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INVITED COMMENTARY

Improving Primary Care–Specialty Care Communication

Lessons From San Francisco's Safety Net

With the advent of health care system reform, patient-centered medical homes and accountable care organizations have emerged as solutions to the fragmentation and duplication that characterize the US health care system.¹ Given the increasing burden of chronic disease, the success of these models depends in part on improving the primary care–specialty care interface.

The interaction between PCPs and specialist consultants is not a trivial issue—it has a central role as a driver of health care quality² and cost.³ Moreover, the importance of the PCP–specialist nexus is underscored by the sheer number of physicians potentially involved in any given patient's care. A recent study⁴ found that in caring for 100

Medicare patients, the average PCP needs to coordinate care with 99 other physicians working across 53 practices.

O'Malley and Reschovsky use a large, nationally representative sample of physicians to rigorously confirm a problem that previously has been reported in smaller, localized studies. Despite the wide recognition that PCP–specialist communication is critical for high-quality patient care, the authors found that communication between PCPs and specialists occurs inconsistently. Remarkably, only 69.3% of PCPs and 80.6% of specialists report “always” or “most of the time” sending basic patient information to each other. Furthermore, this retrospective, self-reported survey data may in fact represent an overestimate.

The authors go one step further to identify system factors that correlate with the likelihood of PCP-specialist communication. Three practice characteristics are positively associated with communication for both types of physicians: “adequate” visit time with patients, receipt of quality reports regarding patients with chronic conditions, and nurse support for monitoring patients with chronic conditions. Use of HIT is associated with higher rates of communication by specialists, although not by PCPs.

In the context of health care system reform, these findings provide reassurance that we are on the right track. Escaping the tyranny of the 15-minute visit, using clinical data to improve individual and population health, and practicing team-based care—all supported by the use of a robust EMR—are some of the fundamental building blocks of a successful patient-centered medical home.⁵ Nevertheless, even when all 4 supports are applied to a PCP practice, the probability of communication to a specialist only increases from 63.9% to 82.7%. This begs the question, “Can’t we do better?”

Despite the fact that HIT was not associated with increased PCP communication, HIT remains a promising avenue for improving PCP-specialist communication. An example of this is eReferral,⁶ an electronic referral management and consultation program we developed for our safety net system. For the clinics and services that currently use eReferral, PCPs electronically submit all new patient referrals for specialty care. Each referral is electronically reviewed by a specialist physician or nurse practitioner who can respond in a variety of ways: approving a routine or urgent specialty clinic appointment, asking for additional information, recommending additional studies before a clinic visit, or providing management strategies for the PCP. The specialist reviewer’s response is sent to the PCP, who can relay additional information, questions, or comments back to the specialist in an iterative fashion using the eReferral application. All exchanges are captured in real time in the patient’s EMR.

Although the original impetus for the program came primarily from concerns regarding wait times for specialty care, eReferral has resulted in a qualitative shift in the communication and relationship between PCPs and specialists in our system. This shift has in turn produced organizational changes in the larger safety net health care delivery system.

From the PCP perspective, eReferral increases the efficiency of communication that previously would have occurred in a diffuse fashion via facsimile transmission, mail, telephone calls, and paging. Over time, eReferral has also evolved into a tool for communication that enhances collaboration between PCPs and specialists. Many PCPs use eReferral to request specialist advice and guidance for patients whom they do not necessarily want to be seen in clinic. Using eReferral in this manner addresses some of the inherent problems of traditional “curbside” consultations, such as incomplete patient data and no documentation of the interaction, while retaining the benefits of rapid response, opportunity for case-based education, convenience for patients, and cost savings associated with avoidance of a formal consultative visit. The administrative burden of communication is also re-

duced by automatically populating relevant demographic and clinical data. A survey⁷ found that more than 70% of referring PCPs thought eReferral enhanced their ability to track referrals, allowed for better guidance of previsit evaluation, and improved overall clinical care.

From the specialist perspective, eReferral improves the consistency and clarity of communication from the referring PCP. When a patient presents for a visit, the specialist is guaranteed not only a legible consultation request but also one that has a clear consultative question because it has been vetted by a specialist reviewer. A survey of surgical specialists found that compared with prior paper-based methods, eReferral resulted in a 75% decrease in referrals for which there was difficulty discerning the reason for consultation and a nearly 80% decrease in referrals that were considered inappropriate.⁸ eReferral also provides a systemwide overview of all incoming referrals for specialty reviewers, which allows for consistent and equitable triage and identification of topics for which referring physicians, nurse practitioners, and physician assistants may benefit from additional education. Finally, and perhaps most significantly, eReferral enables specialists to provide timely and pertinent specialty care advice with or without an in-person consultative visit.

From an organizational perspective, the implementation of eReferral in a complex system (26 primary care clinics and 30 specialty clinics and services, representing 13 distinct organizations) has been challenging but has significantly strengthened safety net partnerships in San Francisco, California. Importantly, our efforts have been synergistic with San Francisco’s universal access to health care initiative⁹ and our local Medicaid managed care plan’s efforts to create a more defined and integrated safety net system.¹⁰

Our program is not a panacea for the current lack of meaningful coordination of care between PCPs and specialists. Because it is solely focused on the initial stage of the consultative process, eReferral does not address the continuing challenge of timely, ongoing communication between the referring PCP and the specialist who sees a patient in clinic. Although PCPs believe eReferral improves clinical care, they also feel burdened by the shift in clinical work from the specialist to the PCP. In addition, eReferral presents new challenges for PCPs in communicating with their patients about specialty care. Instead of, “I’m referring you to the specialist,” the message may be, “I’m consulting with my specialist colleague to see what else we need to do, which may include sending you to the specialty clinic for a visit.” Furthermore, the program is only as good as the specialist reviewer and how helpful he or she is for referring PCPs. Finally, this type of electronic consultation system is not sustainable in a fee-for-service environment unless insurers begin to pay for specialist time spent conferring with PCPs rather than solely paying for patient visits.

Nevertheless, electronic referral programs clearly represent an improvement over traditional referral practices.^{11,12} As the Office of the National Coordinator moves forward with developing additional measures of meaningful use and the Centers for Medicare and Medicaid Services experiments with new payment models, we urge policymakers to devote attention to ways that HIT can

be used to ensure communication and coordination between PCPs and specialists. We can do better.

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Financial Disclosure: Drs Chen and Yee have served as implementation consultants for L.A. Care Health Plan, and Dr Yee has served as an implementation consultant for CalOptima.

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