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Positioning Physician Practices to Deliver High-Value Care:
The Interface of Primary Care and Specialty Care

Learn
Serve
Lead

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Disclaimer

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Hypothetical cases of referred patients

Janie arrives with her parents at the specialist's office, with no one having a clear understanding of the purpose of the visit.

Mr. Foster returns to his PCP after a referral. The PCP must rely on Mr. Foster's report of the specialist's advice/ recommendations as no information has been sent.

Mrs. Smith arrives at the specialist's office, but the tests that were done by the PCP are not available, so the specialist orders repeat testing and asks the patient to return for another visit.

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Hypothetical cases of referred patients

Johnny receives follow-up care indefinitely from both the specialist and the PCP for the same problem.

In the interval between Ms. Taylor's referral from her PCP and the specialty visit, she has developed a new issue. She brings this up during the visit with the specialist. Specialist 1 responds by referring her to Specialist 2 rather than back to the PCP. The PCP is unaware that she is receiving care from Specialist 2.

Mr. Jones is referred but skips the specialty visit due to the inconvenience of a long wait, a long drive, missed work, and an unfamiliar setting. No one follows up to ensure that referral has been completed.

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Setting the stage: Referrals in the U.S.

1 in 3 patients is referred to a specialist each year (**1 in 2** for those 65+) (Forrest 2002)

Referral volumes have **doubled** in past decade ('99-'09) (Barnett 2012)

As of 2013, **more office visits occurring with specialists** than with PCPs (NAMCS data)

Patients seen by primary care in U.S. have a greater than **2-fold greater rate** of referral than similar patients in U.K. (Forrest 2010)

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Why have referrals become so much more prevalent?

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Why more referrals?

Increased supply and availability of specialists

Expansion of increasingly specialized clinical knowledge

Changing perception of PCP scope/ expertise

Limitations of 15-20 minute visit

Parental/ patient expectations

FFS payments and productivity incentives

Increase in specialist to specialist referrals

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So, with all this practice at referrals, we're really good at it, right?

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Referral process is **“often incomplete and needlessly inefficient”** (Kunkle, 1964)

The referral process **“often falls short of its goals”** (Lee et al, 1983)

The referral system is **“not consciously designed and leaves much to be desired”** (Gandhi et al, 2000)

Listed as a prominent risk in a patient’s **“perilous journey through the health care system”** (Bodenheimer, 2008)

Cited from Mehrotra, Forrest, 201

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Community of Clinical Faculty: Impact on Culture

Yesterday

Today

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Why should we care about communication and coordination between providers?

Fragmentation

↓ Quality ↑ Costs

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A new premium on Efficiency & Value

ACOs

Bundled payments

Global, risk-based payments

Capitation

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VIEWPOINT

Patient Referrals
A Linchpin for Increasing the Value of Care

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The success of accountable care organizations (ACOs) under global payment may depend in part on a common yet poorly understood clinical decision: the patient referral in the outpatient setting. Fundamental to collaboration among physicians and other health care professionals, patient referrals have been largely ignored in the payment reform debate.

Referral rates in the United States more than doubled from 1999 to 2009, with about 10% of outpatient visits resulting in a consultation or visit to another physician.[1] Referrals seem to be both underused and overused, with clinical information often poorly transferred between physicians and frequent confusion between primary care physicians and specialists over the specialist's role.[2] Yet little is known about referrals. By systematically measuring and evaluating referrals in their physician networks, ACOs may be able to better target efforts to improve care coordination and reduce spending.

Referrals may be driven by a number of factors. Physician knowledge gaps due to specialization create a natural demand for referrals. Time pressures on outpatient clinicians may intensify this demand, because number of physicians was 3.0 times greater in the same comparison, correlating with imaging, diagnostic tests, and minor procedures used on the order of 1 to 3 times as frequently.[3] Surveys of primary care physicians suggest that for a patient with a given clinical profile, the largest variation in clinical decision making between high- and low-spending regions was in the likelihood to refer.[4]

Referrals also affect prices. Given fee differences across private payers, shifting referrals from more expensive to less expensive clinicians and health care organizations may garner price discounts. Among early ACOs in Massachusetts, initial savings measured through claims were largely achieved by referring patients to physicians and facilities that charged lower prices, consistent with early efforts by these ACOs to control referral patterns.[5]

In addition, referrals may affect quality. Fragmentation of care increases with the number of physicians a patient sees, reflecting the challenges in communication and teamwork among physicians in a complex delivery system. Medicare beneficiaries with chronic diseases such as heart failure or diabetes see a median of 8 to 10 physicians in a year, and the typical primary care physician needs to coordinate care with hundreds of other physicians for a panel of patients.[6] Poor continuity of care is associated with more preventable hospitalizations, complications of

Much can be learned from examining patterns of physician referrals within a single organization.

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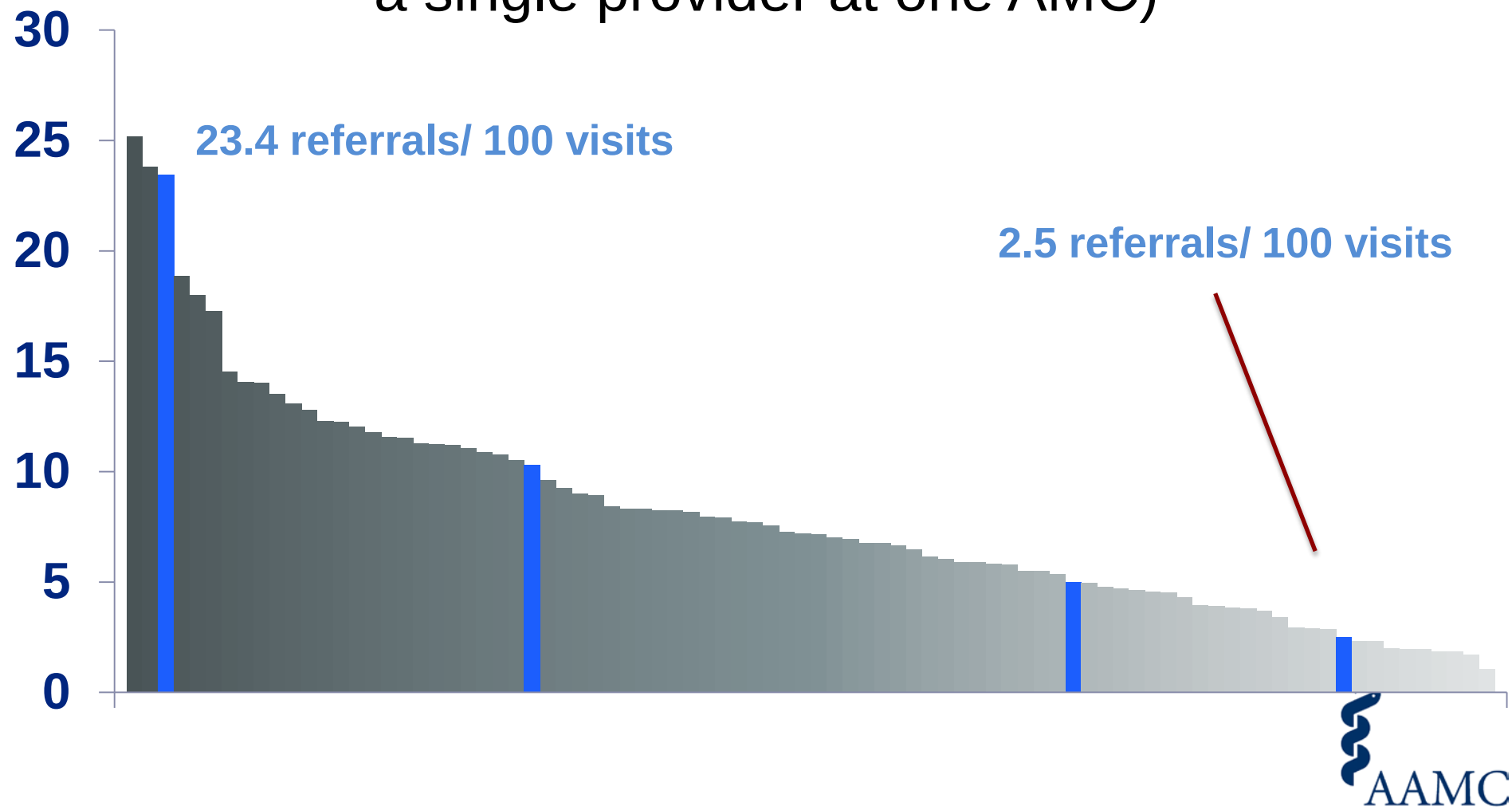
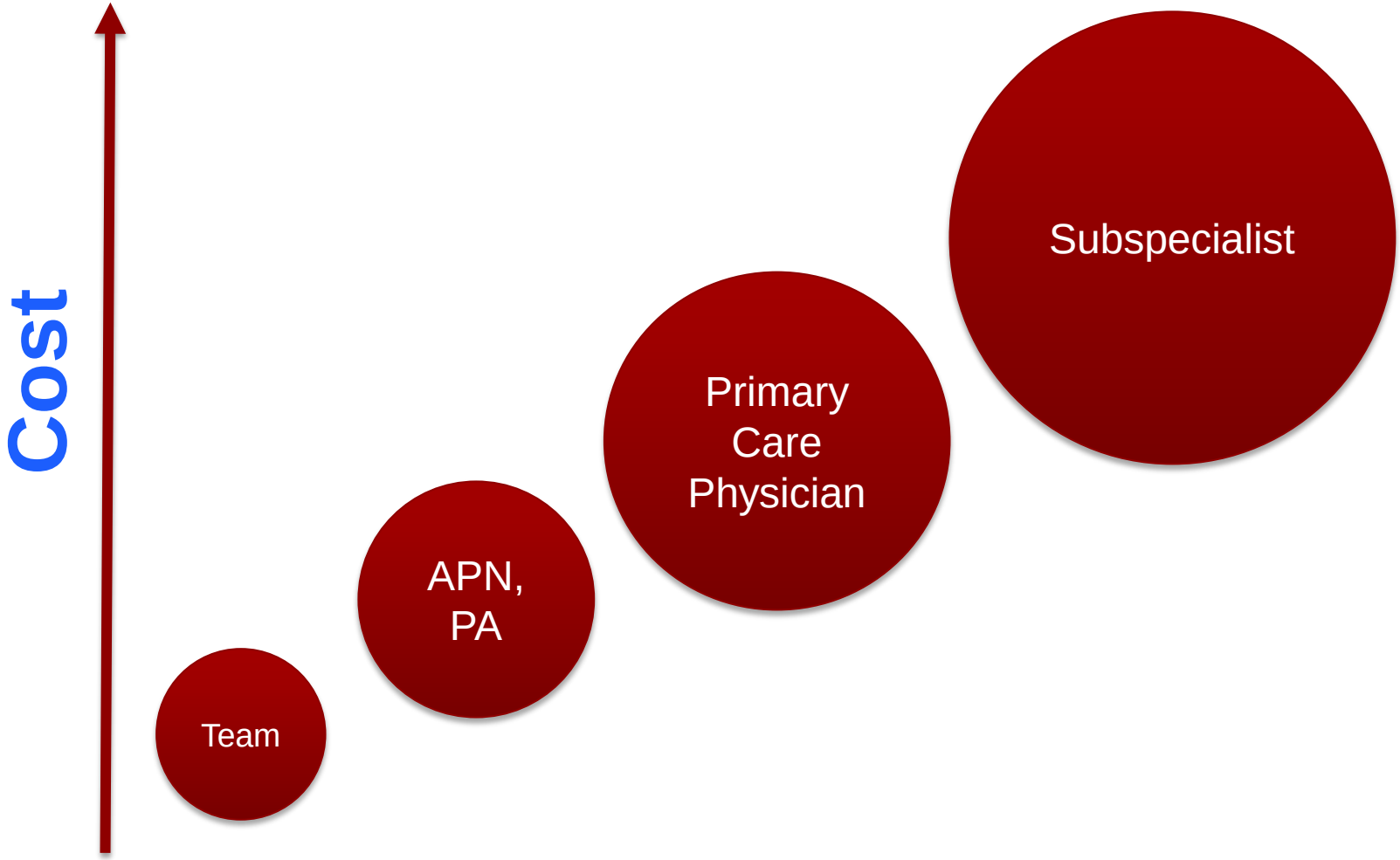
Referrals rates are highly variable across PCPs

