

Systems Challenge for Primary Care and the Specialties: Relationships and Access

Roundtable Discussion

Introduction

The request for manuscripts by *The Permanente Journal* generated tremendous response from the Permanente community. Interestingly, most articles submitted to the Health Systems Management section of the *Journal* dealt with issues concerning referral-system challenges, specifically the difficulty of creating systems that result in acceptable access to specialists. Clearly this is an issue that all Permanente Medical Groups are dealing with.

For this edition of *The Permanente Journal*, six physicians from six different Permanente groups recently discussed what their groups are doing to address this *Systems Challenge*. By sharing their experiences, these physicians will help us all take the first steps toward a Program-wide solution.

- Lee Jacobs, MD, Editor

Dr. Lee Jacobs: I would like to start the discussion by first asking panel members to give our readers their perspectives on the relationship between the primary care practitioner and the specialists, especially as it impacts the specialty referrals. What has been the experience of your groups?



Dr. Andrew Golden: In San Diego, the problem of access to specialists has been essentially resolved by programs implemented over the past few years. However, at times there is definitely tension between the primary care physicians and the specialists. This problem gets to be more significant when there is an imbalance in the workload of one or the other, either as a perception or by objective measures, especially during times of rapid membership growth.



Dr. William Caplan: I would agree. Certainly there has been a tension within Northern California. Primary care practitioners have felt they were being asked to manage the health needs for these large populations, and because our Medical Groups have been organized around specialty care, there have been feelings by primary care of not being adequately supported.



Dr. Steve Lieberman: I think that there is built-in tension between specialists and primary care physicians. It goes back to our training, when the specialists had to do more years of training, had to be on call more, and when we finally went out in practice, the specialists got paid more, worked different hours, and had different lifestyles.

Panelists:

Patricia Behlmer, MD—Co-chairperson of the Internal Referrals Committee (TSPMG)

Tony Bianchi, MD—Director of Utilization Management (CPMG)

Andrew Golden, MD—Chief, Department of Family Practice (SCPMG)

William Caplan, MD—Director of Operations Development (TPMG)

Steve Lieberman, MD—Chief, Department of Urology (NWP,PC)

Walid Sidani, MD—Associate Medical Director for Medical Operations (OPMG)

Moderator: Lee Jacobs, MD, Editor, Health Systems Management section of *The Permanente Journal*



Dr. Patricia Behlmer: In Georgia, we are slightly different from the California and Northwest Regions in that we are probably more primary care-focused and probably have a greater number of specialists who have had significant private practice experience. At least initially, these specialists tend to be a little less questioning as to the appropriateness of referrals because of their past experiences in which fee-for-service referrals were encouraged. With that said, we also experience a level of tension, not so much with the non-discretionary referrals—that is, referral of the cancer patients, or patients with acute appendicitis—but rather with the discretionary situations.



Dr. Tony Bianchi: In Colorado, one major contribution to this tension is the manner of allocating FTEs in primary care and specialty care. Primary care is given resources as membership grows, whereas specialty care more often than not remains the same. The intent is to have more of the patient's care provided by a primary care provider, implying that the scope of practice of the primary care physicians must continue to expand in the future as they are given the time and resources. The optimum scope of practice is obviously a source of controversy between specialists and primary care physicians.



Dr. Walid Sidani: Specialty access in Ohio has been a major problem for several years. We had an operational gap between the specialists and the primary care providers as well as a gap in relationships. At times,

“Specialty access in Ohio has been a major problem for several years. We had an operational gap between the specialists and the primary care providers as well as a gap in relationships.”
-Walid Sidani, MD



written referrals just seemed to be lost. We have taken measures to close this gap, primarily by getting specialists and primary care providers to solve problems together.

Dr. Jacobs: Tell our readers about some of the programs your Regions have instituted to deal with this challenge.

Dr. Lieberman: Several years ago in the Northwest group, we initiated the "Urophone" program, in which one of our six urologists would be available by cellular phone for the primary care physicians. We have strongly encouraged, but it is not mandatory, that primary care physicians call on any referral during office hours. If a referral is inappropriate, we have the opportunity for one-on-one education and resolve the issue. If a referral is to be scheduled, we can recommend the most appropriate lab tests and x-ray films before the visits, many times eliminating extra unnecessary follow-up visits with us.

Dr. Jacobs: What kind of response have you received from primary care providers?

