



CALIFORNIA  
HEALTHCARE  
FOUNDATION

## **Understanding Common Reasons for Patient Referrals in Difficult-to-Access Specialties**

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

*by*

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May 2009

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## About the Foundation

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# I. Introduction

IT IS WELL ESTABLISHED THAT UNINSURED and publicly insured Californians, who generally rely on community clinics and other safety-net providers for their medical care, face significant challenges in gaining timely access to specialty care services.<sup>1</sup> The many factors affecting access include low or no reimbursement, a limited supply of specialists in some geographic areas, and poor communication between primary care providers and specialists.

In addition to policy-level efforts to address provider reimbursement and supply, there are significant opportunities to optimize the use of existing specialty resources in the safety net through innovative use of provider resources, technology, and new care models. This could include expanded primary care provider training to manage common presentations, the introduction of new specialty consultation methods such as telemedicine or electronic consultation, or greater use of physician extenders for common procedures or screenings, among other measures.

In order to identify strategies that appropriately address specialty care needs, it is essential to clearly understand the typical clinical scenarios that generate referrals within individual specialties and the specific services or tasks that are requested.

In June 2008, the California HealthCare Foundation commissioned a series of interviews with experienced primary care providers at community and public hospital clinics to address these questions and to gain greater insight into typical referral processes, identify specific challenges, and gather ideas about how to address access problems.

The primary purpose of this project was to clearly describe the most common clinical presentations for

safety-net clinics within difficult-to-access specialty services and discuss strategies that could lead to more optimal use of specialty resources.

A secondary purpose was to provide a framework for thinking about optimizing specialty resources and initiating discussion among the provider community for developing, testing, and disseminating effective strategies.

## II. Background and Methods

THE PROJECT FOCUSED ON FOUR DIFFICULT-to-access specialties: dermatology, gastroenterology, neurology, and orthopedics. The 2007 Specialty Care Access Survey of California community clinics identified these four specialties as among the most difficult to access for primary care safety-net providers.<sup>2</sup> The degree of difficulty varies among regions and between community clinics and the public hospital clinics.

Recently Chris Forest, M.D., Ph.D., of the University of Pennsylvania, created a typology of referral models that describes five responsibilities for specialists and referring physicians. This typology was used as a preliminary framework for categorizing referral types. The five responsibilities are:

- Cognitive consultation;
- Procedural consultation;
- Comanagement with shared care;
- Comanagement with principal care; and
- Comprehensive and coordinated care.<sup>3</sup>

Eleven experienced primary care physicians at public and nonprofit safety-net clinics were selected to participate in structured telephone interviews. They represented a convenient sample of California clinics with a spectrum of profiles, including a wide range in terms of size, populations served, mix of insurance and funding sources, relationship with the local community, history, and geographic location. The physicians were selected because they practice primary care medicine at the site, know the referral experiences of colleagues (either as medical directors

or from working closely with others over a long period at the clinic), and were considered innovative problem-solvers.

In addition to gathering background information about the current referral environment and presence of on-site specialty services, the interview instrument queried providers about issues in each of the four high-problem specialties. Questions focused on the common clinical scenarios that produce referrals, the clinical and patient information shared with the specialist (both content and methods for data-sharing), and the expected role of the specialist in each of the common referral scenarios. The final stage of the interview asked respondents to brainstorm nontraditional ways to receive the advice and services currently delivered through specialty consultations.

Interview results were reviewed for common themes and innovative programs and ideas. This study is qualitative research, and results should not be considered quantitative.

### III. Overview of Referral Processes, Systems, and Expectations

ALL THE PHYSICIANS INTERVIEWED acknowledged that specialty access is a problem, and most recognized the four specialties on which we concentrated as among the biggest challenges. At each clinic a single process is used to make all referrals, regardless of specialty. A change in this process could affect many referrals. All but the smallest clinics use a form (usually developed internally) that provides the specialist with patient demographic information, clinical questions to be addressed, relevant medical history, and the level of urgency. Some clinics include space to make explicit whether the referring physician requests ongoing management or expects to have the patient returned for future management in primary care. Physicians at most of the clinics said such communication is unnecessary because the specialist's expectation is that all patients will be managed by primary care after the initial consultation, unless otherwise specified. Most of the primary care physicians said they are comfortable managing the clinical problems after the initial consultation as long as the specialist provides clear instructions and remains available for follow-up if the patient's condition deteriorates. Many of the primary care providers took pride in managing all the problems of their patients, with guidance from—but not delegation of care to—specialists.

