

# Improving the Primary Care–Specialty Care Interface

## *Getting From Here to There*

**M**S JONES PRESENTS TO HER PRIMARY CARE physician (PCP), Dr Sanchez, with symptoms of persistent diarrhea. Using prereferral guidelines posted on his practice's electronic referral system, he rules out *Clostridium difficile*, other bacterial and parasitic infections, and celiac disease. He refers her to a gastroenterologist, Dr Lee, for further evaluation and possible colonoscopy. When Ms Jones arrives, Dr Lee reviews the electronic referral, which includes Dr Sanchez's contact information and consultative question along with the patient's relevant history and laboratory results. After assessing Ms Jones, Dr Lee discusses the risks and benefits of colonoscopy with her to further evaluate the diarrhea. After the visit, Dr Lee dictates a note outlining the findings of the patient's assessment and the recommendations to Dr Sanchez. Within 2 days, the note can be found in the electronic medical record that both physicians use.

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This type of coordinated care—characterized by integrated decision support, clear indications for referral, and timely sharing of information between PCPs and specialty care physicians—is unfortunately the exception rather than the rule in today's health care system. Patients who transition between primary care and specialty care often encounter lapses in communication, duplication of diagnostic testing, and ambiguity regarding physician duties and responsibilities.

In this issue of the *Archives*, Forrest<sup>1</sup> provides a thorough overview of the primary care–specialty care landscape in the United States. He explores drivers of specialization and explicates the fundamental differences between PCPs and specialty care physicians that translate into differing decision-making styles, with significant implications for patients and the nation's health care system. Rather than continuing the traditional on-upmanship that seeks to prove the superiority of primary care over specialty care or specialty care over primary care, Forrest presents a typology of specialists' clinical roles that can serve as a framework for clarifying the mutual expectations and roles of PCPs and specialists in patient care. Given current realities, using this framework to improve the primary care–specialty care interface will require (1) attending to the “medical neighborhood,” (2) better defining the concepts of comanagement and shared care, and (3) establishing standards of communication.

### ATTENTION TO THE MEDICAL NEIGHBORHOOD

The ability to implement the proposed typology depends on patients having a medical home, or at least a PCP. This has not been true for many Americans. Of Medicare beneficiaries, only about 14% see a specialist for care during a 1-year period.<sup>2</sup> Indeed, access to specialty care has been considered a patient right and, more recently, an issue of consumer choice, with patients purchasing health insurance coverage that allows more direct access to specialists.<sup>3</sup> Nonetheless, there is a movement afoot to give the medical home a central role in health care reform efforts.<sup>4</sup>

However, even if every patient had a medical home, most patients would not have the same experience as Ms Jones. In our fragmented delivery system, the majority of PCPs refer their patients to specialists based on patient insurance and personal relationships using paper, fax, and telephone-based referral systems. Without a realignment of relationships and incentives within the medical neighborhood surrounding the medical home, there is little opportunity for the proposed typology to be applied.<sup>5</sup> For example, detailed prereferral guidelines or agreements rarely exist between specialists and their referring PCPs. Moreover, even when such guidelines exist, there are currently few incentives for busy PCPs to follow prereferral guidelines as Dr Sanchez did, and there are even fewer incentives for gastroenterologists to await prereferral evaluation before performing a colonoscopy. The inducement in the present reimbursement structure for PCPs to do less and specialists to do more is often reinforced by specialty society guidelines that raise the specter of medical liability if a PCP or specialist chooses not to follow the guidelines.<sup>6</sup>

Integrated health care delivery systems and multispecialty group practices that are able to develop mechanisms for shared information (ideally via an electronic health record), shared accountability, and shared rewards between PCPs and specialists represent medical neighborhoods where the proposed framework could be applied. Medical neighborhoods are well suited to adopting referral guidelines that are evidence based, not “eminence based,” and that are implemented in the context of the whole person, not just a particular disease condition.<sup>7</sup> An added benefit of the wired medical neighborhood is the ability to leverage information technology to establish and track the local ecology of health care (eg, how many referrals are generated for a given specialty, for what conditions, and for what purpose).

