Rethinking the consultation process

Optimizing collaboration between primary care physicians and specialists

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Although collaboration between family physicians and other specialists is of critical importance to the care of many patients,[1] the work flow process of consultation remains suboptimal. Consider the traditional sequence of steps employed when a typical family physician obtains a consultation from a specialist colleague (**Figure 1**). First, a consultation request form, the format and content of which is most often determined by the physician seeking consultation, is completed. This request is usually faxed to the consultant's office, where it is reviewed, often by an administrative assistant who has his or her own triaging method. Additional data might be sought. Ultimately, the request for consultation is either accepted or declined, and the consultant's clinic books an appointment, often transmitting the details back to the family physician's office to communicate to the patient *(to us, this seems a particularly ludicrous step).* The consultant subsequently meets and evaluates the patient, and generates (and sometimes implements) a management and follow-up plan. Details of this plan are then dictated and sent back—occasionally with considerable delay—to the family physician, who implements some or all of it, resuming care of the patient.

Although commonplace, this process is unnecessarily complex and fails (or potentially fails) in several ways. Meaningful exchange between the consultant and the family physician is compromised by the use of asynchronous communication, which limits each party's ability to understand the clinical context and delays delivery of pertinent information. In addition, because the communication tools themselves are often chosen by the party using them rather than the one receiving the information, they might not provide the necessary details. For example, the purpose of consultation might not always be clear to the consultant, causing him or her to address issues that are irrelevant from the perspective of the family physician and patient. Similarly, without all the pertinent data, the consultant might act unilaterally in a way that might not be in the patient's best interest. With respect to patients' experience, continuity of care is often fractured as a single component of their care shifts either temporarily or permanently to a new provider in a new setting, requiring travel and acclimatization to an environment removed from their primary care home. Finally, the "work flow map," from sending the consultation request to booking the eventual appointment, is clearly inefficient and wasteful.

This article has been peer reviewed.
Can Fam Physician 2012;58:825-8

Alternative model

We propose an alternative (**Figure 2**). Termed the *shifted outpatient model,*[2] this model has been long employed in rural settings and particularly well articulated in the psychiatry literature. This model involves inviting consultants into the primary care practice for regularly scheduled, dedicated sessions, during which the consultants make themselves available to assess patients, communicate directly with primary care providers, and participate in the clinic's educational initiatives. The consultant, in essence, becomes integrated into the primary care practice, receiving both clinic space and time, as well as administrative support. Although difficult to implement in the case of specialities that require specific equipment or technical functions (eg, ophthalmology, surgery), it remains ideally suited to many other areas of practice, including general internal medicine, many medical subspecialties, psychiatry, and pediatrics.

This model is additionally well-supported by the relevant literature. For example, Faulkner et al[3] found that referral rates to specialists in secondary or tertiary care settings declined with primary care–based specialist programs. Gruen and colleagues' systematic review[4] of specialist outreach clinics in primary care settings found that this model improved access to care and, when part of more complex interventions (including formal collaboration with primary care physicians and educational initiatives), resulted in improved outcomes and less inpatient resource use. This model also very much embodies the "patient-centred medical home" concept, which has been reported to improve many aspects of primary care in Canada.[5]