About one-third of the clinics interviewed use an electronic system to initiate consultations. Some use a Web-based referral tracking system and others use a referral system embedded in an electronic health record (though most with EHRs are still developing modules for referral tracking). The electronic systems have some major advantages over paper, according to users. These systems allow for much better tracking

of consultations, including wait times for a consult in each specialty; identifying patients who fail to keep appointments; and gauging demand. Electronic systems also enable the use of decision support rules at the time of consult ordering to ensure appropriate work-up prior to referral.

Although referrals can be processed and tracked more conveniently, the clinics with electronic referral systems cannot yet exchange all clinical information between primary care and specialists. This part of the information transfer is still paper-based for all the clinics with whom we spoke. To ensure a productive consultation, clinical information must arrive before or with the patient. Today, some patients show up to a consultation lacking referral paperwork or personal knowledge of their medical information to guide the specialist. This leads to an unproductive initial visit, requires rework at the specialist office, and reduces the specialist's enthusiasm for receiving future patients from the referring clinic.

Many clinics address this fundamental problem by compiling the clinical information for the consult in duplicate, sending one copy ahead through postal or interoffice mail and giving the other copy to the patient to bring to the visit. Several clinics use a referral coordinator (some paid, others volunteer) to personally organize this process. One community clinic even includes with all consult requests the cell phone number of the lead physician in order to provide the specialist with access to any missing information at the time the patient is seen.

Most of the physicians interviewed defined successful consults in three ways. First, they want to ensure that the clinical issue is adequately addressed, based on symptom resolution, the information

conveyed back to the primary care physician (PCP), and the patient's own interpretation of the encounter. Second, the patient must be seen in a timely fashion. Most physicians indicated that timeliness varies depending on the type and severity of the clinical problem. When long waits are anticipated, the primary care provider must weigh the benefits of initiating treatment expediently but without full knowledge of the medical management issues versus the potential delay in sending the patient to a specialist who has the extra insight and experience. Third, consult fulfillment is judged on the quality of the specialist's communication back to the primary care physician — regarding explanation of the clinical problem and, most importantly, providing instructions that allow the PCP to execute and follow through on the management plan.

## IV. Findings

THE FOLLOWING SECTION DESCRIBES THE most common reasons for referral within four difficult-to-access specialties, as shared by the primary care providers at 11 safety-net clinics. Additionally, it outlines strategies clinics are using to increase access to specialty services. The appendix to this paper provides an overview of common reasons for referral, the proportion of referrals each represents, and access strategies to consider.

### Dermatology

#### Common Clinical Presentations

The most common reasons cited for dermatology consultations were:

- **Masses requiring excision beyond the capability of the PCP.** Almost every PCP expressed comfort with performing punch, shave, and excisional biopsies. Most also felt comfortable excising the majority of superficial masses including skin cancers. Few, however, had confidence in removing large lesions or ones in cosmetically important areas or in close proximity to important organs (such as the eye). Only one community clinic had internal expertise to perform Mohs surgery—an advanced method for removing skin cancers. PCPs expect that once the procedural consultation is completed, the patient will return to the clinic for all management. This category accounted for approximately half of the dermatology referrals in most of the clinics.
- **Skin rashes that fail to respond to typical treatments and continue to cause discomfort or problems.** All the PCPs expressed comfort in

managing the majority of common rashes with topical steroids and other routine approaches. Only after a series of treatment failures would most PCPs refer these patients to a dermatologist for a more definitive cognitive consultation that produces a diagnosis and treatment recommendations. PCPs expect that these cases will be referred back to primary care for treatment and follow-up management; hence they desire teaching and treatment coaching spelled out in the consult note. These cases account for the majority of the remainder of dermatology consults.