(Referrals/ 100 PC visits; each bar represents a single provider at one AMC)



Efficiency across the care continuum



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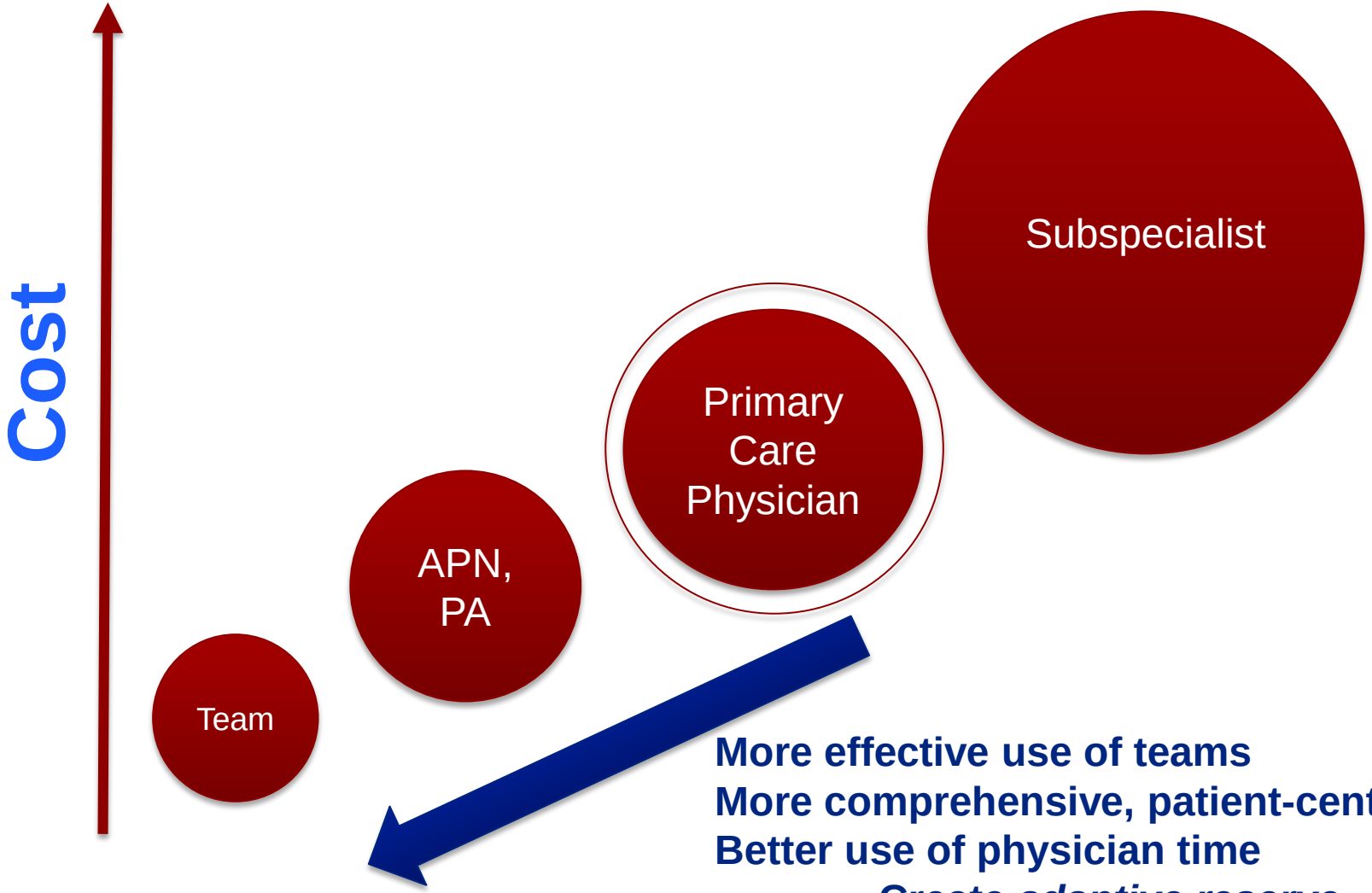
Efficiency across the care continuum



More effective use of teams
More comprehensive, patient-centered care
Better use of physician time
Create *adaptive reserve*