Dr. Lieberman: Pediatricians like it a lot. Busy primary care providers resent having to pick up the phone and call us. My contention is that it is easier to pick up the phone and call us than it is to initiate a referral in another way.

Dr. Caplan: Northern California has been experimenting with this Northwest Region cellular phone approach in orthopedics and urology, and in a variety of different departments. Our model is basically the same. One of the real, nice aspects of this is that if the specialists are nearby, they can go to the exam room of the primary care physician and essentially perform a co-visit at that time, basically a consultation on site. This model accomplishes many things, one being an educational component in the transfer of knowledge one on one, especially helpful in orthopedics, where you can demonstrate a procedure or technique in the office setting. Most important, members have really liked this. Overall, it has worked out quite well.

Dr. Lieberman: We do a lot of that also. It is amazing how much the members like that kind of service. For example, I can come from across the street to quickly assess a scrotal mass of a patient in the exam room of the primary care provider. Members are incredibly satisfied with this kind of service.

Dr. Sidani: In Ohio, we have adopted the Northwest model but had to switch to a pager system because the cellular phone did not work in many of our buildings. Now we have nine specialty departments available daily on a "consult pager." I do agree

with what's been said. Our experience has been that this type of primary care specialty communication has greatly resolved our access problem and has enhanced collegiality in our group. Primary care practitioners in Ohio have been extremely pleased that they now have someone to talk to.

Dr. Jacobs: Sounds like what you all are describing is the integrated group practice in action. Andy, as a primary care physician, what is your response to this consultant phone or pager system?

Dr. Golden: I guess I have a mixed reaction to this system. I'm a little skeptical that the phone or pages would actually get answered in a timeframe that would meet my needs. If I am reassured that it does, then I would be more accepting. I like the aspect of having the patient prepared for the consult. I'm also fairly realistic in realizing that if you have to call rather than write out a consult, you might think more before requesting a consult. So I can see how it would work if it is convenient for the primary care physician to make that call. I would be interested to hear what percentage of calls would actually result in an appointment rather than telephone advice. That may be hard to sort out because sometimes I just call up the urologist to ask questions without the intent to refer.

Dr. Lieberman: In terms of the prompt response, the only limiting factor is cellular phone technology, as Walid mentioned. When we are in certain parts of the hospital, the basement, or in x-ray, the phones just won't ring or we get cut off during a conversation; it's extremely frustrating to the physicians. In terms of appointments, we actually studied this. A third of the calls would be seen that day, a third would be given routine appointments, and a third would not need to be seen. In addition, we surveyed the primary care physicians, and 85% were overwhelmingly satisfied. We probably need to repeat this survey again, because use of the Urophone has decreased recently, probably secondary to the influx of new physicians.

Dr. Bianchi: In Colorado, we have a mandatory telephone consultation process for the gastroenterology, neurology, and cardiology departments, and are planning processes for the urology and head and neck departments. We have good, objective data to measure primary care acceptance. In gastroenterology, for example, 80% of primary care physicians were extremely satisfied. Primary care physicians must know what to ask specialists. Also, they must know their patients well to supply specialists with the requested information. We need to measure and value this type of telephone work. Special-

"We surveyed the primary care physicians, and 85% were overwhelmingly satisfied."
- Steve Lieberman, MD



“Rather than a punitive approach to inappropriate referrals, it was a positive educational approach.”
 - Andrew Golden, MD

ists need to be good teachers, have good telephone manners, and to see this as a valuable service.

Dr. Jacobs: What other strategies have your Regions undertaken?

Dr. Golden: In San Diego, we developed a solution for the long wait times for specialty appointments. We established an absolute standard of 80% of referrals being seen within 2 weeks of the date of referral, and developed a monthly monitor that reported that access. If a specialty did not meet that standard in two consecutive reporting periods, the department would have to work two extra unpaid hours per week. If the standard was still not met after another month, the required extra work increased to 4 hours. As a result of making these consequences clear, most departments rearranged their priorities and made enough appointment slots available for consults, sometimes at the expense of returns and even of OR time. Implementation of such a program raises the issue of resource needs. Our program developed a basis to allocate resources, when available. If a department was unable to meet the 2 week access standard despite working the 4 hours of extra unpaid work each week, they would be in a priority position to receive additional resources. This model set up a format for departments to prove that they need increased staffing.

Dr. Lieberman: The Northwest also adopted this San Diego approach. What’s interesting is that this gave specialty departments the incentive to fix their system problems in order to be more efficient.