- **A smattering of other causes.** There are a few cases for such conditions as severe psoriasis (in which case the PCP usually does desire comanagement by the specialist).

The proportion of consultation needs in these categories was remarkably consistent across sites, with the exception of one clinic that has an advanced excision suite and can manage essentially all mass removals internally with primary care providers trained to perform the procedures.

#### Access Strategies

The vast majority of referrals appear to be for either mass excisions beyond the capability of the PCP or for rashes that fail to respond to typical treatments. In most cases, the PCP is seeking a one-time procedural or cognitive consultation with referral back to the PCP. Strategies for increasing access may include the co-location of dermatology services at the primary care site, telemedicine or other efficient opportunities to consult with a dermatologist, and/or



targeted procedural or cognitive training for PCPs—though the physicians interviewed noted that these strategies would not eliminate off-site referrals. Strategies currently used by interviewees include:

- **On-site specialty services.** Several sites have a dermatologist practice at the clinic for a half day every two to four weeks. Nonetheless, almost all clinics still required some traditional referrals to off-site dermatologists.
- **Telemedicine.** Three of the physicians use telemedicine services for some or all of their dermatology consults, and all have found that it works well for the second category of referral described above. However, all are skeptical that this method could manage all their consults because of the need for surgical support on excision of challenging masses. But even those not using teledermatology services acknowledge that it could help address some level of referral needs.

## Gastroenterology

### Common Clinical Presentations

By far the most common reasons cited for gastroenterology (GI) referrals were to perform endoscopic procedures. Many clinics indicated that the shortage of endoscopists in their community was not limited to the safety net. The common scenarios are presented below:

- **Colonoscopies to screen for colon cancer.** This was the overwhelming need for about half the clinics because this procedure is their primary screening test for colon cancer. Because colon cancer screening is recommended for all patients starting at age 50, this can represent a very large volume of referrals. In clinics where alternative screening strategies were utilized—typically

hemocult screening with follow-up colonoscopy among those who test positive or have warning signs such as weight loss or change in bowel habits—colonoscopy referrals were significantly reduced but still represented one-third to one-half of GI referrals. Among those clinics that rely on colonoscopy for screening, this indication represents well over half the consult needs. In all cases this is seen as a procedural consult: Primary care providers expect a test result they can subsequently manage. Testing for screening purposes is not considered urgent, and a delay of perhaps up to 30 days is acceptable. If the test is to follow up warning signs or a positive hemocult, more rapid consultation is expected.

- **Upper endoscopies.** Typically used to evaluate persistent dyspepsia, upper endoscopies were the second most common GI consult requested by all clinics. The majority of these requests were to evaluate patients with persistent upper GI symptoms for cancer or pre-cancer after prolonged full courses of acid suppression therapy. For this type of endoscopy, the PCP expects a procedural consultation. The primary care physician can then make use of the findings to execute a treatment plan. This request represents about a third to half of the GI consults.
- **Liver disease management.** For about half of the clinics interviewed, patients with liver disease—either hepatitis C or advanced liver disease—represented the third most common type of referral. The prevalence of hepatitis C in this patient population is high, and treatments are complicated and toxic. About half the clinics did not report this condition to represent a large share of referrals due to internal management expertise among primary care clinicians.

## Access Strategies

The majority of GI consult requests are for procedures, while a notable minority of referrals is for comanagement of patients with hepatitis C/advanced liver disease. Options for increasing access to screenings may include expanded training of primary care providers and/or mid-level providers to complete selected procedures (i.e., colonoscopies); and broader use of alternative screening methods. Strategies for addressing liver disease may include expanded training of primary care providers and other training/partnership mechanisms that facilitate effective comanagement. Strategies currently used by the clinics include:

- **Alternative screening methods.** Some of the clinics relied on alternative screening strategies, such as a hemocult screening and, if merited, a follow-up colonoscopy.
- **Expanded primary care expertise.** About half of the clinics reported developing internal management for hepatitis C/advanced liver disease patients by creating expertise in one or two primary care clinicians who essentially ran their own liver clinics. For these clinics, liver disease represented a small proportion of GI referrals. In some instances the internal capacity to treat such patients grew out of necessity because local gastroenterologists declined to see this cohort.
- **On-site specialty services.** While several of the clinics considered offering endoscopic procedures themselves, they all concluded that the infrastructure required to support such an approach—physical space, expensive equipment, cleaning processes, sedation expertise, and procedure training—was prohibitive.

