



## STREAMLINING PATIENT FLOW FROM PRIMARY TO SPECIALTY CARE: A CRITICAL REQUIREMENT FOR IMPROVED ACCESS TO SPECIALTY CARE

### Executive Summary

When physicians believe their patients may require the expertise of another physician, effective, timely and informative communication between all physicians is essential to ensure appropriate use of specialty care services. The results of physician surveys indicate a lack of informative referral communication exists in Canada. Significant variation exists in referral request processes\*. This is contributing to the poor access to specialty care that many patients are experiencing.

Some of this variation is necessary, however, which means that a single, standardized solution to improve the entire referral and consultation process is not feasible. Nonetheless, while communication processes and information requirements for referral requests vary considerably, the communication and information needs in consultant responses is essentially the same for all referring physicians. Unfortunately, provision of this information is often lacking. This problem can be addressed through standard communication protocols because all referring physicians benefit from receiving the same types of information in response to referral requests; for example, acknowledgement of referral receipt or patient consult reports.

Furthermore, when referrals are initiated, specific types of requests can benefit from standardization of communication methods and information requirements. Such activities are already underway in Canada in select areas. These successful initiatives, used together as complementary approaches to address the varying needs of referral requests, should be adopted throughout the country. Visit CMA's [Referral and Consultation Process Toolbox](#)<sup>1</sup> for examples.

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\* For the purposes of this policy statement, this term applies to all situations where another physician is contacted regarding patient care.

Recognition, in the form of appropriate compensation, must also be given to the time spent preparing and analyzing referral requests as well as conducting consultations. Support for the use of information technology infrastructure, where available, will also facilitate efforts to streamline referral and consultation processes.

It should be noted that, while the language of this policy statement has a focus on primary to specialty care referrals, the concepts and recommendations apply to referrals between all specialties.

## RECOMMENDATIONS

- All stakeholders, especially physicians, but also, where appropriate, office assistants, nurses, other health care providers as well as patients, must be engaged in an early and meaningful way regarding any initiative that has a goal to improve referral or consultation processes.
- There is no single best way to access specialist expertise; as a result, a combination of complementary initiatives (e.g., formal consultation systems, standardized referral processes with central intake systems and/or physician directories) should be implemented to reduce variation in the approaches that are used and to facilitate more timely access to specialty care for patients.
- While acknowledging the referring physician's ability to interpret certain test results, the referral must be accompanied by appropriate information to allow the consulting specialist to fully assess the request, and the referring physician must be informed of what is "appropriate".
- The referring physician (and family physician if different), as well as the patient, should be kept informed, in a timely fashion, of the status of the referral request, using standardized procedures, minimum information requirements and timelines.
- Physician and/or physician practices should receive compensation and support in recognition of the time and effort undertaken to communicate appropriate information regarding referral requests as well as to conduct electronic or real-time consultations.

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### Introduction

When a physician decides that a patient requires the expertise of another specialist, the most appropriate next step can range from the specialist answering a question to assessing the need for a particular procedure or treatment. No matter how simple or complex the specialist's involvement may be, successful communication between all physicians is critical. Unfortunately, this does not occur as often as it should. In October 2012, a survey of physicians on the topic of referrals found that while over half of both

family physicians (52%) and other specialists (69%) agree that referral communication is effective, two-thirds of family physicians noted that some kind of communication problem was a main source of frustration for them; for example not being informed about: referral receipt, the patient's appointment, a treatment plan, or that the specialist does not do the service requested. A similar proportion of specialists noted a lack of basic or supporting information (e.g., reason for referral or lab test results) as a main frustration with referral requests.<sup>2</sup>

The most appropriate method of communication differs depending on the degree of specialist involvement that is required. There are no standards about which method of communication is the most appropriate or effective, or what information is required, for each situation. Referral request processes† vary significantly; not only across specialties but among specialists within a particular specialty and even within a geographic region. Examples of this variation include: some consulting specialists will accept referrals only if the referring physician has used their specific referral form; others accept referrals using only one particular communication method (e.g., by fax); and others accept referrals on just one day each month. Such variation creates inefficiencies because referring physicians must familiarize themselves with each request process that is required by each consulting specialist. The range and quality of information provided in a referral request also varies considerably; for example, too little information (i.e. no reason for referral provided), insufficient information (i.e. out-of-date or a lack of lab or imaging tests), or too much information (i.e. non-contributory family history).