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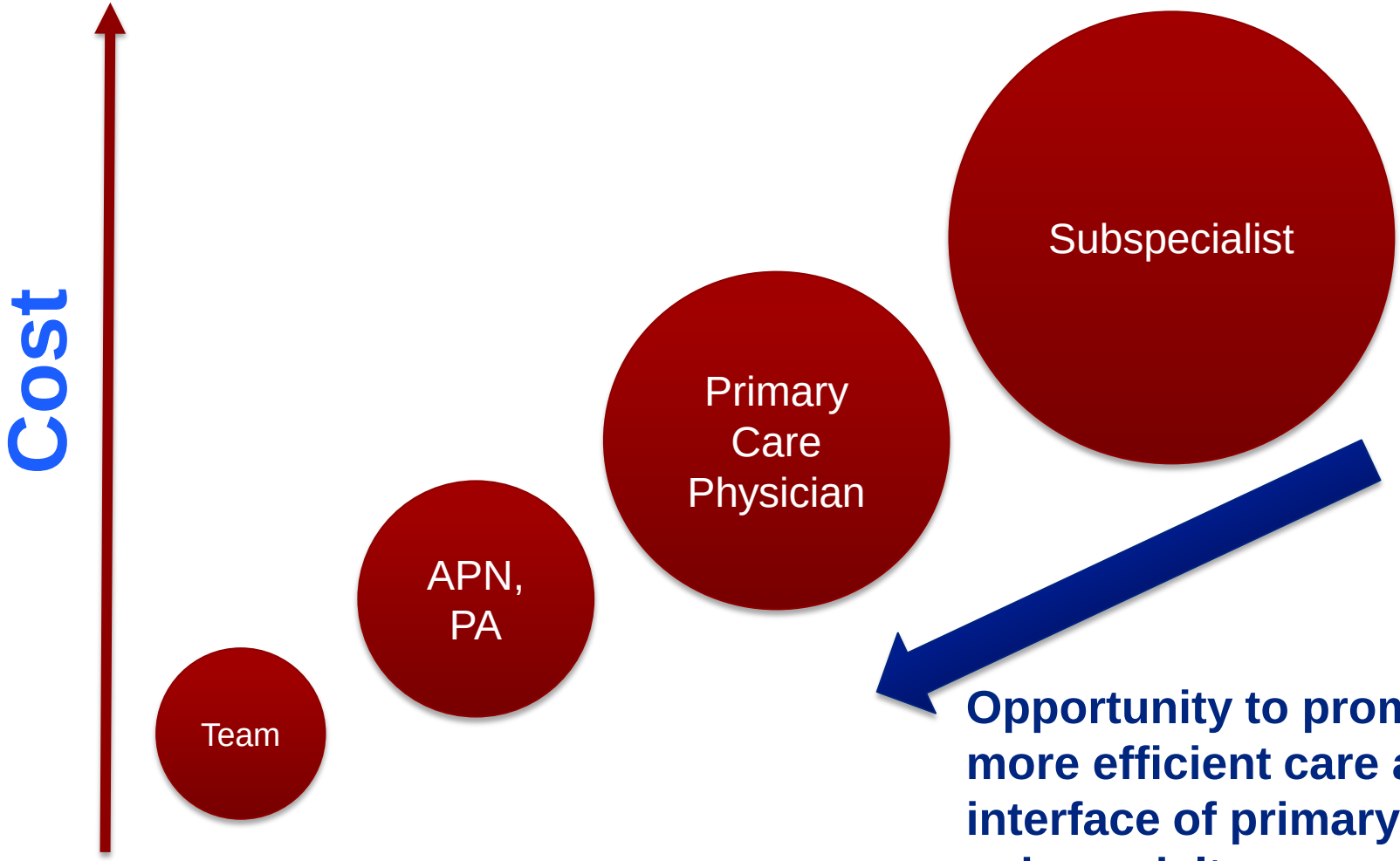
Efficiency across the care continuum



Opportunity to promote more efficient care at the interface of primary care and subspecialty care

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Innovations that

- Reduce fragmentation
- Enhance primary care comprehensiveness
- Right size referral rates
- Improve access to specialty care

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CORE Coordinating Optimal Referral Experiences:

Implementing eConsults and Enhanced Referrals

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Evolution of the CORE Model

AAMC receives 3 year, $7M award from CMMI

Sept 2014

AAMC, with UCSF providing content expertise, convene 5 AMCs to implement the CORE model (eConsults & enhanced referrals)

The CORE model implemented across 15+ medical & surgical specialties

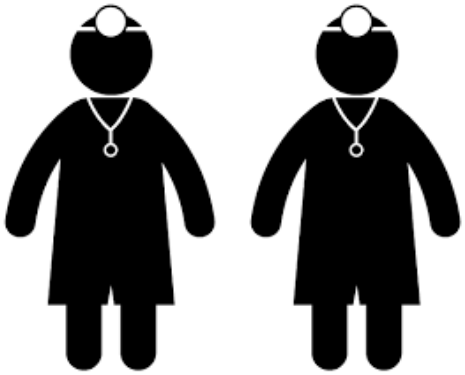
Program expansion to 7 additional AMCs (outside of the initial CMMI grant funding)

March 2016

Innovation in Action

As of 2016, across the participating AMCs, over 1.2 million primary care patients can benefit from Project CORE through timely clinical input, greater convenience, improved access, and lower costs.

12
AMCs



2,000
Primary Care
Providers

1.2 Million
Primary Care
Patients

CORE Coordinating Optimal Referral Experiences: Implementing eConsults and Enhanced Referrals

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Current AMCs working with AAMC to implement the CORE model

Project CORE Goals

By improving care delivery at the primary care – specialty care interface, the CORE model seeks to:

- Improve **specialty access**
- Enhance **primary care comprehensiveness**
- Reduce **unwarranted variation** in referral thresholds
- Improve **communication and coordination** between primary care and specialists
- Improve **quality** and **convenience** for patients
- Control **costs of care**

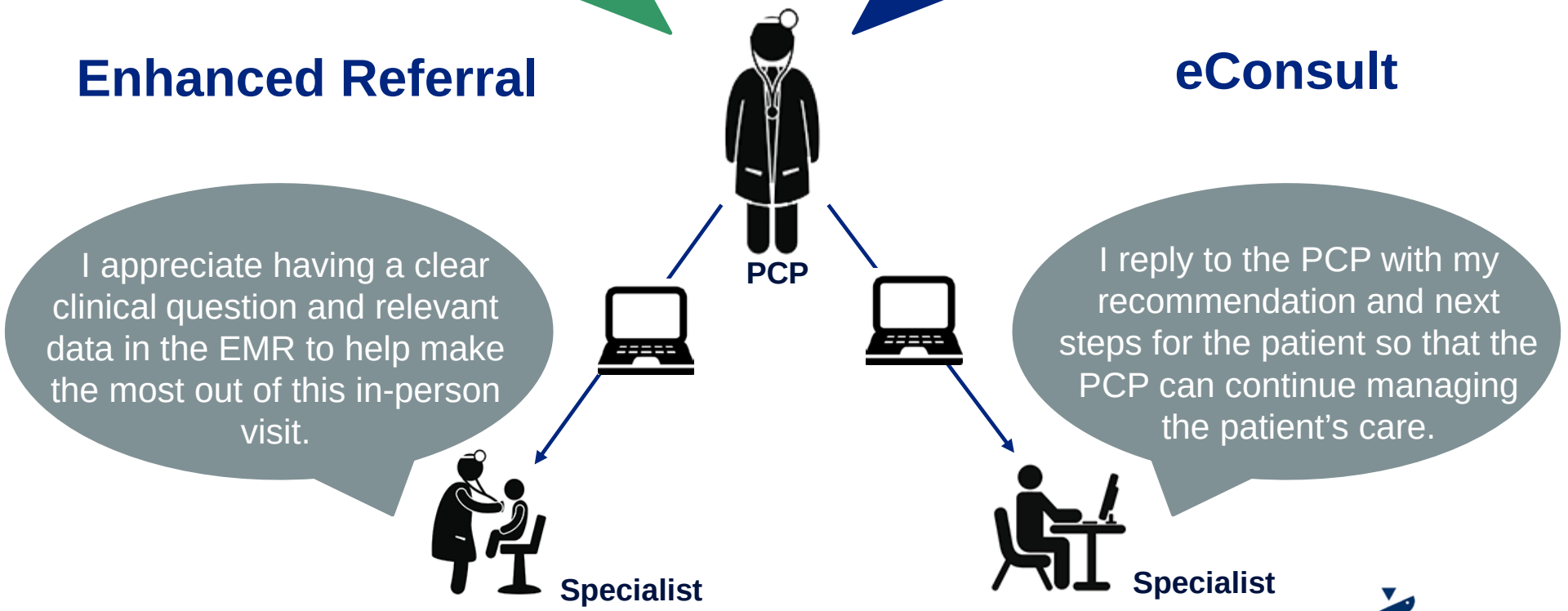
Optimizing Care in the EMR

My patient needs to see a specialist about a specific clinical issue.

I have a clear clinical question for a specialist to help me manage my patient's care plan.

Enhanced Referral

eConsult



I appreciate having a clear clinical question and relevant data in the EMR to help make the most out of this in-person visit.

I reply to the PCP with my recommendation and next steps for the patient so that the PCP can continue managing the patient's care.