## Neurology

### Common Clinical Presentations

Neurology referral needs fall into several clinical areas. Some of the physicians mentioned that neurologists have the time to conduct more thorough neurologic examinations and to perform certain diagnostic tests, while the time available in primary care settings is much more limited.

- **Management of seizures, especially initial workup and active management for severe cases.** This represents one of the instances where PCPs frequently expressed a desire for comanagement with the specialist, often with the specialist taking principal responsibility for the clinical problem. The reasons cited for referring seizure patients commonly fall into two categories. For the initial seizure workup, it is important to diagnose the etiology of the seizures and to classify the seizure type for appropriate treatment decisions. There are also necessary tests, such as EEG, that generally cannot be conducted by PCPs. Newer and more toxic medications are often indicated for management of severe seizure patients, and most PCPs said they are not comfortable prescribing them. Most clinics indicated that about half of neurology consults are for seizure management.
- **Management of severe migraines.** The majority of PCPs said they are comfortable managing most headache cases, but noted that severe migraine patients require a greater level of expertise than they can offer. The volume of consults for migraines varied widely, most likely reflecting the inconsistent levels of expertise and confidence among primary care providers in managing this condition. The newer migraine medications are very expensive, and some physicians indicated

that referrals to neurologists could help patients gain access to these drugs.

- **Movement disorders.** Patients with movement disorders such as Parkinson’s disease were cited by about half of the clinics as requiring consultation with specialists. As with migraine patients, PCPs seek help with medication management for severely ill patients for whom complex, toxic, and expensive medication regimens are employed.
- **Diagnoses that require a thorough neurologic exam to elucidate findings and to steer the diagnostic evaluation.** Diagnoses that require thorough neurologic exams were also cited as a referral need by some clinics. One clinic with poor access to a neurologist found a way to eliminate these referrals altogether. The PCPs book the patient for a long visit at their own clinic, during which they conduct a very thorough neurologic exam. They then call a neurologist in the community to “present” the case and get management feedback in a low-tech form of telemedicine.
- **Electromyograms and nerve conduction studies.** Some clinics rely on neurologists to perform these tests, particularly for patients with repetitive motion injuries (e.g., carpal tunnel syndrome) that are not well controlled with conservative treatments. This need was variable because some clinics found alternative sources for these tests, such as hospital technicians or physiatrists, who can perform them more quickly and economically. Several primary care providers expressed interest in a telemedicine service for these tests, though none currently use one.

The demand and need for neurology services seemed to vary greatly according to availability of

community neurology resources and clinic comfort with managing some of the problems outlined above.

## Access Strategies

Overall, a significant portion of neurology referral needs are for the cognitive expertise of the specialist to diagnose the patient and develop and comanage treatment—including a notable need for medication management. To that extent, there is value in exploring strategies that strengthen primary care expertise and/or provide opportunities outside of an in-person visit to access the specialist’s expertise. This may include telemedicine, e-consults, curbside consults, and other strategies that do not require a patient visit. Strategies currently being pursued by the clinics include:

- **Expanded primary care expertise.** As noted, one clinic with poor access internalized the expertise necessary to conduct a thorough neurologic exam with follow-up presentation to the specialist via telemedicine.
- **Telemedicine.** As stated, one clinic conducted the initial neurologic exam and presented the case for comanagement to a neurologist via telemedicine. Also, several clinics expressed interest in using telemedicine services for electromyograms and nerve conduction studies.