This lack of standardization is problematic. In this context, standardization means simplification rather than obligation. Standardized processes facilitate communications for referrals by removing ambiguities about which method is most appropriate for each situation. Communication methods and the types of information that are transferred between referring physicians and consulting specialists vary based on numerous factors, ranging from those beyond the control of physicians such as regulations and available technology, to those

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completely within their control such as their own individual preferences.

An effective way to facilitate appropriate and timely access to specialty care that is within the control of the health care profession is to explore the rationale behind these varying communication and information preferences and address these variations by developing, with meaningful participation and approval from physicians and their administrative staff, standard processes for requesting a specialist referral and for communicating back to the referring physician.

**Recommendation:**

All stakeholders, especially physicians, but also, where appropriate, office assistants, nurses, other health care providers as well as patients, must be engaged in an early and meaningful way regarding any initiative that has a goal to improve referral or consultation processes.

Some of the provincial Colleges of Physicians and Surgeons have guidelines or standards of practice specifically about referrals and consultations. The most comprehensive of these are the College of Physicians & Surgeons of Nova Scotia's (CPSNS) [Guidelines for Physicians Regarding Referral and Consultation](#)<sup>3</sup> and the College of Physicians and Surgeons of Alberta's (CPSA) Standard for Practice on [The Referral Consultation Process](#).<sup>4</sup> In addition, the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (Royal College) developed collaboratively [a guide to enhancing referrals and consultations between physicians](#).<sup>5</sup> While these documents do not discuss which method of communication should be used for each referral request scenario, they do provide guidance in a

number of areas, including:

- minimum requirements for information that should be provided with all referral requests
- information that should be conveyed to patients (e.g., why they are being referred, information about the specialist appointment, etc) as well as who should be providing this information
- processes that should be followed for patients requiring ongoing care from the consulting physician

While standardization of the minimum information requirements that should be included in communications between referring and consulting physicians is essential for finding efficiencies with referral processes, these efficiencies will not be fully realized without proper consideration of the information technology infrastructure that is used to convey this information. The way in which the information is provided should not require additional effort for either the sender or the receiver. Electronic referral systems, where all data necessary for an informative referral can be easily obtained by the appropriate physician from the patient's electronic health record, would be the best way to ensure that this occurs. However, until this becomes a reality, a suitable compromise can be found by allowing flexibility in the format in which the information is provided.

### **Communication from Primary Care to Specialty Care**

When the extent of a specialist's involvement in patient care is simply providing a second opinion or advice about appropriate next steps, standardizing the process for this kind of communication is relatively straightforward. This is because the variation that exists in this situation is primarily due to

the availability of the consulting specialist and the methods of communication that each referring physician can use to contact the specialist.

Certain regions of the country have established consultation services whereby specialists participating in the program must respond to consult requests within a specified time frame. Examples of effective consultation systems include the telephone advice line known as [Rapid Access to Consultative Expertise \(RACE\)](#)<sup>6</sup> in BC or the secure electronic consultation system known as [Building Access to Specialist Care through e-Consultation \(BASE\)](#)<sup>7</sup> in the Champlain Local Health Integration Network (LHIN) in Ontario. Such services have proven quite effective at reducing the number of unnecessary referrals<sup>8,9</sup>; thereby ensuring more appropriate use of specialty care and helping to reduce wait times for this care. Through both of these systems, specialists ensure that they are available to respond to the consult question in a timely manner and each system uses only one form of communication.

At the other end of the spectrum of specialist involvement in patient care, when the patient sees the specialist, there is a much greater degree of variation in what is required of the specialist – from one-time interventions such as surgical procedures, to chronic care. The best approach for streamlining the referral process in these more complex situations varies, depending on the type of specialist care that is required.

