

Consultation Guidelines for Primary Care Providers

In 1998, Partners Community HealthCare (PCHI) performed a major survey of patient satisfaction. The good news was that the network looked better than available benchmarks on most dimensions of care, including patients' experience with specialty referrals. The bad news was that 28 percent of patients reported that their specialist did not appear to be familiar with their recent medical history.

Even though 28 percent was significantly lower than the benchmark, PCHI found this number to be, well, *embarrassing*. This embarrassment probably pales compared to that of specialists who find themselves fumbling through papers in front of the patient, in futile search for background information. Or that of primary care physicians (PCPs) who face patients without information about what transpired during the visit with the specialist.

Of course, embarrassment is not the only issue when quality and efficiency of care are at stake. In a study of inpatient consultations, PCHI found that the requesting physicians and consultants completely disagreed on both the reason for the consultation and the principal clinical issue 14 percent of the time.¹ Not surprisingly, when the two physicians disagreed on the reason for consultation, the requesting physician was significantly less likely to find the consultation useful.

Improving Referral Communication

The challenge of improving the consultation process has become charged by the financial issues inherent in risk contracts. PCPs and patients *need* specialists to deliver specialty care. But many PCPs are exposed to the financial consequences of test ordering and therapeutic interventions by specialists. Costs to the PCP's risk pool can be increased unnecessarily by some well-intended specialists' practices, such as:

- ◆ Ordering tests that have already been performed at the referring physician's institution.
- ◆ Performing tests or other interventions that might have been performed at lower cost at the referring physician's institution.
- ◆ Referring patients to another specialist at a teaching hospital, when that care might have been given by a community specialist who was in the same "risk pool" with the referring physician.

What is needed is better communication about both clinical and financial issues between referring PCPs and consultants. Ideally, the referral process should be geared up to improve that communication, and make it happen more reliably. The goal of risk contracting is *not* to manage referrals—the goal is to

manage the patient's care. In other words, medical management is not avoiding specialty care, but rather, ensuring that it is used appropriately—and to direct patients toward specialists who are truly working in partnership with PCPs.

In discussions with specialists about the need for efficiency, good communication, and cost-effective care, a common response emerges—whether they are based in the community or at teaching hospitals. All too often, specialists have to see patients referred for consultation without information on the prior clinical evaluation.

As PCHI has looked more deeply into this problem, we found instances in which such information was sent prior to the consultation, but was not available to the specialist at the time of the evaluation. (Some offices mistakenly consider such information relevant for billing purposes only.) However, we also found many instances in which specialists were being asked to see patients without prior information. It seems clear that pressure for "accountability" must be felt by both parties in the consultation relationship.

The PCHI Medical Management Committee therefore considers the following standards for PCPs and other referring physicians:

- ◆ Written or telephone communication with specialists prior to the consultation.
- ◆ Identification of the patient as a PCHI contract patient.
- ◆ Identification of the referring physician as a PCHI colleague.
- ◆ Identification of the question to be addressed by the specialist.
- ◆ Identification of any tests or procedures to be performed by the specialist.
- ◆ Description of prior evaluation, including major tests and procedures.
- ◆ Identification of any limitations on the scope of care for the consultant.

Explicit communication of these data should improve communication in both directions. In the future, software may help us ensure that these data are communicated reliably. In the interim, we have to rely upon physicians to remember that all relationships—including that with a consultant—require time and effort from both parties. ■

Reference:

- 1 Lee TH, Pappius EM, Goldman L. Impact of inter-physician communication on the effectiveness of medical consultations. *American Journal of Medicine*. 1983;74:106-12.

by
Thomas H. Lee,
M.D.

Dr. Lee is
Medical
Director for
Partners Community
HealthCare,
Inc., in Boston,
Massachusetts.
