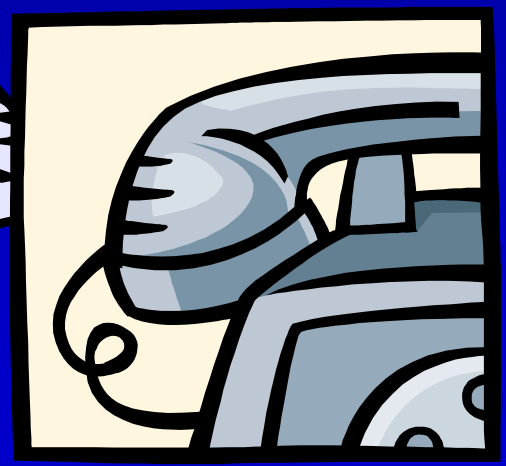
Generalist-specialist communication as part of coordination of care

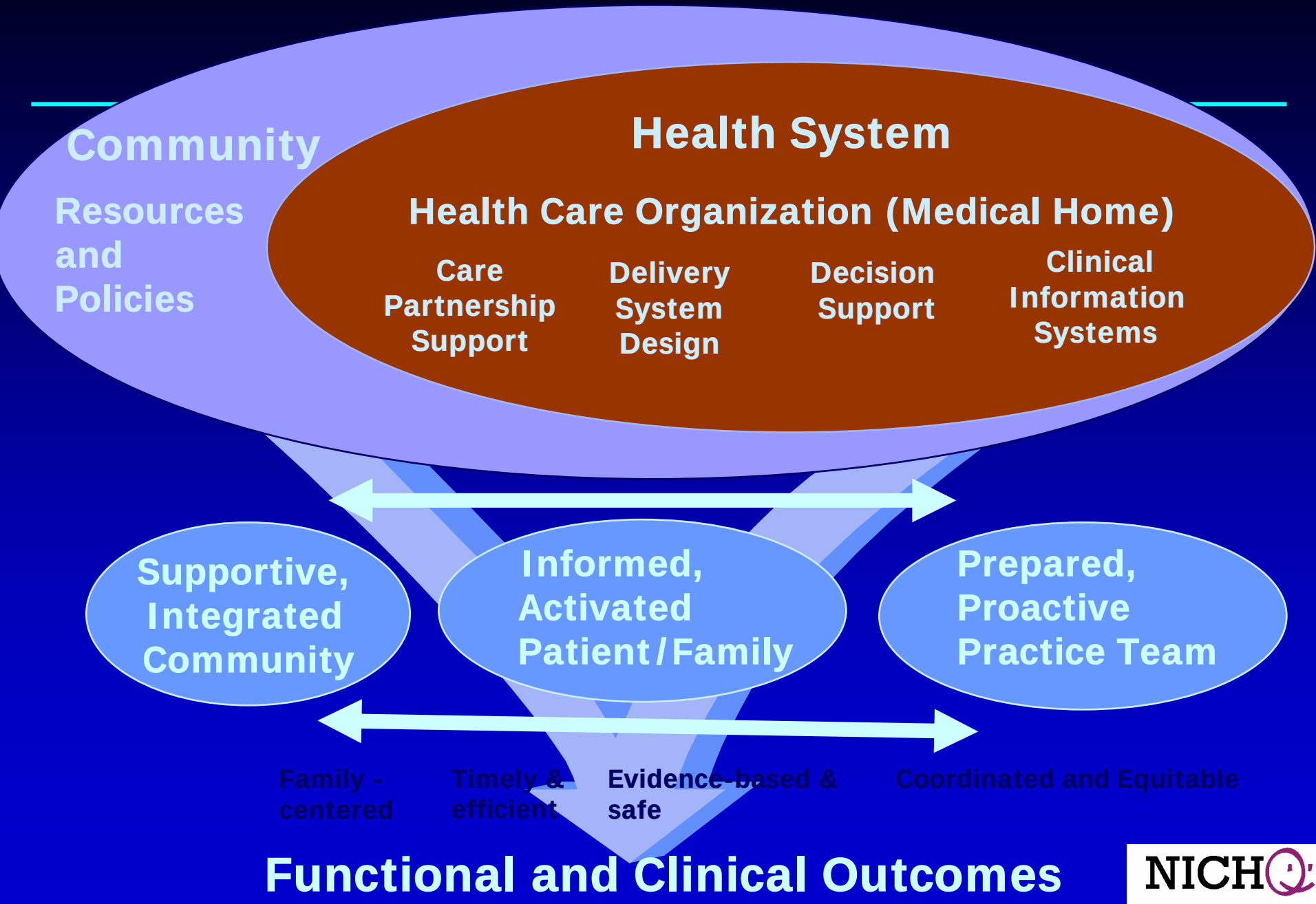
Christopher Stille, MD, MPH
Division of General Pediatrics
UMass Medical School