#### *Central Intake*

With central intake referral systems, the referring physician sends a referral request to one location. This central location can be organized in two ways; central triage or pooled referrals. With central triage, referrals

are assigned to specialists based on their level of urgency. With pooled referrals, each referral is allocated to the next available specialist, who then does the triaging. The differences in where the triaging occurs exist due to a number of factors; including the type of care the specialty provides as well as the number of specialists in the geographic region. However, for both types of central intake systems, the referring physician follows a standard process regardless of the specialist who assumes care of the patient.

Regardless of the type of central intake method that is used, the option to choose a particular specialist must always be available. However, even with this option in place, a central intake system of any kind is not necessarily the most appropriate solution for all specialties. This is often the case when ongoing patient-specialist relationships are quite common. For example, a woman might prefer that the same obstetrician cares for her during all of her pregnancies, or patients with chronic conditions such as arthritis or diabetes and require continuous care throughout their lifetime. In these situations, coordinating a central intake program where a significant proportion of specialist appointments are repeat visits is difficult.

#### *Physician Directory*

A physician directory might be a more useful referral tool in situations where specialties do not have sufficient numbers of specialists in one geographic region or for those that have a high degree of sub-specialization. Such directories provide, at a minimum, details of the services each specialist provides and does not provide. Those that provide information regarding wait times, especially those with information on the wait for the first specialist visit, are extremely useful for referring physicians as it allows them to select a specialist with the most appropriate wait time

for their patient and, where relevant, it also allows the referring physician to develop an appropriate care plan based on the time the patient must wait for specialty care.

Despite the fact that the complexities with specialty referrals mean that there is no one solution that is appropriate for all types of specialties, the extreme variation in processes that currently exists is also unnecessary.

#### **Recommendation:**

There is no single best way to access specialist expertise; as a result, a combination of complementary initiatives (e.g., formal consultation systems, standardized referral processes with central intake systems and/or physician directories) should be implemented to reduce variation in the approaches that are used and to facilitate more timely access to specialty care for patients.

Standard referral information requirements for specialty groups with similar needs, such as most surgical specialties, have been effectively established in some areas of the country. For example, in Calgary, Alberta, a major initiative known as [Medical Access to Service](#)<sup>10</sup>, has, among other things, successfully developed a standard referral form and process for central intake for multiple specialties. While most of these specialties also request additional information, each specialty has agreed on a standard set of minimum requirements. These standards were developed collaboratively with physicians and could be expanded nationwide, while taking regulatory and technological differences into account.

When establishing the requirements for an informative referral, consulting specialists must acknowledge that the referring physician may not have the expertise necessary to

appropriately interpret certain test results. In such cases it is the consulting specialists who should order these tests.

**Recommendation:**

While acknowledging the referring physician’s ability to interpret certain test results, the referral must be accompanied by appropriate information to allow the consulting specialist to fully assess the request, and the referring physician must be informed of what is “appropriate”.

**Communication from Specialty Care to Primary Care**

What must not be overlooked is that referral communication is bilateral. Informative and timely communication from the consulting specialist to the referring physician is also critical for a successful referral. Such a referral can be defined as one where the patient receives appropriate and timely specialty care where all parties – patient, specialist(s), referring physician and family physician (when the referring physician is not the patient’s family physician) – are aware of all of the patient’s relevant interactions with the health care system as well as any follow-up care that may be required. To ensure this occurs, after the referral request is initiated, the referring physician (and family physician if different) should be informed, in a timely manner, of the status of the referral at all stages:

- referral receipt
- request for more information
- referral acceptance/rejection (with explanation and suggested alternatives)
- patient appointment has been scheduled
- patient consult notes (including recommended treatment plan and follow-up)

A definition of what is considered “timely” is required. Standards must be established based on what is considered to be an acceptable response time at each stage. The patient must also be promptly informed of the status of the referral request throughout the entire process.