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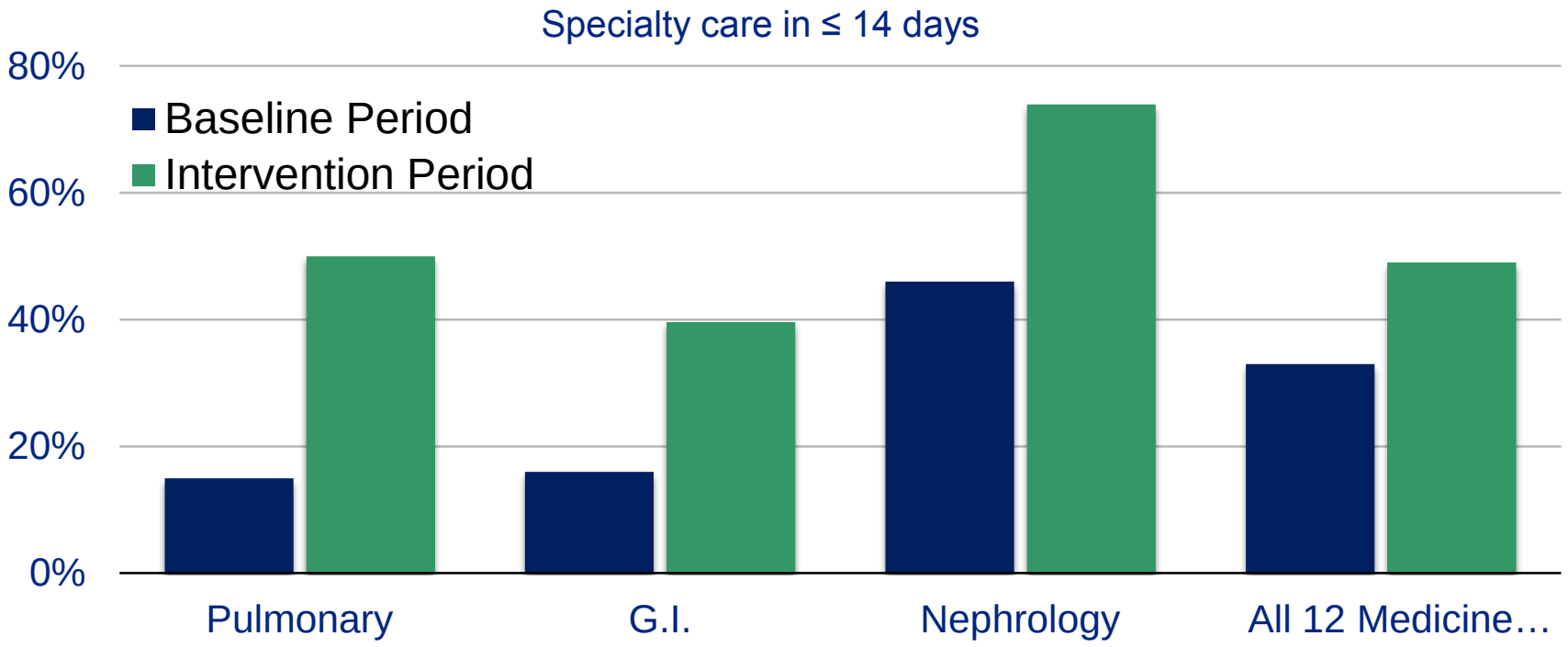
UCSF Results: Access



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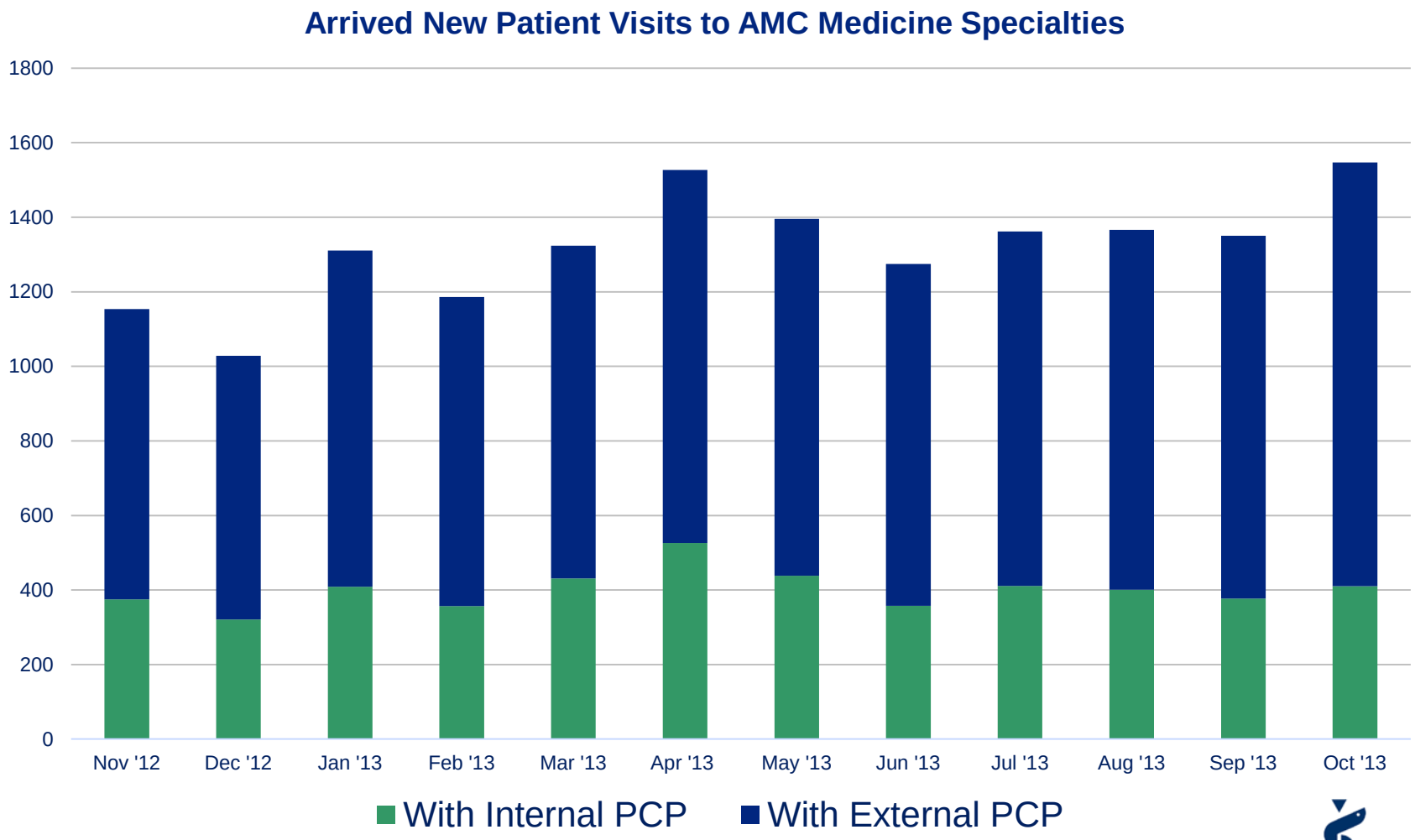
Single AMC: Increased External Referrals



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Single AMC Results: Utilization and Cost

120 days following all referrals & eConsults (n = 13,738)

12%
Decrease in ED visits
(9.8%→8.6%)

17%
Decrease in Pro fees
(p=0.016)

10.8%
Decrease in Admissions
(6.6%→5.9%)

