Building Stronger Bridges with Medical Subspecialists

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When I agreed to run for the privilege of serving as SGIM’s president, I declared in my platform statement that “the most important role of the SGIM president is to lead SGIM in setting and addressing its priorities.” The first priority that I listed was to “strengthen partnerships with organizations that are willing to work with us to advocate for a team-based approach to health care that values the roles of all health professionals in providing high-quality primary care, especially for patients with chronic and complex conditions.”

The idea of building bridges between organizations is consistent with a long-standing fascination of mine. Ever since my uncle entertained me with stories of working on the bridges of Philadelphia, I have had a sense of wonder about the engineering and longevity of bridges. Some have lasted for centuries. What does it take to build a bridge strong enough to withstand all the elements?

Recently, the president of the American College of Physicians (ACP) invited me to attend the ACP’s Internal Medicine Subspecialty Society Leadership Summit. The goal of the meeting was to enhance dialogue between ACP and the subspecialty societies to improve the profession through collaboration and coordinated policy efforts. It seemed like a great opportunity for bridge building.

To put the opportunity in context, I began thinking about how I interact with medical subspecialists in my own practice. One patient came to mind readily, a 74-year-old woman I have seen for more than 20 years. She has congestive heart failure, atrial fibrillation, severe peripheral arterial disease, severe chronic obstructive pulmonary disease, hypercholesterolemia, a biventricular automated implantable cardioverter-defibrillator, and a history of mitral valve replacement complicated by small bowel infarction. Her medications have included furosemide, carvedilol, lisinopril, aspirin, warfarin, tiotropium, and fluticasone/salmeterol, but she has difficulty paying for her medications. She has lived alone since her husband died two years ago. Her functional status has been worsening despite frequent visits and medication adjustments.

Should I consult a cardiologist for assistance in management of her heart failure? As a health services researcher, I know that referral rates in the United States are much higher than rates in other countries—a factor that contributes to increased costs without a corresponding improvement in outcomes. I balk when I hear the voices of primary care advocates saying that specialists are only needed to address conditions too uncommon for primary care physicians to maintain competence or for procedures requiring special expertise or equipment.1,2 Surely, I know how to manage heart failure, thanks to my residency training at the University of Pittsburgh. But that was more than 25 years ago. As a so-called evidence-based medicine expert, I can review practice guidelines, but they don’t answer all the questions about what to do for someone with her combination of problems. Then I ask myself, am I certain that I am providing the best possible care for this complicated patient who has had a suboptimal response to treatment?

I make the referral. I remind myself that referrals are more likely to facilitate coordination of care than when patients seek out specialists on their own1 and that patients like mine are more than capable of finding a cardiologist on their own. Did you know that only one third of visits to medical subspecialists come from clinician referrals?2

What do I expect the subspecialist to add? For the sake of my patient, I expect the subspecialist to use his special expertise to improve my patient’s response to treatment. Silently, I hope for reassurance that I’m already doing everything right. In this case, the subspecialist’s first recommendation is to add spironolactone, citing evidence of efficacy in patients with severe symptoms. Unfortunately, my patient did not tolerate spironolactone when she tried it previously. Nevertheless, I talk with the cardiologist and my patient, and we try it again. What else can the subspecialist add? For common conditions like congestive heart failure, I expect the subspecialist to provide access to valuable ancillary services, such as anticoagulation monitoring and disease-specific dietary or behavioral counseling.

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perspective are the inconvenience and cost of seeing another physician, especially a patient like mine who feels like she spends more time at Johns Hopkins clinical sites than at her home.

What problems could arise from making the referral? One of the most common problems I see is the extra testing that many subspecialists find necessary to perform. In my experience, much of the testing is duplicative or unnecessary, depending on whether the subspecialist receives and pays attention to information from my records. A bigger problem is conflicting advice that leads to confusion about the management plan. I have been taking care of this patient long enough that she knows to call me if she has a question about any recommendation she receives from a specialist.

How could my clinical interactions with medical subspecialists be improved? Having an electronic medical record has helped to facilitate better communication about the patient’s medical and social history. However, I still need to take time to communicate directly with each subspecialist—an essential component of coordinating care for which I am not currently reimbursed. I could do more to clarify roles when sharing care with a subspecialist.