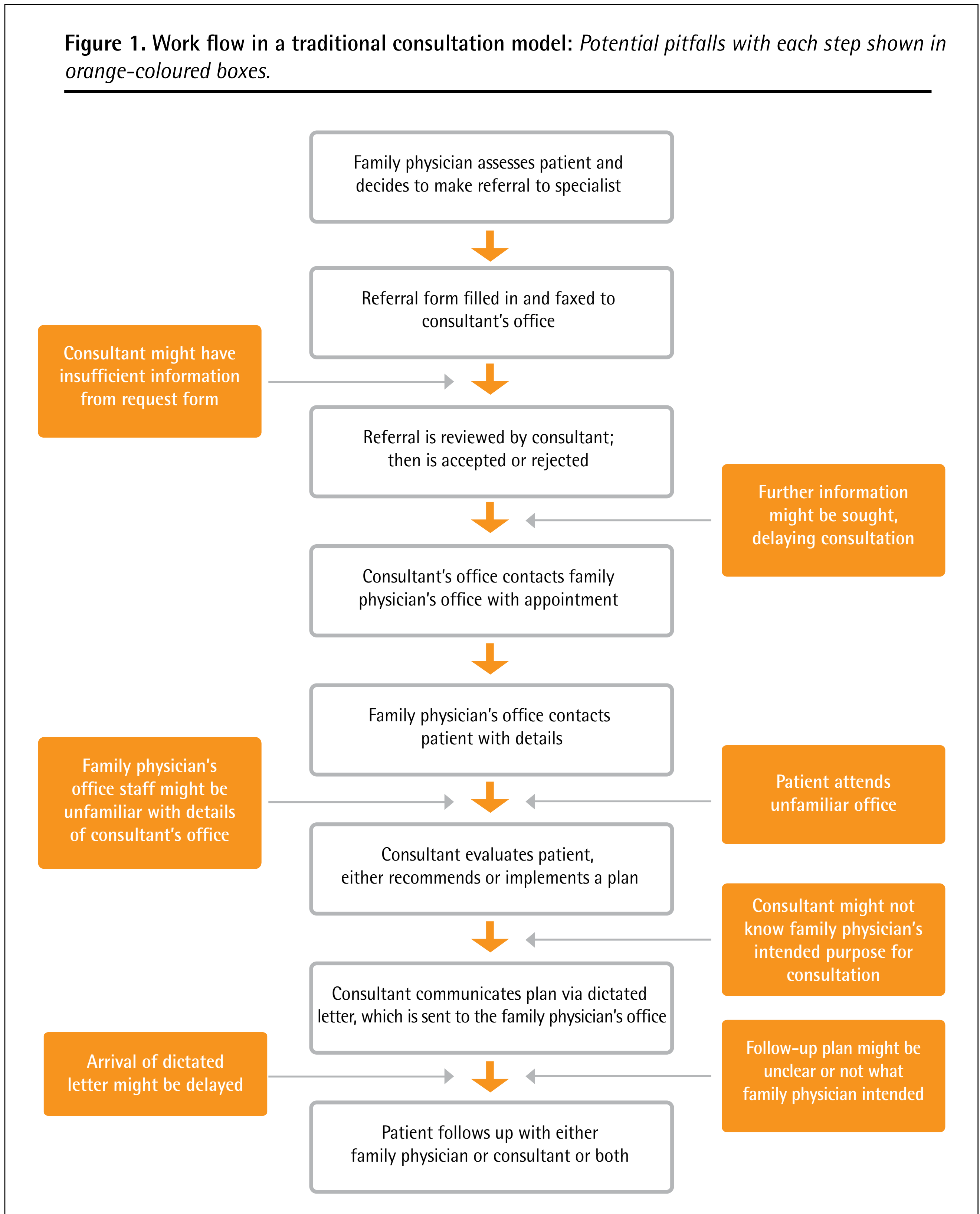
Designed to serve

At our academic primary care practice, this approach has been fully operational for general medical consultations for more than a year, and during this time, we have come to appreciate its numerous advantages. By fostering a relationship between consultant and family physician, it facilitates interphysician communication, both synchronous and asynchronous.[6] The consultant can contribute to the development of a customized consultation request form, ensuring that the information deemed relevant by all parties is included and elucidating the

La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro d'août 2012 à la page e423.