## Orthopedics

### Common Clinical Presentations

Orthopedic service referral needs varied greatly among the clinics interviewed. This is accounted for, to a large extent, by the variation of on-site expertise and service located at individual clinics. There is no single common pattern, however, and the expectations of the clinics for when to consult a specialist varied widely:

- **Injuries to large joints such as shoulders, hips, and knees.** These cases, which represent about a third of orthopedic cases, usually require the specialist to conduct a thorough exam, review imaging studies, and sometimes perform a procedure. While most PCPs say they are comfortable injecting steroids into most large joints, they refer patients whose joints are either chronically deteriorating or significantly damaged through acute injury. In these cases the PCP expects the orthopedist to manage the case to completion if a procedure is required, and then to refer back to the clinic for ongoing care. Clinics with an orthopedist on-site initially handle these cases, referring them to a surgeon only if an operation is needed.
- **Casting and splinting of acute injuries.** These treatments make up approximately one-third of orthopedic cases, although the incidence varies considerably among clinics. Some are able to perform almost all of this work themselves (especially if one or more of the physicians also works in the emergency department), and therefore rarely use orthopedic referrals for this purpose. Community clinics with an orthopedist on-site usually handle these cases without external referral.
- **Back injuries.** Only a few clinics said that their orthopedists are willing to operate on back injuries in this population, and some orthopedists don't want to see these patients at all. In such situations, particularly when pain is severe and chronic, the patients are usually sent to pain management clinics.
- **Joint replacement.** As with back injury cases, some orthopedic groups will not even consider seeing patients in need of joint replacements because the prostheses are expensive and

Medi-Cal reimbursements are low. In these cases patients are managed non-surgically with pain management and physical therapy, usually by the PCPs.

### Access Strategies

Orthopedic referral needs vary by clinic and encompass cognitive referrals, procedural referrals, and patient management. The interviews suggest that strategies worthy of consideration are the addition of on-site orthopedic services, as well as expanded primary care training to address non-surgical problems. However, clinics should assess whether this is the best use of a PCP's time. Strategies being pursued by clinics include:

- **On-site specialty services/use of mid-levels.** One model that seems to work for several orthopedic groups is to place a member of their own group at the clinic site on a weekly, biweekly, or monthly basis. This person is often a physician assistant or an orthopedist near retirement. His or her job is to manage most of the non-surgical cases such as fractures and sprains, and to screen cases that are most appropriate for the surgeons to see. This enables workups of the more severe patients and doesn't clog the orthopedists' offices with less severe cases.
- **Expanded primary care expertise.** A PCP at one clinic is comfortable performing casting and other minor orthopedics due to experience working emergency department shifts for several years. The question for other clinics is whether completing this training is an effective use of a PCP's time.

## V. Access Strategies to Consider

REVIEW OF THE PRACTICES USED BY THESE 11 clinics reveals a number of strategies to improve specialty care access. Each clinic is different, so not all strategies are universally applicable; each needs to be adapted to local circumstances. Another set of strategies might be developed by interviewing the specialty clinics that provide, or could provide, services; this analysis explored the issue only from the referring physician perspective.

### Ensure Appropriate Referrals

- **Ensure clean consults for specialists.** Ensure that all data arrives before or with the patient so that every consult is productive. Referral coordinators, either employed or volunteer, can manage this process effectively and prevent the primary care provider from using lots of time for this administrative function. Referral coordinators also can help patients to attend their consultations, build and maintain relationships with specialists, and ensure that specialists return clinical information in a timely fashion.
- **Complete the patient's workup before referring to the specialist.** The primary care physician should initiate the workup and clearly present the clinical question to the specialist. Some physicians even suggested spelling out their working differential diagnosis to indicate the level of thinking prior to referral. View the specialist's role as spending time synthesizing and analyzing the data, not ordering it. In some clinics one physician reviews all consult requests before they are sent, to ensure that appropriate workup has been conducted. Others use (or plan to use) an

electronic referral system to prompt PCPs for appropriate workup prior to referral.