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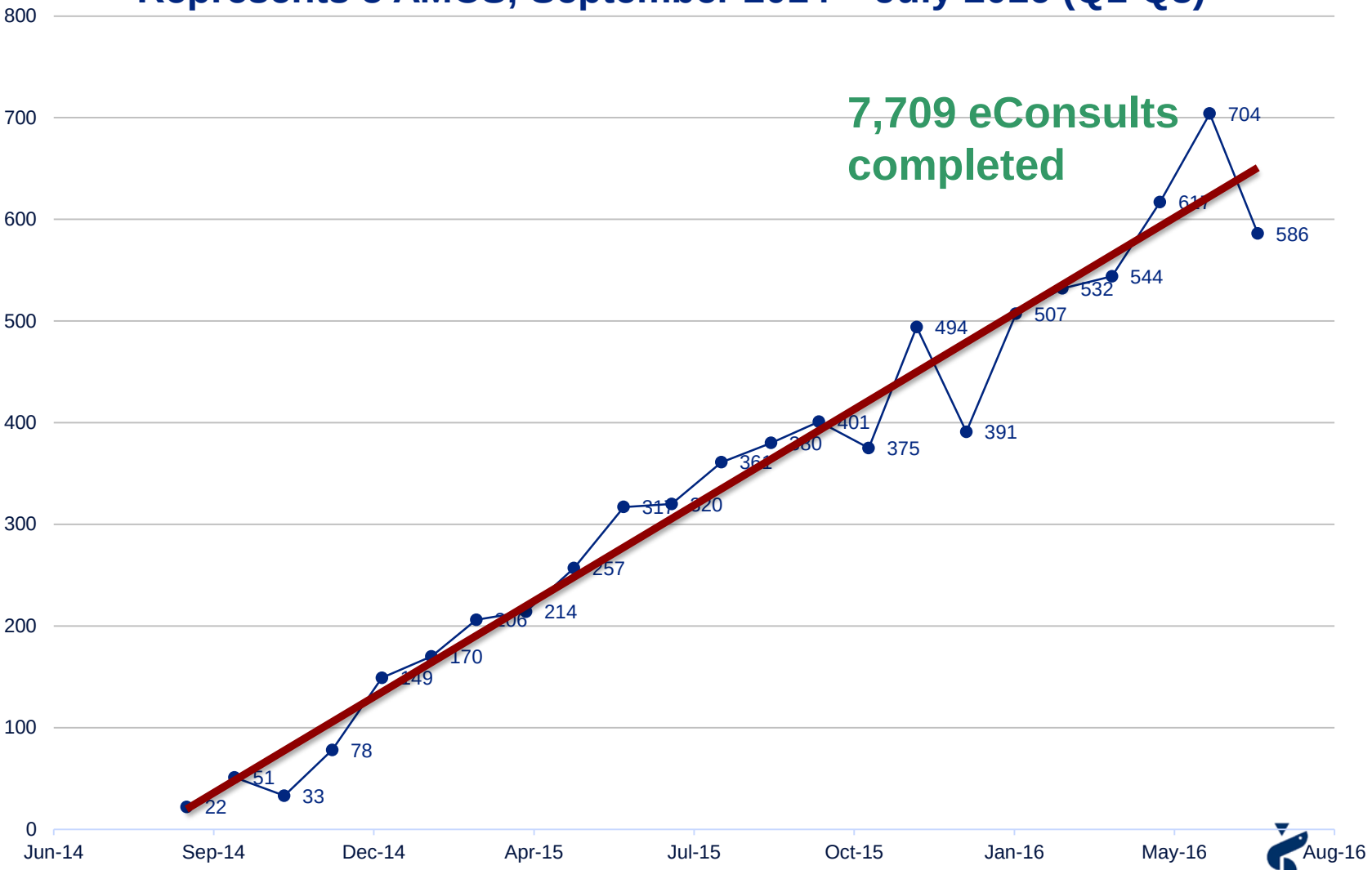
CMMI Collaborative: eConsult Volume

Represents 5 AMCS, September 2014 – July 2016 (Q1-Q8)



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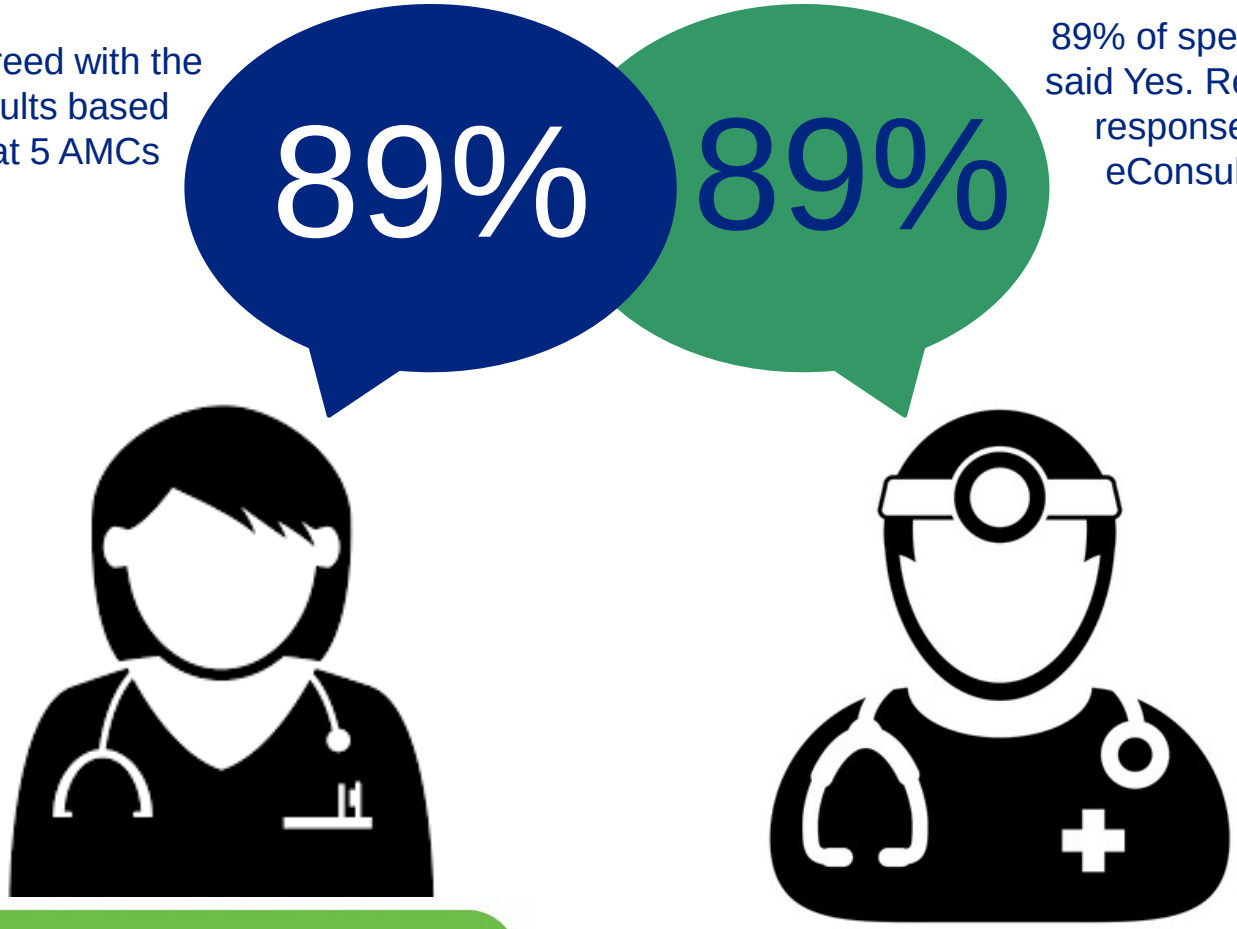
Provider Satisfaction Survey

PCP Survey: I am highly satisfied with this eConsult response.

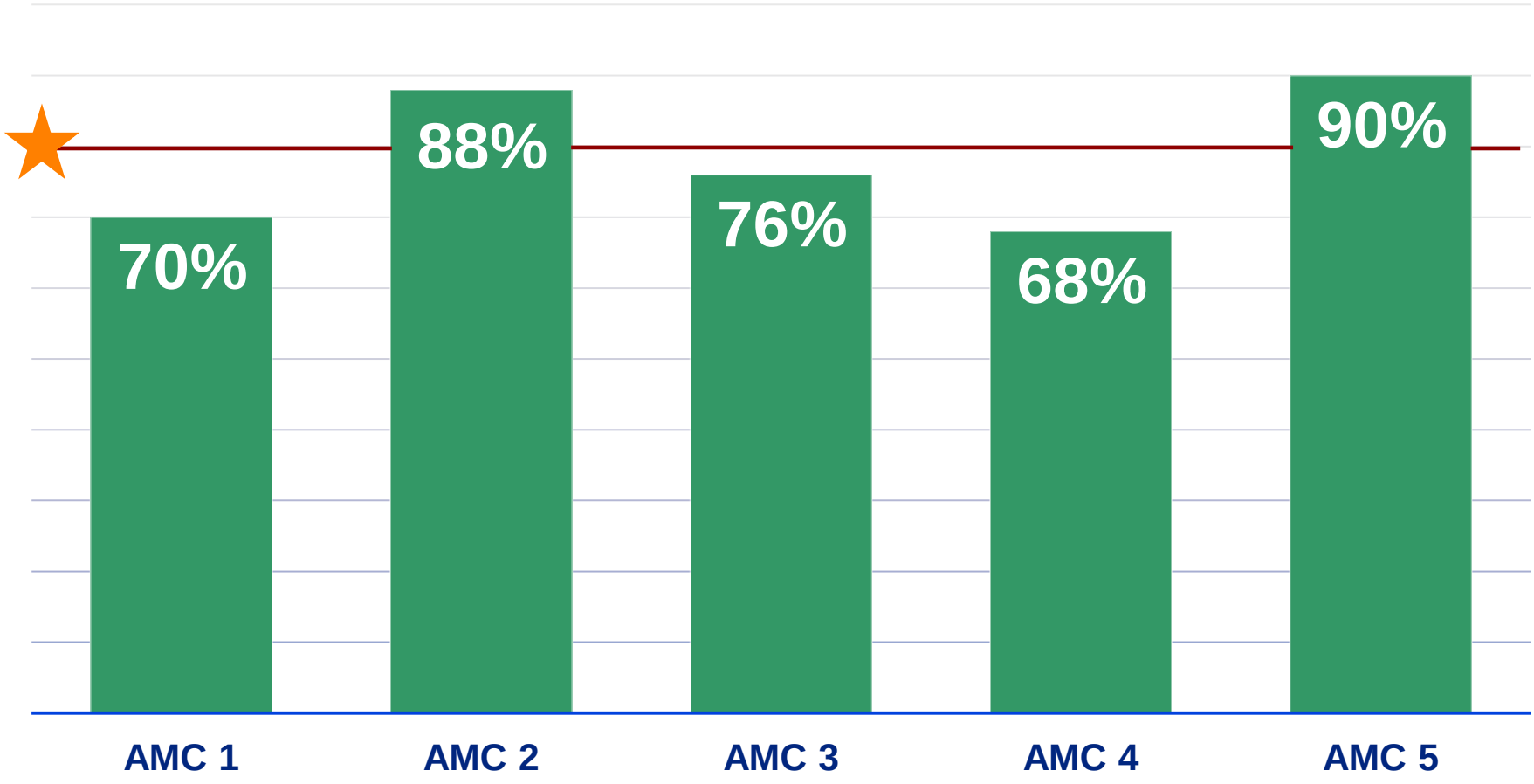
89% of PCPs agreed with the statement. Results based on 316 PCPs at 5 AMCs



Specialist Survey: Was this eConsult question appropriate?