February 5, 2004

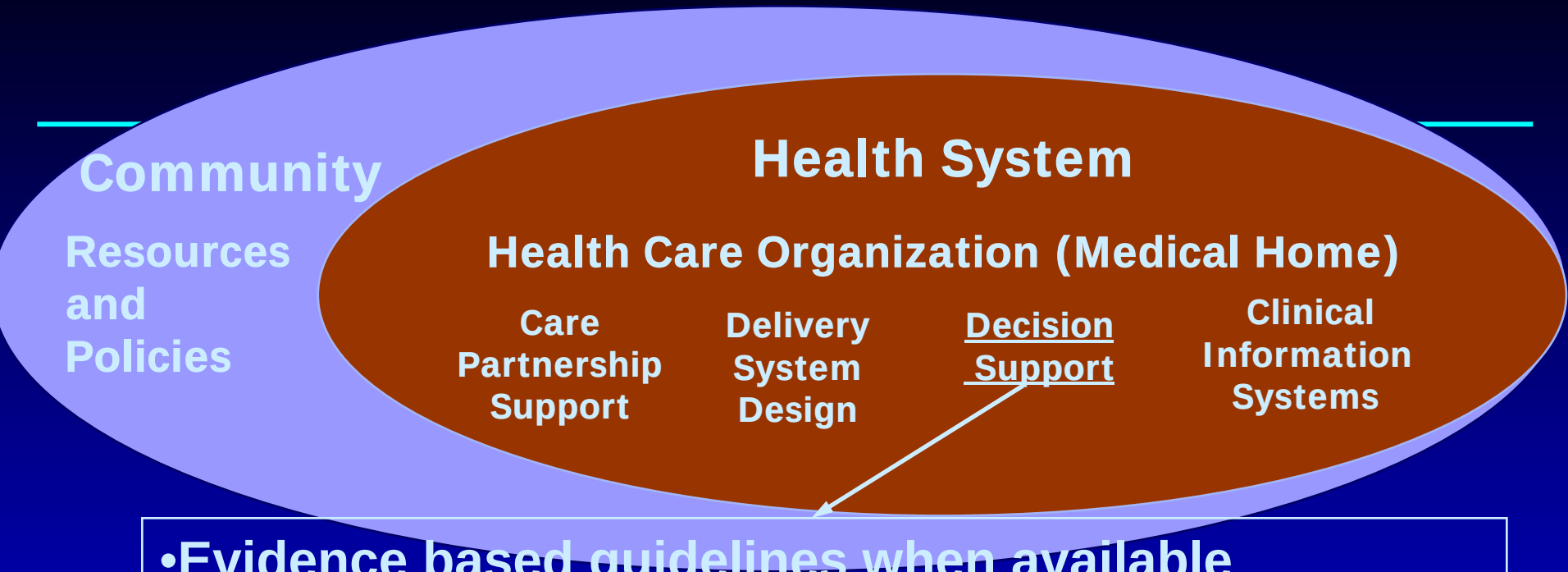


Theory and Background

Care Model for Child Health in a Medical Home



Care Model for Child Health in a Medical Home



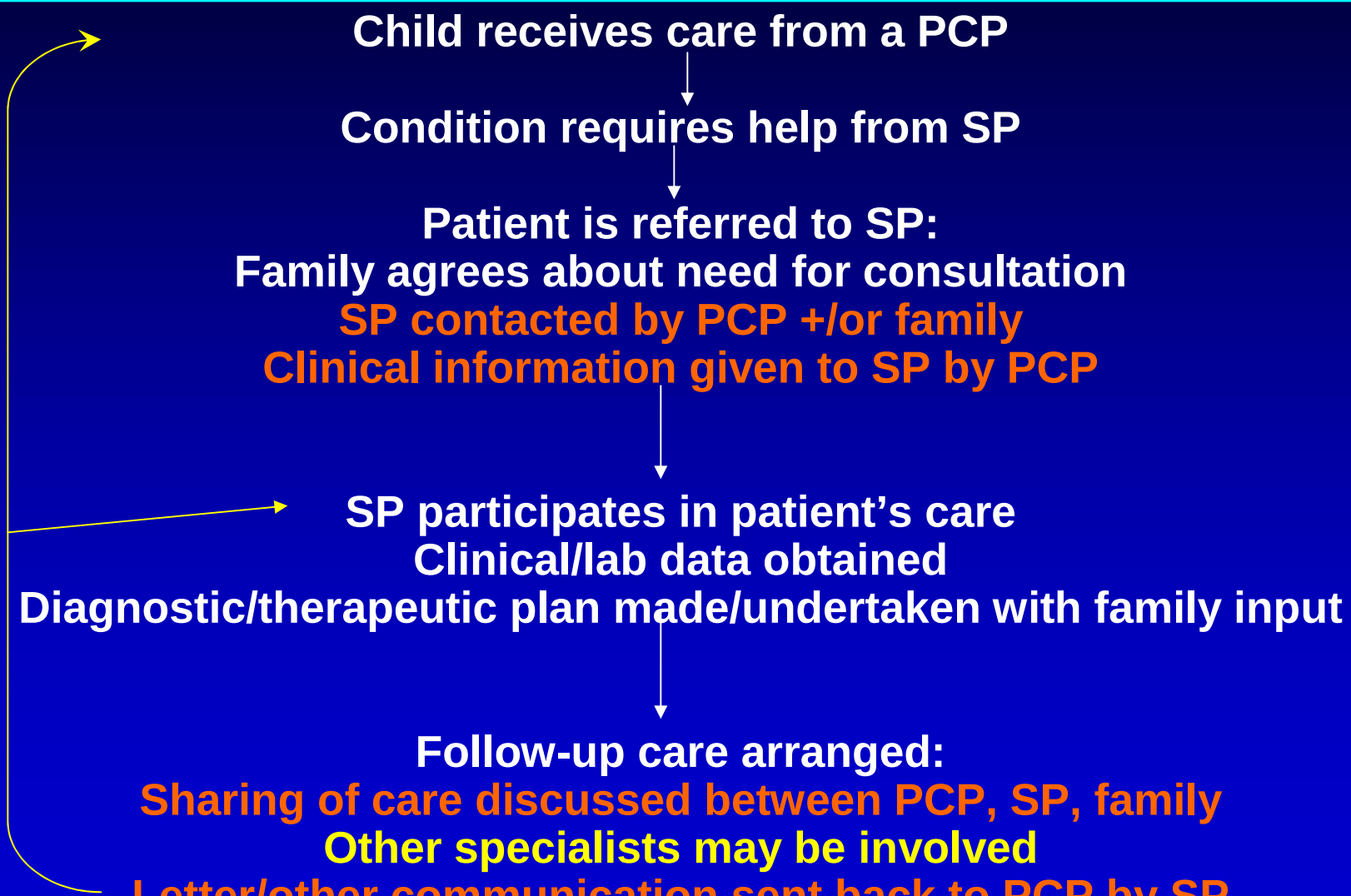
- Evidence based guidelines when available integrated into practice systems
- Family expertise integrated with professional knowledge
- Pediatric subspecialists and PCP exchange information in real time
- Effective approaches to clinician education are used

NICHQ

Chronic Care Model: Adults→ kids

- Adults: higher prevalence, fewer different conditions (e.g. diabetes, hypertension)
- Children: greater number of conditions, each is much less common
- Result: greater reliance on specialist co-management
- Parents as primary caregivers/advocates: “3 heads are better than one”
- Developmental and educational dimensions
- Fewer established guidelines

Communication in shared care



Communication and quality of care for CSHCN

- AAP, 1999: Major barrier to effective coordination of care
- IOM “Crossing the Quality Chasm” report (2001): Absence may lead to fragmentation of care, duplication/omission of services, unmet needs, potential for medical error
- Some data in adults, few in children on exactly what happens: generally, lots of room for improvement

Communication between general pediatricians and subspecialists

- Referrals: Forrest (PROS), 2000
  - examined all first-time consults generated from practitioner network
  - point of view of generalist: info. received
  - 51% of referrals result in letter at 2 months
  - 31% of letters discuss sharing of care
  - subspecialist/family point of view not mentioned
  - CSHCN, repeat referrals not examined

Communication and parent satisfaction

- Parental satisfaction with inpatient care: Homer, 1999
  - Poor physician-parent communication #1 contributor to parent dissatisfaction
- How can we (physicians) communicate well with parents if we don't know what each other is saying???

Ideas and notes from the field

Communication: what are the ingredients?

What helps? What hurts?

Study 2000-2002: questions

- What factors help or hinder good communication between PCPs and SPs in their care of CSHCN?
- Which of these are most important?
- GOAL: build foundation for observational/intervention study
  - What should we measure and improve?

Methods: two stage design

- Focus groups with 14 general and 10 subspecialty pediatric providers from Central Mass.
  - "what are the issues?"
- Survey of general and subspecialty pediatricians from New England, based on focus group findings
  - "which issues should we prioritize?"