- **Have specialists triage consult requests.** This is a variation on the idea of having a PCP screen all consults prior to referral. The advantage of the specialist triage model is that some cases can become teaching opportunities. This model has been developed at San Francisco General Hospital and many of the clinics find it attractive.
- **Make the PCP (or surrogate clinician) available to the specialist in real time.** By having a cell phone or hotline to the PCP, the specialist can get any question answered at the time of the consult, should the information not be available in the referral request materials.

### Expand Primary Care Site Expertise

- **Only refer cases that really need a specialist.** By strengthening the skills of PCPs at a clinic, especially for common conditions referred to specialists, specialists can give more attention to patients in greatest need, rather than to those whose cases are more routine. One method that has been successful is to create a series of teaching sessions by specialists on common problems they see. The content should include background about the medical condition and clarify what workup should be conducted prior to any referral. These trainings can be done as learning lunches (sometimes for continuing medical education credits) or through telemedicine education, and can be codified in handouts, manuals, videos of the lectures, or Web-based referral guides.

- **Increase internal clinic capacity in specific specialty areas.** This is most common today in hepatitis C, HIV, mental health, and diabetes management, where one or more PCPs at a clinic gain additional expertise and take on the cases. In essence, the PCPs act as local specialists. Assuming this role usually requires additional training at an academic medical center. In some cases the mentor for such programs continues to provide backup on difficult cases and can be a referral destination for very challenging cases the local expert cannot handle alone. This model seems to offer the additional benefit of professional satisfaction for the PCP. Other areas where this could be explored include seizure management, rheumatology, and women’s health issues.

### Increase Non-Visit Tools to Support Consult Needs

- **Create a method to handle ad hoc questions without a full consult.** Many cases could be managed by the PCP with a brief, timely “curbside consult” with a specialist. This would eliminate a referral and expedite care. Unfortunately, few clinics have any way to get such information in a timely fashion, and specialists are loath to perform such consults without a means of reimbursement. These curbside consults could be done by phone or using telemedicine. Addressing this problem would require reengineering the referral process, but it could have dramatic consequences for specialty access.

### Bring Specialty Services On-Site

- **Ensure that procedure equipment is available at community clinics.** Inexpensive and simple procedures could be done more frequently

at community clinics, obviating the need for referrals. Some examples include spirometry, echocardiograms, biopsies, and possibly nerve conduction studies. It is worth exploring whether some endoscopies could be performed without referral to gastroenterologists.

- **Bring specialists on-site.** Most specialties require only small amounts of time, so the commitment from specialists is low. This model is particularly attractive for large surgical specialty groups that can send a physician assistant or member of the specialty group to see patients and screen for surgical cases. Today the specialists who most commonly see patients at the clinics are orthopedists, gynecologists, psychiatrists, and dermatologists. For specialists, the benefits of going to the clinic include: low or no overhead, less clogging of their own waiting rooms, the ability to teach PCPs in person, the elimination of billing hassles (if paid directly by clinics), the opportunity to see “great pathology,” and a break from the monotony of the usual practice environment. It is sometimes possible to recruit physicians who are near retirement or already retired to perform consults on-site on an infrequent schedule. This varies greatly by community.

### Expand the Use of Telemedicine

- **Push for greater adoption.** Several clinics already use telemedicine, and one rural clinic makes extensive use of such services. The opportunity to expand to more sites and more specialties is great. These consultations are best for cognitive consults or for reviewing images and data, and possibly for the “curbside consult” model described above. Differences between asynchronous “store-and-forward” consults and real-time videoconferencing lead to important

choices with regard to specialties selected, business model, and technology requirements. Local challenges abound for telemedicine to work well, including upkeep of equipment, embedding the service into the medical office workflow on both ends, timely access to the service, adequate space, and a sustainable reimbursement model for specialists. The University of California, Davis, is the recognized leader in this area, and they and others can be expected to continue to push for greater adoption of telemedicine.

opportunity for teaching, and the clinics can offer cases with advanced pathology as an enticement. For most academic medical centers, serving the uninsured is part of their mission. Pursuing opportunities to expand relationships with local institutions, including academic medical centers, nonprofit hospitals, and other providers, may be a promising avenue for safety-net clinics to pursue.