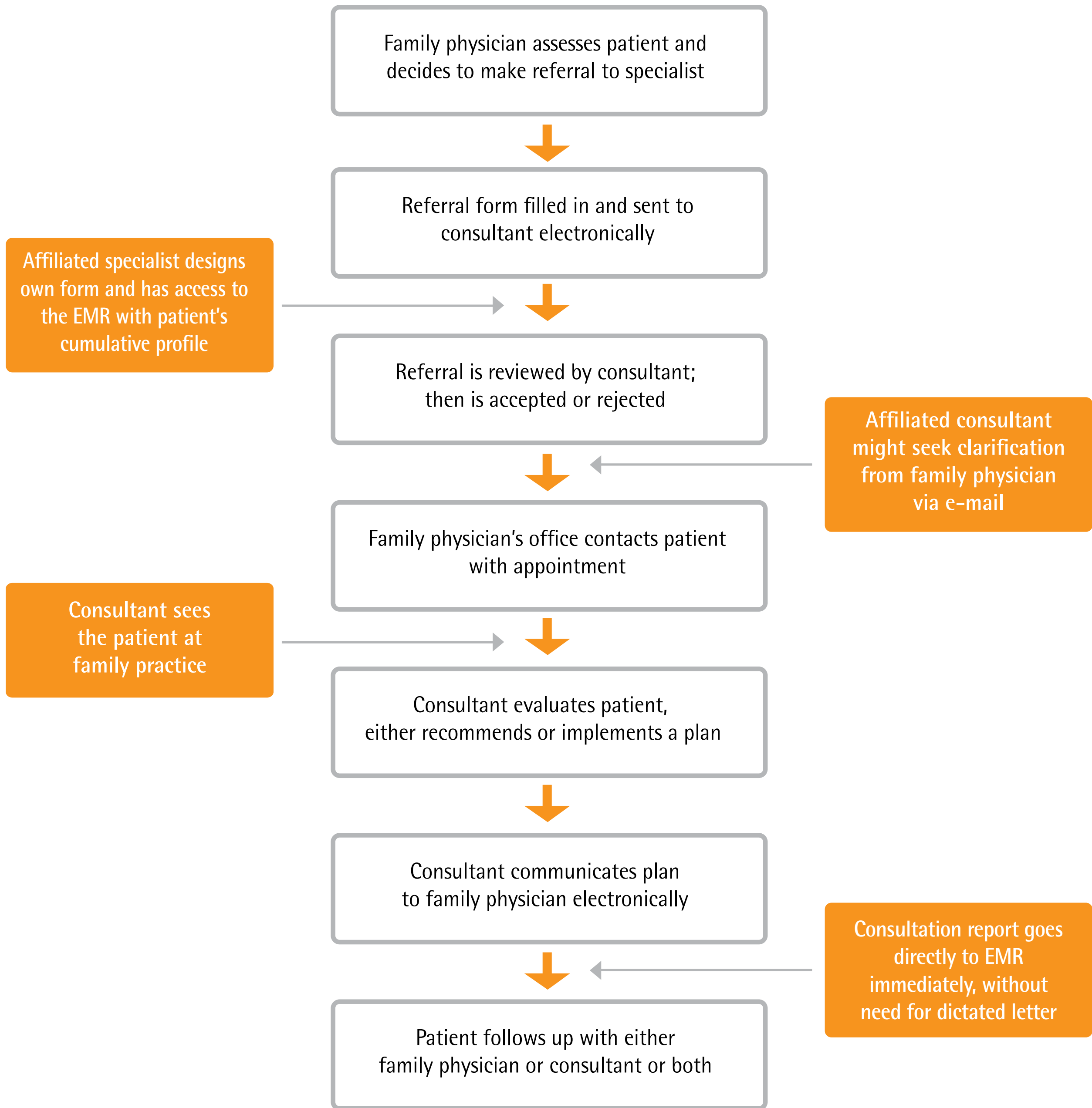
nature of the consultation request. (For example, is the request for a one-time opinion? For ongoing collaborative care?) After the consultation is completed, this model further facilitates ongoing dialogue regarding the recommendations provided, as well as which party is responsible for implementing the various components

Figure 1. Work flow in a traditional consultation model: *Potential pitfalls with each step shown in orange-coloured boxes.*



of the suggested plan. With the introduction of electronic medical records to many Canadian primary care practices, consultants can directly input their notes and recommendations into the patient's electronic chart, obviating the need to dictate a letter (and the delay this imposes), and making the plan easily accessible to the family physician when the patient next presents to the clinic. Finally, this model is preferable for patients: They can obtain specialist opinion in a setting in which they are known and comfortable; arrange follow-up with

Figure 2. Work flow in a family practice–based model: *Potential improvements to each step shown in orange-coloured boxes.*



EMR—electronic medical record.

their family physicians or specialists immediately and directly; and experience continuity of care in a psychologically salient manner.

Implementation of the model at our site was facilitated by Ontario Ministry of Health and Long-Term Care sessional funding for specialists affiliated with family health teams. The family health team provided dedicated clinic space and clerical staff, and arranged for the consultant's training on the practice's electronic medical record. The department chief made the practice's family physicians aware of the service through several communications, and the on-site internist presented details of the service and target referral population at departmental rounds. After accumulating a year of experience with this model, we asked full-time and part-time family physicians at our site to compare this on-site general internal medicine consultation model with the previously outlined traditional model through an electronic survey. Fifteen of 26 (58%) family physicians responded, 80% of whom had referred at least 1 patient. Timeliness, communication, and ease of access to the consultant were rated as superior to the traditional model by 10 of 12 respondents. When asked to compare whether the consultation question was more adequately answered in the on-site versus traditional model, the same proportion thought this aspect was preferable to the traditional model. Clearly, larger, more formal studies looking at hard outcome data will be required to conclusively demonstrate benefits.

In Ontario, Alberta, and New Brunswick, there is now sessional funding for specialists to have consultations within primary care settings. Remuneration compares favourably with fee-for-service billing for typical clinical time in most specialties. In Ontario, 110 of 186 family health teams currently have registered affiliated specialists (Ministry of Health and Long-Term Care, written communication, October 2011), representing what we believe to be underuse of this promising model. The many advantages we have highlighted make this a truly beneficial situation for all involved, most notably the patients this system is designed to serve. We encourage specialists and primary care practices alike to consider this model of consultation; by fostering partnership between these often-distinct parties, it provides, with minimal obstacles, efficient, patient-centred care.

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Acknowledgment
Dr Frost is supported by a scholarship from the Donald J. Matthews Complex Care Fund.

Competing interests
None declared

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The opinions expressed in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

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