89% of specialist eConsultants said Yes. Results based on 693 responses from specialist eConsultants at 5 AMCs

Primary Care Faculty Usage of eConsults



**Cumulative use through July 2016*

Source: AMC Monthly Reports (July 2016)

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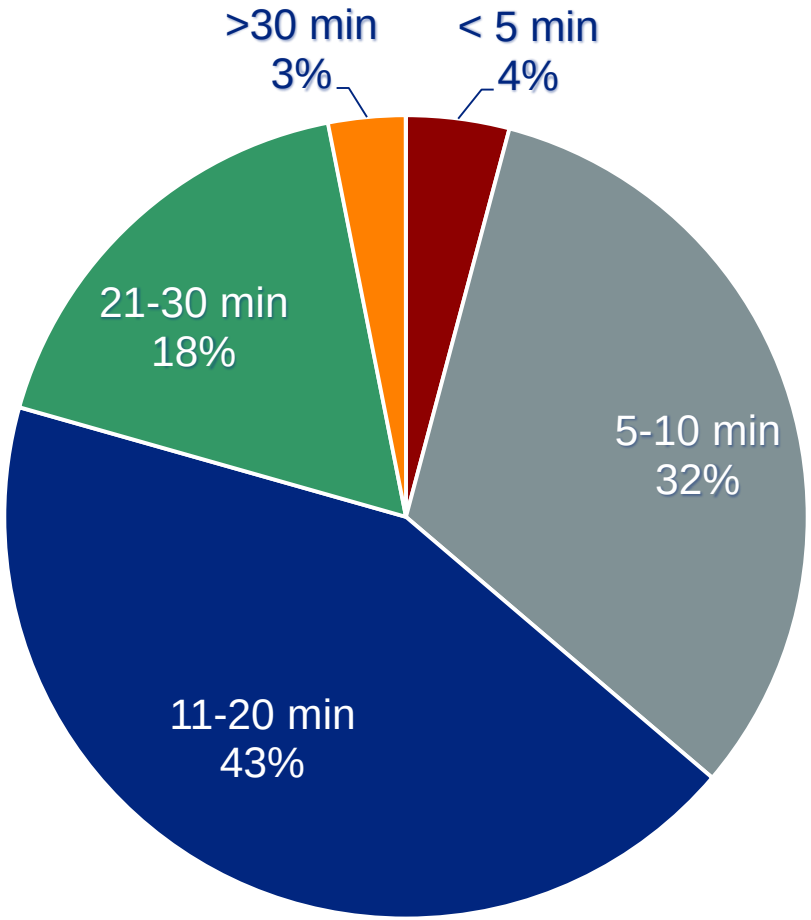
Specialists: Total Time to Complete eConsult



**Responses by specialist eConsultants at 5 AMCs upon closing eConsult encounter (n = ~2200 eConsults)*

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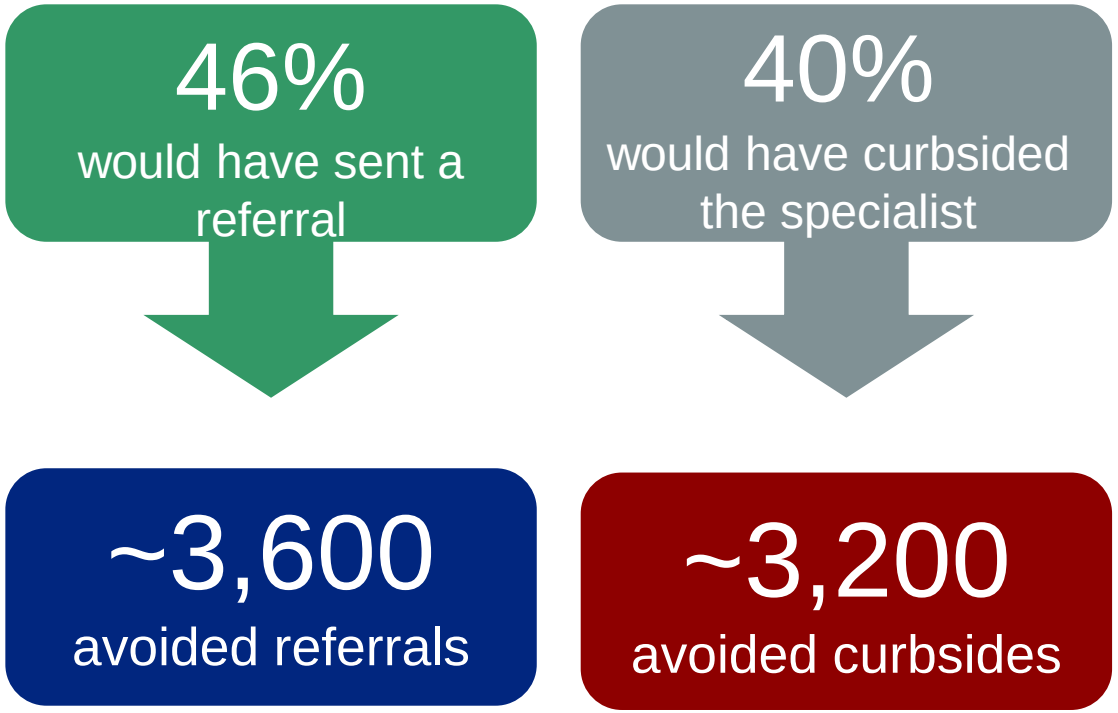
Impact of eConsults

*~**8,000** eConsults completed by PCPs thru August 2016*

*Based on a survey of PCPs at 5 CORE sites after completing an eConsult

"In the absence of an eConsult option, what would you have done?"



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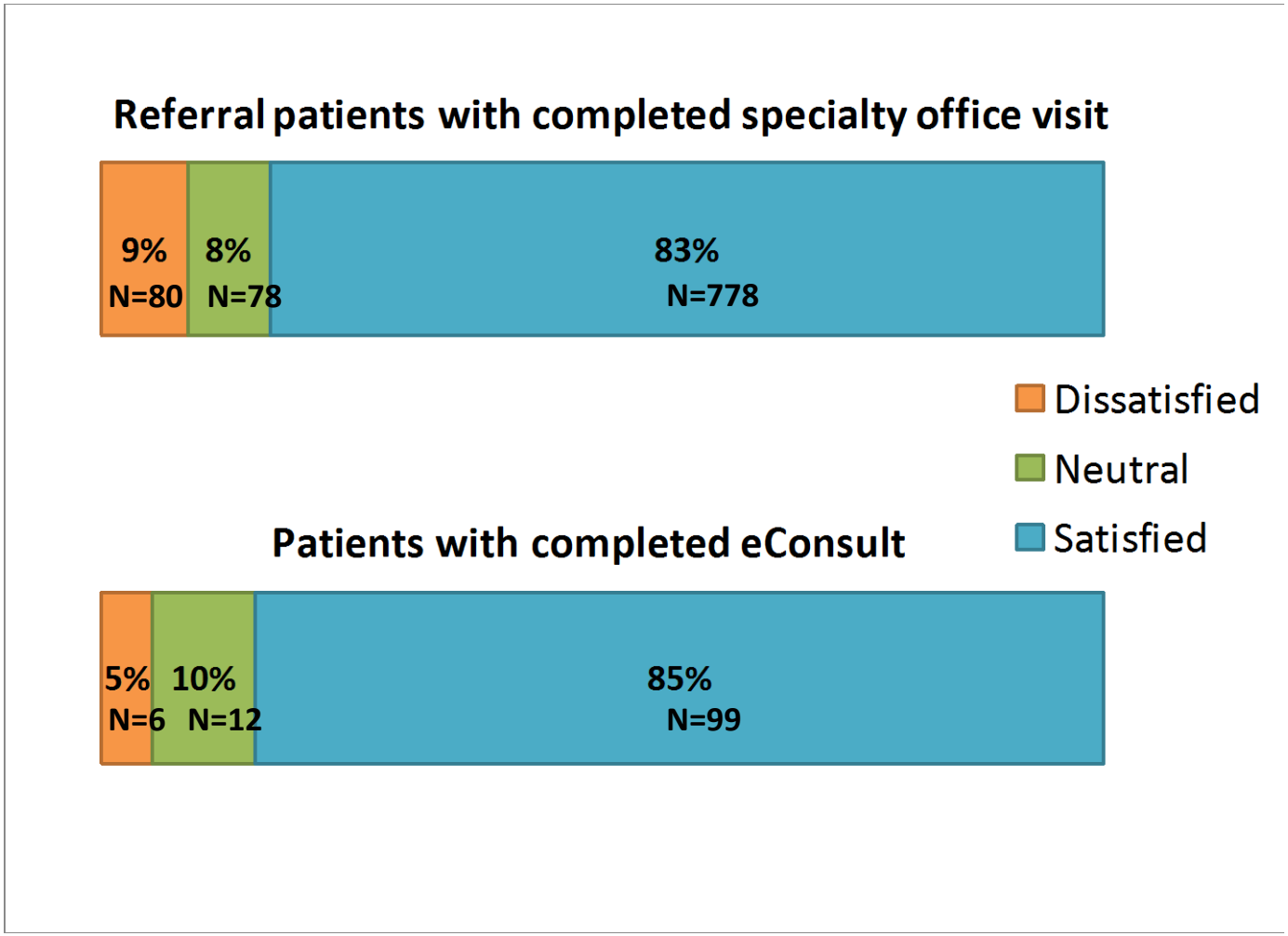
Patient survey: Preliminary results
Satisfaction with recommendations made by the specialist