## DEFINING COMANAGEMENT AND SHARED CARE

Perhaps the biggest barrier to implementing the proposed typology is reaching some agreement between PCPs and specialists on what consultancy, comanagement, and principal care entail. Studies comparing the clinical assessments of referring and specialty care physicians have shown significant areas of dissent. In one early study of physician communication in the consultative process, referring physicians and consulting physicians disagreed on both the reason for consultation and the principal clinical issue in 14% of consultations studied.<sup>8</sup> In a more recent study on the avoidability of specialty referrals, both primary and specialty care physicians thought that many referrals were potentially avoidable but failed to agree on 34% of the cases.<sup>9</sup>

Given a lack of agreement on basics such as whether or why a referral is needed, it should be no surprise that there is also disagreement over when a comanagement approach should be used as opposed to either physician playing a principal role. When PCPs and specialists are asked about relative responsibility in specific scenarios such as, "Who should care for minor illness, related to the reason for referral?" and "Who should manage medications?" there are significant differences between the 2 groups.<sup>10</sup> In a study of PCPs and specialists caring for children with diabetes, each group preferred a principal role in its primary domain but a comanagement role in the other group's primary domain. That is, PCPs were more likely to feel that they should be the principal physician for routine, preventive care, while specialists were more likely to favor a comanagement model; however, on diabetes-specific care measures, specialists were more likely to feel that they should be the principal physician, while PCPs were more likely to favor a comanagement model.<sup>11</sup>

From a patient perspective, it is unlikely that there can or should be strict guidelines across these various scenarios. Individual physicians' familiarity and comfort level with a given condition, as well as patient preferences and physicians' accessibility to the patients, will need to play an important part in actual patient management. At the same time, patient safety and quality of care demand better definition of the specific domains of potential comanagement such as pharmacologic therapy (who prescribes, monitors, and refills medications), referral management (who refers patients to additional specialists), diagnostic testing and communication of results, tracking and management of screening and surveillance tests, and patient education. If Ms Jones is diagnosed as having ulcerative colitis, it will be critical for Drs Sanchez and Lee to know who will be responsible for monitoring her symptoms, titrating her medical therapy, and scheduling her colorectal cancer surveillance. Development of a common vocabulary and shared vision for apportioning responsibility for a given patient's care would ensure that comanagement does not degenerate into duplicative prescribing, delays in diagnosis, and dispersed care.

## ESTABLISHING COMMUNICATION STANDARDS

Traditionally, there has been little attention during medical school or postgraduate training to transitions of care

and communication across these transitions. This lack of attention includes the primary care–specialty care interface, which has been marked by poor, or even absent, communication. One study of referral processes at a university medical center showed that, while referring physicians provided patient background information in 98% of cases, the purpose of the referral was explicit in only 76% of cases. The referring physicians fared even worse: consultants communicated their findings to the referring physicians in only 55% of the consultations.<sup>12</sup> Nearly 2 decades later, things had not significantly improved: a study at another academic medical center found that 32% of specialists received consultative information from the referring PCP, while 75% of referring physicians received communication back from the specialist.<sup>13</sup> These lapses in communication result in inefficiencies, including "repeat referrals" on the part of PCPs, and inability of the specialist to adequately address the patient's issues.

When communication does occur, the content is often judged to be inadequate. In a teleconsultation system designed to serve as an alternative to specialist referral, consultations that did not specify a clinical question, identify an intervention, or describe the hoped-for outcome of the intervention were 6 times more likely to result in a recommendation for a formal referral than those that contained all 3 elements.<sup>14</sup> Another study analyzing the content of specialist communication back to the referring physician found that only 62% contained management suggestions and 30% included plans for comanagement.<sup>15</sup>

The recent clarion call for the institution of electronic health records throughout the health care system will both demand and facilitate standards for PCP–specialist communications. In our vignette, Ms Jones benefited from such electronic health record–enhanced communication between Drs Sanchez and Lee. There is a pressing need to establish—and teach—more uniform standards for communication that will ultimately serve as the currency of comanagement.

Forrest's<sup>1</sup> proposed typology has great potential as a conceptual framework for establishing the respective and mutual duties and responsibilities of PCPs and specialists. Implementation on a practical level will require the right delivery system, a clearer understanding of the application of comanagement to clinical practice, and improved consistency and quality of communication between primary care and specialty care physicians. Our hope is that, in the end, all patients will have the same experience as Ms Jones.

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