Dr. Jacobs: I would think that as an educator, the specialist is in a good position to use referrals to teach the referring physician and maybe

decrease what they feel are inappropriate referrals. Have your groups tried any strategies to facilitate constructive and timely feedback from specialists to the referring physician?

Dr. Behlmer: In Georgia, hoping to increase the quality of feedback to the referring physician, we added a section to the bottom of our referral form for the specialist to comment if guidelines were followed or not. It didn’t really work. Specialists were reluctant to relay true feelings, even though the focus was on helping the primary care provider and not on judging them. Shareholder voting and peer input during our appraisal process reinforced this hesitancy to give feedback. We probably need to focus on those providers that send high-quality, appropriate referrals. Specialists know who these physicians are who acquire new skills and knowledge. They need to be recognized and in some way presented as role models.

Dr. Sidani: We also tried several attempts to resolve the problem with this kind of feedback, but we were only partially or temporarily successful.

Dr. Golden: We have also tried many different approaches in San Diego, and none of them have been very successful. We have tried having the specialist put a sticker on the consult copy returned to the referring physician when the referral did not meet guidelines. These stickers were preprinted with a specific guideline on each. The enthusiasm for doing this quickly waned. For a period of time, the orthopedic department tried to call for “clarification” of referrals that they found lacking and to suggest further care prior to referral. We also tried a “Referral Assessment Form” to be completed by the consultant and sent to the referring physician with opportunities to improve identified. It was seldom used.

Dr. Jacobs: Andy, why do you think these initiatives were not successful?

Dr. Golden: I think everyone is busy enough, and understanding and tolerant enough, that on a day-by-day basis individuals don’t feel it is worth taking the time. They would rather just direct their energies to taking care of patients scheduled and the other demands of the day.

Dr. Jacobs: Have any of you undertaken an initiative that attempts to decrease referral demand through primary care provider CME-related education?

Dr. Golden: We have a model for doing so that I wish was used more often. Our gastroenterology department did a study of referrals, identified those they felt were inappropriate, and placed them in categories. They found that the highest number of inappropriate referrals was based on the inaccurate diagnosis of iron deficiency anemia, leading to refer-

Panel discussion summary

Interventions	Panelists' Value Rating
Cellular phone/pager systems	High
Mandatory two-week minimum waiting time for specialty appointments	High
Specialty feedback to PCP after referral	Low
Specialty educating PCPs after study of inappropriate referrals	High
Referral guidelines	Low-moderate
"Open Access" to specialties New Member Others	High Low-moderate
Direct booking by PCP	High



als for endoscopy. So they took it upon themselves to perform an education program for the primary care providers about the diagnosis of iron deficiency and continue to do that on an ongoing basis with reminder memos each year. They found this worked to decrease the inappropriate referrals. Rather than a punitive approach to inappropriate referrals, it was a positive educational approach.

Dr. Lieberman: We also have a set of guidelines in written form; we call it the "Urophone Yellow Pages." These guidelines address the 10 most common reasons people are referred to urology, determined by my review of over 1000 patients referred to urology. We then went to various clinics to educate providers and to discuss use of the Urophone, emphasizing what information should be obtained before the phone call.

Dr. Behlmer: An integral component of our redesign efforts in Georgia has been to assist primary care health care teams in expanding their capabilities, with an initial focus on teaching dermatology and orthopedic skills. Although the programs have been extremely well received by primary care providers, we have not yet documented a change in practice habits among the teams. We realize that we will have to adjust scheduling processes, both to get patients to the primary care team for problems previously dealt with by specialists, and change visit types so primary care practitioners have time to apply their new learning."

Dr. Bianchi: Since we have computer tracking of referrals by physician, we can identify primary care physicians who refer at a significantly higher rate than their peers. If subsequent chart audits suggest a need in this area, the primary care physician is encouraged to use CME time in this specialty area. With this strategy, we have actually seen an improvement in individual's referral rates. By the way, these decisions were made by primary care peers along guidelines.

Dr. Caplan: We have defined the scope of practice for primary care practitioners, which is basically a list of skills and competencies which they can be expected to possess, and which are established in collaboration with primary and specialty chiefs. For the first time, we have spelled this out in detail. Similarly to what Patricia mentioned as one of Georgia's strategies, these lists have been developed as part of the redesign across Northern California.

Dr. Jacobs: Do you think that your Region's experience in referral guidelines or in disease management programs improved the quality of referrals or decreased the number of referrals?

Dr. Sidani: Over the years, we have created sets of referral manuals. They are rarely used.