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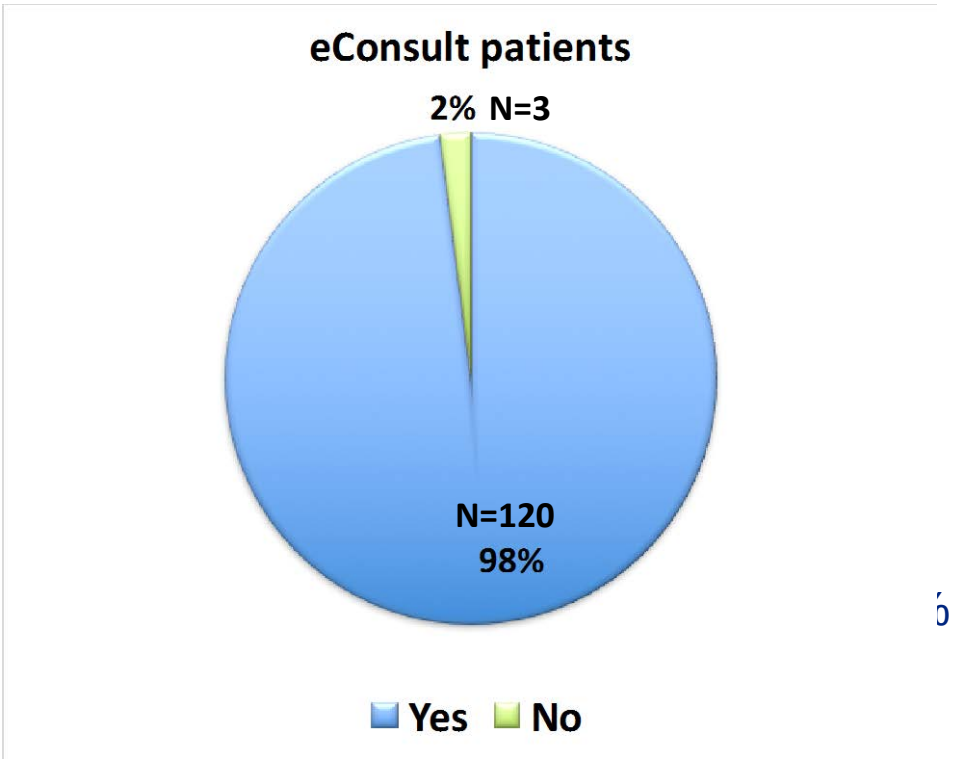
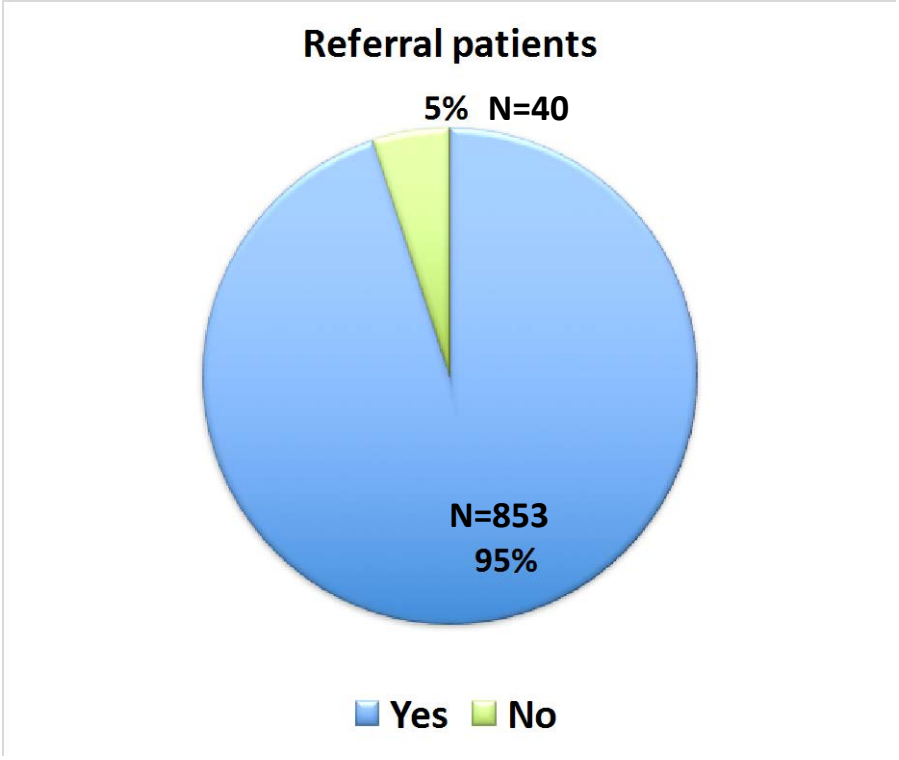
Patient perspectives: Agree that the specialist's recommendations were clearly explained





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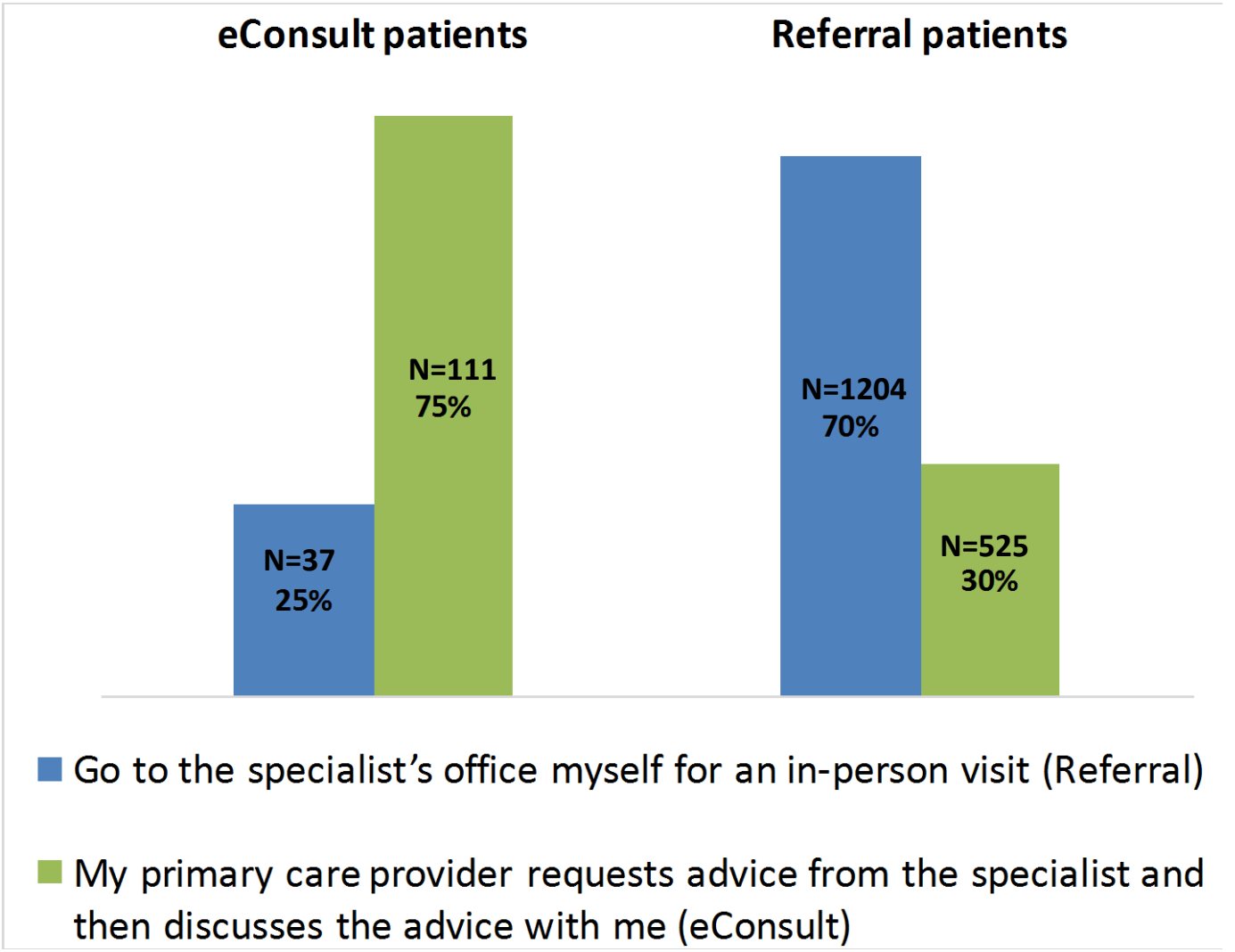
Patient preference for future management of a similar problem