## Build Institutional Relationships

- **Establish and enrich relationships with local specialists.** Many physicians stressed that all medicine is local and relationships with the specialist community are crucial to gaining access for consults. This is especially true for the smallest clinics. Opportunities to forge these relationships in the hospital include rounds (particularly on weekends, when there is more time to interact with other clinicians), during emergency department shifts, and while serving on hospital committees. Other professional activities to foster community with specialists include local medical societies and community task forces. Equally important in small communities are non-medical pursuits. It may be important to appeal to the spirit of community service in everyone.
- **Form alliances with local institutions.** Many nonprofit hospitals have community benefit investments and grants to satisfy their community benefit requirements. Such funds can be used to support specialty connections. One nonprofit hospital expects specialists applying for admitting privileges to agree to provide some portion of care to the uninsured. Local academic medical centers can see the community clinics as an

## Appendix: Overview of Common Referral Scenarios and Strategies for Improving Patient Access

CLINICAL PRESENTATION/SCENARIO	PCP NEED	REFERRALS		STRATEGIES TO CONSIDER
		TYPE	PERCENTAGE (approximate)	
<b>Dermatology</b>				
<p>Masses requiring excision beyond capability of PCP:</p> <ul style="list-style-type: none"> <li>• PCP comfortable w/punch, shave, excisional biopsies; most superficial masses including skin cancers</li> <li>• Limited confidence in removal of large lesions and those in cosmetically important areas or close to important organs</li> </ul>	Procedure completed and patient returns to PCP for ongoing management	Procedure	50%	On-site specialty service
<p>Skin rashes that fail to respond to typical treatment:</p> <ul style="list-style-type: none"> <li>• PCP comfortable w/majority of common rashes</li> <li>• Referral to dermatologist after series of treatment failures for diagnosis and treatment</li> </ul>	Diagnosis provided and treatment completed; patient returns to PCP for ongoing management	Cognitive consultation, procedure	25% or more	<ul style="list-style-type: none"> <li>• On-site specialty service</li> <li>• Telemedicine</li> </ul>
Severe cases requiring comanagement (i.e., severe psoriasis)	Diagnosis, treatment, and comanagement of patient	Comanagement	Limited	
<b>Gastroenterology</b>				
Colonoscopies to screen for colon cancer	Screening performed	Procedure	50% or more	<ul style="list-style-type: none"> <li>• Alternative screening methods</li> <li>• Conduct procedures at clinic site</li> <li>• Expanded procedure training (PCPs/mid-levels)</li> </ul>
<p>Upper endoscopies to evaluate persistent dyspepsia:</p> <ul style="list-style-type: none"> <li>• To evaluate for cancer/pre-cancer in patients w/persistent upper GI symptoms after full courses of acid suppression therapy</li> </ul>	Procedure completed, PCP uses findings to execute treatment plan	Procedure	33-50%	<ul style="list-style-type: none"> <li>• Conduct procedures at clinic site</li> <li>• Expanded procedure training (PCPs/mid-levels)</li> </ul>
Hepatitis C or advanced liver disease	Specialist develops, manages treatment	Comanagement (principal)	Varies	Expanded PCP expertise/mini-specialists