Dr. Golden: I think that they have helped a little,

but not to the level that we had thought when we initially designed them.

Dr. Caplan: I would probably say the same. There is possibly some benefit. It's something we probably haven't measured extensively, but with the increasing pace of work and the demands on primary care providers, getting people to refer to the guidelines is not simple.

Dr. Behlmer: The real strength for us has been having the specialists and primary care physicians equally involved in designing the guidelines. This process has helped diminish some of the tension, while establishing some specific expectations. We also haven't seen significant changes in referrals, in part because they have not been fully utilized in the process of patient care.

Dr. Lieberman: I don't think that the primary care providers have the time to consult the guidelines. I do a lot of "guidelining" over the Urophone. We can get a lot more done quickly without expecting them to have to look up the guideline. Although we wrote the guidelines, they don't commonly get used.

Dr. Jacobs: Are your guidelines online in the Northwest?

Dr. Lieberman: Yes, they are online and very easily accessed, but they are still not commonly used. I can only speak for my department, and I don't think the guidelines have impacted the number or quality of our referrals.

Dr. Jacobs: Any other strategies that you have been working on to improve working relationships and referral procedures?

Dr. Caplan: In Northern California we're implementing a large redesign of primary care and part of that has been the recognition that we have to find a more effective way of offering specialty service to this primary care population. There has to be a much more collaborative and integrated approach than in the past. We're doing this by developing a set of specialty interface agreements between each of the specialty services and primary care, with the intent being to support the primary care teams that will be caring for these defined populations of members. These agreements really help define and clarify the referral and relationship issues. To develop these, each specialty group meets with its primary care colleagues using a template which outlines the basic set of agreements to be reached, and describes expectations for both sides and how access will be offered. I believe that these agreements will be extremely helpful. We're doing this based on the recognition that traditionally, we have not worked particularly well together.

"We're doing this by developing a set of specialty interface agreements between each of the specialty services and primary care"
- William Caplan, MD

Dr. Lieberman: We address this problem in our chiefs' meetings, where the expectations of one department to another have been developed. We would take two or three departments at each chief's meeting and ask a specialty department if they have met the expectations of the primary care department and how they could do better. In turn, the specialty department would describe what they would expect from primary care physicians, such as assisting in managing hospitalized patients.

Dr. Bianchi: In Colorado, we have had specialists work in the primary care department so they could teach while providing hands-on patient care. This has worked well. We would like to see primary care physicians work in specialty departments and then become the primary care experts in this area.

Dr. Jacobs: Let's focus for a few minutes on access. I would like to hear how our panelists react to the phrase "open access to specialists."

Dr. Caplan: I think this is something that is very active in the California marketplace. However, when our competitors market open access, frequently they are selling open access with a price tag. They might charge increased copayments or have a different premium structure or a more limited list of providers. So it is something that people are using in Northern California to try to get a competitive advantage. We have not felt as yet the need to develop open access models.

Dr. Golden: I'd say the same thing for San Diego. Recently our membership has grown dramatically. We cannot say that lack of direct access to specialists is having a marketing impact. We still promote ease in getting to a specialist when needed, and we moni-

tor that using the STAR survey. So I would say, no, we haven't felt the pressure to develop an open access system for speciality care.

Dr. Lieberman: We also have not done anything in open access, and there really isn't any pressure in the market to do so.

Dr. Bianchi: With regard to open access to specialists, I believe we have to be very careful that in giving the patients what they want, instead of what they need, we are not compromising their overall care. The specific focus of specialists may not be as valuable overall as the broad approach of primary care physicians. We are also a complex organization, and for the system to work well, we need the primary care physician or team to help patients get through the system. So while I agree that we need well-functioning referral processes, direct access to the specialists may result in inferior care. It doesn't serve us or the patients well.

Dr. Caplan: We don't feel that direct access is precluded by the relationship of primary care and specialists. In fact, in certain situations, a patient probably should have direct access to specialists, such as when multiple visits are required for a condition, or for a specific type of clinical problem. Criteria would be worked out in service agreements between specialty and primary care departments.

Dr. Jacobs: So advice nurses might be able to send a patient directly to specialty care, depending on protocols created from these agreements?

Dr. Caplan: Yes, based on the presenting complaint.