Focus groups: top themes

POSITIVE EXAMPLE

- **"...Like for example , I have a baby with congenital hypothyroidism, that came up from another area and at this point, ready to start on medication, obviously the endocrinologist doesn't have an appointment for two or three months, but I was able to call the specialist and tell them what the [situation was] and we agreed with a plan. She agreed that she could see the baby in two or three months but we have a plan already for what we should do in the time before the baby is going to be seen by them. I'll be able to talk to the Mom and say we already have a plan instead of telling the Mom we have to wait three months for the specialist. In the meantime, I'm going to be managing….some parents don't feel comfortable if they don't have that extra opinion."**

Focus groups: top themes

NEGATIVE EXAMPLE

"... So, I did an x-ray and sent it to the specialist just to answer my question, "what could this be"? ...I sent [him]to a specialist but I had already made my diagnosis ... the specialist definitely never read my note and just said – he sent me a letter back saying it was an eleven year old kid with [diagnosis] – that's all it said, and then it says, "agree with your plan, continue with same medications." ... I don't think he had answered my real question I had for him, if he had read my letter he would have. I was right, but what was my gain by sending this kid to a specialist? I didn't expect him to change the medications, but to tell me if there was something else to do."

Focus groups: conclusions (*Ambulatory Pediatrics* 3: 147-153, 2003)

- Clear division of responsibility critical, especially when care more complex/more specialists involved. This can help greatly.
- Timeliness and efficiency are paramount
- Bidirectional communication equally important
- E-mail promising, but some concerns
- Education of PCPs by specialists key
- “Transparent thinking”
- Lots of other messages (?priority)

New England survey, 2001

- 495 general and specialty pediatricians from New England surveyed
- AAP and subspecialty society members
- All specialties providing outpatient non-ER care
- Purpose: determine “priority areas” for intervention, and generalize focus group data
- Most questions derived from focus group study

Survey: results (*Pediatrics*, Dec. 2003)

- Universal agreement that communication critical
- PCPs saw communication as more problematic than SPs (40% vs. 28%, p=.015)
- Biggest problem: LACK OF GOOD SYSTEM
- “Frequent receipt of information” about initial SP visit: 28% of SPs, 70% of PCPs
- Sharing of care infrequently discussed
- Families frequently “primary source” of information

Survey: results

- Top barriers: inefficient phone contact, transcription delay, failure to keep all providers in loop when more than one SP involved
- Top facilitators: communication from PCP to specialist before initial consultation, cc'ing all providers on letters, phone call at time of visit, clear questions from PCP to specialist
- Email: 86% good access but <20% frequent use; specialists>generalists

Survey: targets for intervention

- Timely information transfer before/at the time of the first specialty visit
- Content: discussion of co-management; explicit questions from PCPs; education by SPs about disease, and reasoning behind plan
- Improving efficient phone contact
- Sharing of information among all involved
- Including families but not relying on them as “sole source” of medical information

Observational study

- "Inception cohort" design: follow 200 new subspecialty referrals for six months
- Community practice network (93 physicians, 22 practices) to five medical subspecialties (15 specialists)

Observational study

- **Measure:**
  - **Satisfaction & experiences of families, PCPs, subspecialists (questionnaires after initial consultation, and 6 months later)**
  - **Written communication (chart review at PCP and specialty sites)**
  - **System factors present at care sites (questionnaires)**
  - **Presence/absence of chronic condition**
- Outcomes: presence and content of communication and relationship to satisfaction

Progress so far: n=122

- 59% boys
- Insurance: 20% Medicaid; 76% in gatekeeping plans
- 75% identified as having a chronic condition
- 34% had two or more conditions
- 55% on one or more meds; 22% on ≥2 meds
- 45% had seen other SPs in the past year
- Few practices had any system supports

Message: Children seen at these clinics are complex and have diverse conditions!

Phase 1 results

- Communication rates (first visit): 57% from PCP to SP, 84% from SP to PCP
  - 36% of SPs had “insufficient info to provide optimal care”
- Over 6 months: effect washes out somewhat
  - Only half of patients had another SP visit
  - Satisfaction generally high

The parent role

- 89% of parents desire active role
- 41% of parents feel they are primary communicator between PCP and SP
- 1/3 of parents in this role feel uncomfortable with it
- No agreement between parents, PCPs and SPs about what parent role should be in individual cases

Phase II: pilot intervention

- Focus: getting something QUICK to specialists before consultation, and back to PCP after
- Concise, 1 page FAX-back form- 10 items
- Form initiated when appointment made; completed by both physicians, then given to parents
- Key principle: improving the system (work better, not harder)
- Interested physicians helped design
- SIMPLE

Future directions

- Explore parent role in process more fully
- Link improved communication with “harder” patient outcomes
- Cost-effectiveness of improving coordination of care
- Getting what we do reimbursed!

Take-home points

- Collaboration is not built into the system, in fact, barriers have been built to discourage it. “Parallel play” rules, though people want to be team players.
- Structural and financial incentives need to exist for communication to happen. Building this system takes resources!
- Families can be a great resource, though their roles need to be defined.