CLINICAL PRESENTATION/SCENARIO	PCP NEED	REFERRALS		STRATEGIES TO CONSIDER
		TYPE	PERCENTAGE (approximate)	
<b>Neurology</b>				
Management of seizures: <ul style="list-style-type: none"> <li>• Need for workup, tests, and management</li> <li>• Limited confidence doing initial workup to diagnose and classify seizure type for treatment</li> <li>• Test, such as EEG, cannot be requested by PCP</li> <li>• PCPs not comfortable prescribing newer, more toxic medications or managing ongoing care without support</li> </ul>	Support to diagnose and classify seizure type, complete tests, and develop and manage treatment plans, including medication management	Cognitive consultation, procedure, comanagement	50%	<ul style="list-style-type: none"> <li>• Expanded PCP expertise/mini-specialists</li> <li>• Telemedicine</li> <li>• Curbside consults</li> </ul>
Management of severe migraines: <ul style="list-style-type: none"> <li>• PCP comfortable with most headaches</li> <li>• Comfort managing severe migraines varies widely</li> <li>• Need for expensive medications</li> </ul>	Management of severe migraine cases, including medication management	Comanagement	Varies	<ul style="list-style-type: none"> <li>• Expanded PCP expertise/mini-specialists</li> <li>• Telemedicine</li> <li>• Curbside consults</li> </ul>
Movement disorders: <ul style="list-style-type: none"> <li>• Medication management for severe cases needing complex, toxic medication (i.e., Parkinson's)</li> </ul>	Medication management	Comanagement	Varies	<ul style="list-style-type: none"> <li>• Expanded PCP expertise/mini-specialists</li> <li>• Telemedicine</li> <li>• Curbside consults</li> </ul>
Varied diagnoses requiring thorough neurologic exam	Thorough neurologic assessment and diagnostic evaluation	Cognitive consultation/assessment	Varies	<ul style="list-style-type: none"> <li>• Expanded PCP expertise/mini-specialists</li> <li>• Telemedicine</li> </ul>
Electromyelograms and nerve conduction studies: <ul style="list-style-type: none"> <li>• Mostly for patients with repetitive motion injuries not well controlled with conservative treatments (i.e., carpal tunnel syndrome)</li> </ul>	Series of cognitive tests/assessments	Cognitive consultation/assessment	Varies	<ul style="list-style-type: none"> <li>• Expanded PCP expertise/mini-specialists</li> <li>• Telemedicine</li> <li>• Curbside consults</li> <li>• Find alternative sources to perform tests (e.g., physiatrists or hospital techs)</li> </ul>

CLINICAL PRESENTATION/SCENARIO	PCP NEED	REFERRALS		STRATEGIES TO CONSIDER
		TYPE	PERCENTAGE (approximate)	
<b>Orthopedics</b>				
Injuries to large joints (e.g., shoulders, hips, knees): <ul style="list-style-type: none"> <li>• PCP comfortable injecting steroids in large joints</li> <li>• Referral of patients with chronically deteriorating or significantly damaged joints (acute injury)</li> </ul>	Thorough exam, review of imaging studies, potential procedure; PCP expects specialist to manage case to completion if procedure required, then refer back to PCP for ongoing care	Cognitive consultation, assessment, procedure	33%	<ul style="list-style-type: none"> <li>• On-site specialty services/use of mid-levels</li> <li>• Mini-specialists to inject small joints or to cast</li> </ul>
Casting and splinting of acute injuries	Complete procedure	Procedure	33% (varies according to on-site expertise)	<ul style="list-style-type: none"> <li>• Expanded PCP expertise</li> <li>• On-site specialty services</li> </ul>
Back injuries: <ul style="list-style-type: none"> <li>• Few orthopedists willing to operate on back injuries for Medi-Cal/uninsured population</li> <li>• Severe and chronic pain cases sent to pain management</li> </ul>	Ongoing management	Procedure, comanagement	Varies	Expanded PCP expertise
Joint replacement: <ul style="list-style-type: none"> <li>• Similar resistance to Medi-Cal/uninsured</li> <li>• Non-surgical pain management and physical therapy (generally managed by PCPs)</li> </ul>	Ongoing management	Comanagement	Varies	Expanded PCP expertise

## Endnotes

1. Felt-Lisk, S., M. McHugh, and M. Thomas. May 2004. *Examining Access to Specialty Care for California's Uninsured*. Mathematica Policy Research Inc. for California HealthCare Foundation ([www.chcf.org/topics/healthinsurance/index.cfm?itemID=102587](http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=102587)).
2. Specialty Care Access Initiative. January 2008. *Preliminary Findings: Specialty Care Access Survey*.
3. Forrest, C. March 2008. *Transforming the Specialty Referral Process*. Webcast. California HealthCare Foundation ([www.chcf.org/topics/view.cfm?itemID=133607](http://www.chcf.org/topics/view.cfm?itemID=133607)).



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