Dr. Golden: We also have a special intake process that we promote for new members. Any new member who has been actively seeing a specialist

*"So while I agree that we need well-functioning referral processes, direct access to the specialists may result in inferior care."
- Tony Bianchi, MD*

PATRICIA BEHLMER, MD, has spent 14 years with Permanente. She is Co-chairperson of the Internal Referrals Committee, as well as a neurologist and Physician-in-Chief at the Glenlake facility for The Southeast Permanente Medical Group.

TONY BIANCHI, MD, has been with the Colorado Permanente Medical Group, PC for the past 25 years. He is an internist, and has been Director of Utilization Management for the past 5 years.

ANDREW GOLDEN, MD, is Chief of the Department of Family Practice, San Diego, and serves as the Regional Coordinating Chief of Family Practice for the Southern California Permanente Medical Group. He is a member of the San Diego Area Task Force, and has been with Permanente for 19 years.

WILLIAM KAPLAN, MD, is the Director of Operations Development for The Permanente Medical Group. He is a Board Certified endocrinologist at the Martinez medical center.

STEVE LIEBERMAN, MD, has been with Northwest Permanente, PC since 1982, and has been Chief since 1987. He completed his urology residency at Oregon Health Sciences University, and obtained his medical degree from the University of Southern California.

WALID SIDANI, MD, is the Associate Medical Director for Medical Operations in the Ohio Permanente Medical Group. He is in charge of the Access initiative, patient satisfaction, quality and resource management, and the internal referral process. He has been with OPMG for 20 years.



before joining Kaiser Permanente can have their care transferred and appointments arranged with our specialist without going through primary care to be referred. These patients are then referred back to primary care as appropriate. It is not really a very high volume of referrals.

Dr. Lieberman: We do the same thing.

Dr. Jacobs: Any other related initiatives?

Dr. Golden: As a result of the 2-week appointment standard being monitored, the concept of directly booking referrals when patients are in the primary care office was initiated. In the past, we wrote referrals and told patients that the specialty department would call them. However, as it became important for the specialty department to get the patient into their office, specialists became more supportive of scheduling taking place while the patient is still in the office. Now, 30% of our patients leave the office with an appointment already booked with the specialist.

Dr. Caplan: We are doing the same. The direct booking guidelines get reviewed by the specialists. Certainly it is extremely well received by the members.

Dr. Lieberman: If the patient needs an appointment and is still in the office when we talk to the primary care physician, we have our appointment clerk call the primary care office and give the patient an appointment. The member really appreciates this service. In the past they were never certain when they left their primary care provider's office if and when they would hear from the specialist.

Dr. Sidani: In Ohio, the step from the pager system to direct patient booking has been a tough one for us. By opening up specialists' schedules to primary care, pre-referral pager calls have markedly decreased. Our goal is to give our patients an ap-

pointment with the specialist before they leave the office of the referring physician. We all have work to do in this area.

Dr. Jacobs: Any final comments?

Dr. Lieberman: Refining our referral process is very important to the overall success of the delivery systems. If our changes are always in the best interest of patients, and provide them with the right care, then I think it will be done in the right way. It can be our advantage over any of the capitated systems.

Dr. Behlmer: I believe that this is the most important issue facing our Medical Groups. Our patients expect that they are being cared for by a collaborating group of physicians with a unified mission, and do not expect to fall between the cracks. The quality of the specialty-primary care interface should be the strength of a well-integrated group model.

Dr. Caplan: I believe that if we can do this right and have a rational plan for providing specialty care, it is a very powerful advertisement for Kaiser Permanente.

Dr. Jacobs: I do want to thank our panelists. I believe that you have successfully defined the challenge, offered some solutions to the Permanente community, and I am sure that your comments will stimulate a dialogue—a very necessary dialogue—across the country. As the Advisory Board Company states: “the successful medical groups in the future will be those groups which resolve the service issues around specialty access.”¹ Thanks again for participating. ❖

References

1. To the Greater Good—Recovering the American Physician Enterprise. The Governance Committee of the Advisory Board Company; Washington, DC, 1995.

“I believe that this is the most important issue facing our Medical Groups.”
- Patricia Behlmer, MD

To our readers: I invite your response to this roundtable discussion. I'm sure much more can be said and that many other innovations are in place in other Kaiser Permanente divisions. Please send your comments to Merry Parker, Managing Editor, via fax at (503) 813-2348 or, mail to 500 NE Multnomah Street, Suite 100, Portland, Oregon, 97232. We will publish a representative sampling of responses in future editions of *The Permanente Journal* as the dialogue on this key systems challenge continues.

- Lee Jacobs, MD, Section Editor, *Health Systems Management*