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Benefits of eConsults to patients

Timely access to personalized specialty input

Maintain continuity with a familiar provider and setting of care

Avoid inefficiency of recalling full history to a new provider and staff

Cost savings

Not rationing care – if a specialty visit is preferred or deemed necessary (now or later), still possible

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Limitations and Challenges of eConsults

eConsults alone will not address spectrum of gaps in quality and efficiency at PC – SS interface

Paying for eConsult as a clinical service: uphill battle

Capacity limits:

a. If specialists have meager demand they may resist providing eConsults

b. Limited adaptive reserve among PCPs

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Adaptive Reserve: Considering A Typical Physician's Day in an Ambulatory Clinic…

circa 2008

18 patient visits

24 phone calls

12 Rx refills

17 e-mail messages

20 lab reports

11 imaging reports

14 consultation reports

Baron, *NEJM*, 2008

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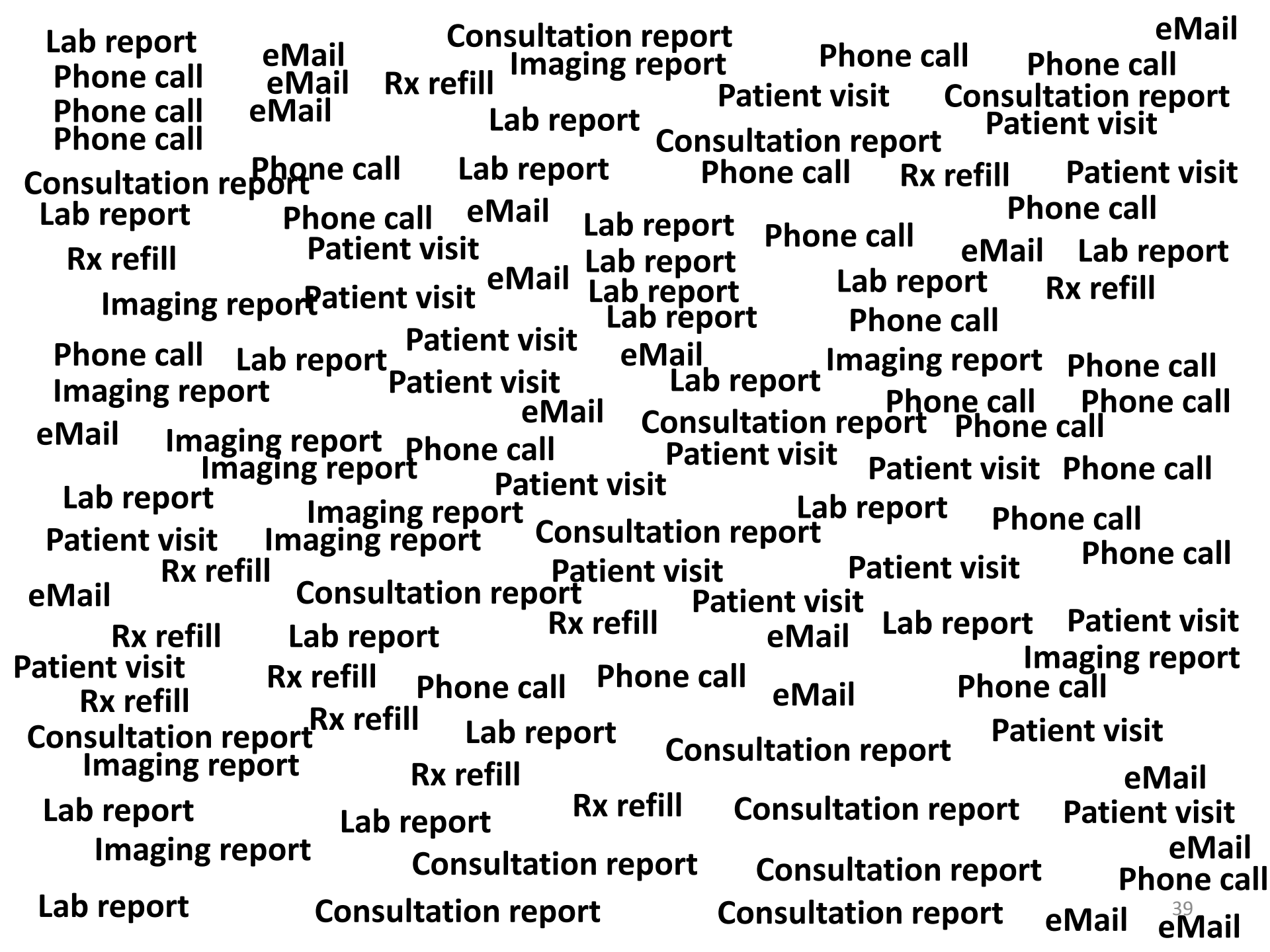
Lab report
eMail
Consultation report
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Phone call
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Rx refill
Patient visit
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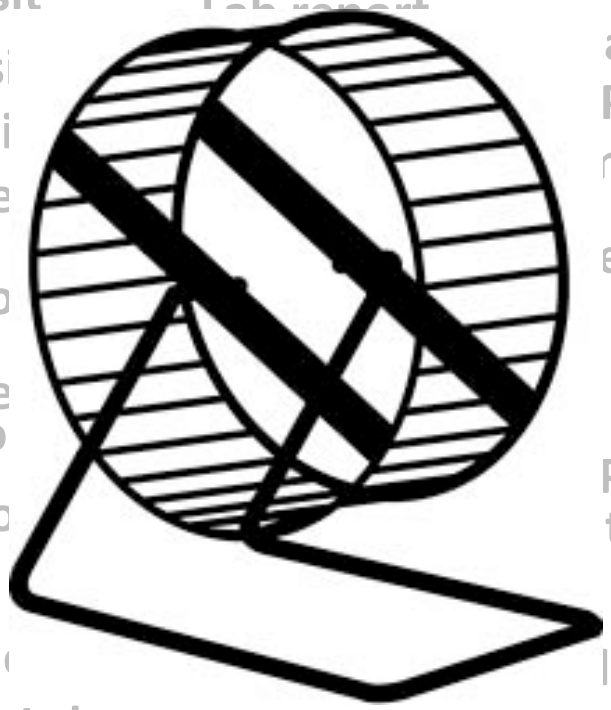

Scaling & Sustaining the CORE Model

Convene third cohort of AMCs

To create an “innovation implementation” collaborative

AAMC work with CMS

On reimbursement and a sustainable payment model

Extension to other care settings

To facilitate transition of care to community-based care team

Expansion at current AMCs

To include children’s hospitals and external, community PCPs

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Implications of team-based care: Satisfaction

Increased physician satisfaction, reduced burn-out

- "This is why I went into primary care"

Increased staff satisfaction, retention

- "My opinion matters. I love being a real part of the patient visit."

Increased patient satisfaction

- "You mean I don't have to pay more for this kind of care?"

Implications of team-based care: Efficiency

Less staff overtime (waiting around for provider to finish his/her day)

Physicians no longer charting after hours at home

Specialist input received more quickly, more specific to primary care needs

In FFS practices: seeing more patients per day; able to grow panels

In global payment practices: more cost for comprehensive primary care services, savings achieved through reduced ED, inpatient, referrals, imaging, generic meds

Implications of team-based care: Quality

Greater adoption of evidence-based care practices (due to standardization)

Higher adherence to recommended screening programs

Improved chronic disease control metrics