What are the implications for SGIM’s relationship with the ACP and medical subspecialty societies? At the ACP’s Internal Medicine Subspecialty Society Leadership Summit, I sat with leaders of 26 medical subspecialty organizations and listened to three speakers: a general internist (Molly Cooke, president-elect of the ACP), a non-procedural subspecialist (James O’Dell, past president of the American College of Rheumatology), and a procedural subspecialist (William Zoghbi, president of the American College of Cardiology). In the ensuing work groups, we discussed how the organizations could work together on medical education reform, workforce issues, advocacy, and how to deliver high-value cost-conscious care. What emerged was great enthusiasm for working together to find better ways to coordinate care wisely. Mindful of the success of the American Board of Internal Medicine’s Choosing Wisely campaign, the group agreed to explore developing care paths and guidelines for collaboration between medical subspecialists and generalists in caring for patients with complex problems. The plan is to follow up with the ACP’s Council of Subspecialty Societies.

How could SGIM strengthen this bridge with the ACP and subspecialty societies? My hope is to engage SGIM members in the work that is needed to develop better guidance on how to share care with medical subspecialists. I am concerned about the limitations of the available evidence. SGIM members have the skills to lead the research needed to develop generic and disease-specific guidance on how generalists and subspecialists collaborate in caring for patients with complex problems. As reported in a recent evaluation of the Medicare Coordinated Care Demonstration programs, the success of care coordination initiatives will depend on their ability to build on lessons learned from previous efforts. Although that evaluation found that none of the programs generated net savings to Medicare, some programs reduced hospitalizations in high-risk subgroups such as patients with congestive heart failure or chronic obstructive pulmonary disease—where we are well positioned to work with subspecialty colleagues. A distinguishing feature of successful programs was a strong working relationship with the patients’ primary care physicians. Clearly, more research is needed on the effectiveness of team-based care for complex patients having a serious condition. SGIM should advocate for support of such research, especially to the extent that it is aligned with the mission of the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Outcomes Research Institute (PCORI). In the educational arena, SGIM members should look for opportunities to expose trainees to team-based care and patient-centered medical home (PCMH) models with differing degrees of involvement of generalists and specialists.

SGIM also has opportunities to strengthen the bridge with medical subspecialty societies through its advocacy work. When I attended SGIM’s recent Hill Day, I talked with Democratic and Republican staff about issues that call for consideration of how we collaborate with medical subspecialty organizations and not just with other primary care...
organizations. For example, the SGIM Health Policy Committee recommends urging the Centers for Medicare and Medicaid Services (CMS) to draft and value a new set of evaluation and management codes to better capture the complexity of work done by primary care physicians. Medical subspecialists, especially those in the cognitive-oriented specialties, could also use such codes to capture the complexity of care they provide.

SGIM will need to determine whether to advocate for payment reforms that incentivize primary care physicians or primary care services. For instance, SGIM needs to decide whether to join the American Academy of Family Physicians in advocating for a separate system of valuing primary care visit codes limited to family physicians, general internists, geriatricians, and pediatricians or to join the ACP in support of a system that could include medical subspecialists who provide primary care services. Some health policy experts and the Medicare Payment Advisory Commission (MedPAC) have recommended splitting Medicare’s Sustainable Growth Rate (SGR) formula into two spending targets—one set higher for primary care or cognitive services and one set lower for procedural or imaging services. In such an approach, the cognitive services of generalists and medical specialists could be rewarded for improving the quality and efficiency of health care. In contrast, the Affordable Care Act has specified that Medicare’s new Primary Care Incentive Payment applies only to primary care services provided by self-designated general internists, family physicians, geriatricians, and pediatricians for whom 60% of total payments come from such primary care services. Medical specialists not designated as general internists do not qualify for the incentive payment, even though they may provide primary care services for many of their patients. SGIM also needs to decide whether to support the ACP in advocating for the PCMH-Neighbor (PCMH-N) concept in which medical subspecialists have a prominent role in coordinating care in a PCMH. The ACP advocates that medical subspecialists can form a PCMH-N if they accept responsibility for comprehensive care of the patients.

According to data from the National Ambulatory Medical Care Survey in 2002 to 2004, 11% of visits with medical subspecialists were classified as being primary care. Furthermore, 52% of visits to subspecialists were classified as routine or preventive visits by known patients that could be performed by primary care providers. Many have argued that while some subspecialists provide primary care services, they may not do so as well as a primary care-trained generalist. However, when the United States faces a growing shortage of primary care physicians, shouldn’t we consider ways to support medical subspecialists who are committed to providing comprehensive care? I don’t mean to suggest that SGIM’s advocacy efforts should be fully aligned with the interests of medical subspecialists, but we should carefully consider how each position that is intended to improve delivery of primary care could affect patients who receive comprehensive care from their medical subspecialists.

I urge you to think about these issues when you are seeing patients, teaching trainees, or conducting related research. Share your experiences regarding the strengths and weaknesses of existing bridges with our subspecialty colleagues. Offer suggestions on what should or should not be done to strengthen those bridges. Help us find the best ways to strengthen the bridges that exist!

References