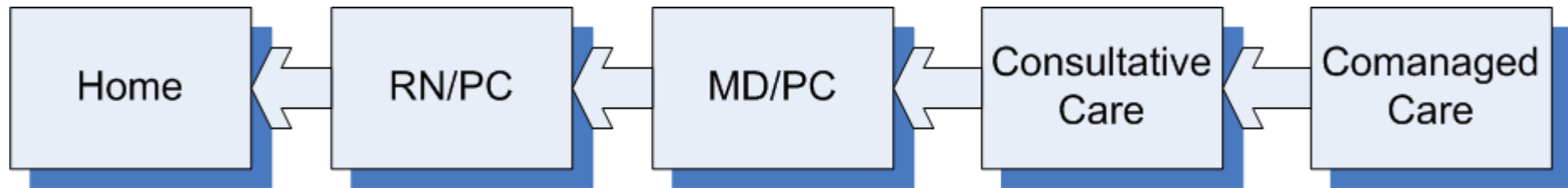
Specialists as Primary Care Physicians

- **About 1 in 4 specialists say they practice some “primary care” (Jacoby, JAMA, 1997), 1 in 7 elders see only a specialist in a year (Rosenblatt, JAMA, 1998), and 1 in 8 individuals in the US identify a specialist as their PCP (Forrest, AJPH, 1998)**
- **Concerns:**
 - Tend to practice in their domain; evidence of lower quality outside their domain
 - More resource intensive practice style than generalists because of higher prior probability of disease associated with specialty referral
 - Among primary care patients, practices are less accessible than those of generalists (Forrest 1998)
 - Provide less preventive care outside of their clinical domain (Rosenblatt 1998)

Linking Referral Models with Referral Innovations

- **Common language and hypothesis generation**
- **Typology facilitates responsibility negotiation**
- **Helps to clarify the types of innovations needed to:**
 - Reduce referral rates
 - Shift care to the left

Shifting Care to the Left



Continuum of Care

Health IT and Referral Process

- **Substitution of Conventional Referral**
 - eReferral
 - Telereferral
- **Reduce Uncertainty**
 - Decision Support
- **Integration**
 - Shared medical record

Effects of Innovations on the Primary-Specialty Care Interface

Reduced Rates of Referral	Shift Care to the Left
Implement EMR	Implement EMR
Decision Support	Decision Support
	eConsultation
	Telemedicine
	Specialist outreach
Mini-fellowships	Mini-fellowships
PHR	PHR
	Transparency/Steerage
	Org Integration
	Virtual Integration

Concluding Questions

- **How can the models be used in practice, for policy-making, and for training?**
- **What are the most promising innovations to “disrupt” the primary-specialty care interface?**
- **Will clarifying specialists’ roles in the continuum of care strengthen primary care?**