Examples of the types of information that should be conveyed include (where appropriate):

- how the referral request will be processed; e.g., pooled referral or central triage
- expected wait time or when the appointment has been scheduled
- whether another specialist has been contacted
- whether a repeat visit is required
- whether the patient has been contacted about anything that is relevant to them; e.g., referred elsewhere, wait time, appointment(s) scheduled

The information and communication that the referring physician requires from the consulting specialist for all referrals is much more homogeneous. In addition, there are no regulatory or technological barriers preventing the provision of this information at the appropriate stages of the referral process. This is one area where communication between physicians is within their control. Therefore, improved communication for responses to referral requests through standardized processes can be much more easily established. Unfortunately this is not the case, causing considerable effort to be undertaken by referring physicians and/or their office staff to track the status of referrals.

Considerably less attention has been given to this part of the process; however, some activities described in the [CMA’s Referral and Consultation Process Toolbox](#)<sup>1</sup> do address

problems regarding the referral response. Central Intake systems are an example. These often include standard response times for at least the first three stages noted above, as well as information about the specialist who has received the referral request.

The previously cited [guidelines](#) developed by the CPSNS<sup>3</sup>, [the standard of practice](#) by the CPSA<sup>4</sup> and the [guide to enhancing referrals and consultations between physicians](#) developed by the CFPC and the Royal College<sup>5</sup> also have recommendations for consulting specialist responses to referral requests (including information requirements and timelines). These resources can be used as a starting point for establishing referral communication standards in both directions and with patients. As an important example, the guidelines for both provincial colleges specifically indicate that the consulting specialist is responsible for arranging appointments with the patient and notifying the referring physician of the date(s).

**Recommendation:**

The referring physician (and family physician if different), as well as the patient, should be kept informed, in a timely fashion, of the status of the referral request, using standardized procedures, minimum information requirements and timelines.

**Compensation and Support**

Another aspect of the referral process that is not given sufficient consideration is the time and effort that is involved in preparing and responding to a referral request. Both preparing an informative referral request and responding to one is time-consuming; very little recognition is given towards this work. In some areas of the country, physicians receive compensation for participating in

electronic or telephone consultation programs. This form of recognition has successfully helped avoid unnecessary referrals and should be expanded nation-wide; however, much more should be done to acknowledge this effort, especially when a specialist visit is necessary.

The time referring physicians spend gathering the necessary data for a referral request, or the time consulting specialists spend analyzing this data, triaging the referrals accordingly and preparing patient consult notes, is almost never acknowledged as part of a physician compensation package. In most jurisdictions this work is considered to be just a component of a typical patient visit. Since many primary care group practices employ administrative staff who are “referral coordinators”; whose main role is to assist physicians in the data gathering and preparation that is required for an informative referral request, as well as following up on referral requests; the process of referring a patient to specialty care is much more than “just a component of a typical patient visit”.

Support for widespread implementation of effective information technology infrastructure can facilitate the preparation of appropriate referral requests and responses and can also encourage timely and informative communication between referring physicians and consulting specialists.

**Recommendation:**

Physicians and/or physician practices should receive compensation and support in recognition of the time and effort undertaken to communicate appropriate information regarding referral requests as well as to conduct electronic or real-time consultations.

## Conclusion

The high degree of variability in both the methods of communication and the information transferred between physicians is a significant barrier to timely access to specialty care for patients. Significant effort by physicians and their office staff is expended unnecessarily in the referral process, not only in initiating or responding to the request, but also in tracking and follow-up.

While there is no single solution that will address all referral communication problems, several complementary solutions exist that can reduce this variability and wasted effort, thereby simplifying the process and facilitating appropriate, timely and informative communication between referring physicians and consulting specialists. Examples of such initiatives can be found in the [CMA's Referral and Consultation Process Toolbox](#).<sup>1</sup>

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## References

- <sup>1</sup> Canadian Medical Association. Referral/Consultation Process. Available at: <http://www.cma.ca/referrals>. Accessed 29 Nov 2013.
- <sup>2</sup> Canadian Medical Association. Challenges with patient referrals – a survey of family physicians and other specialists; October 2012 (Unpublished).
- <sup>3</sup> College of Physicians and Surgeons of Nova Scotia. Guidelines for Physicians Regarding Referral and Consultation. Available at: <http://www.cpsns.ns.ca/Portals/0/Guidelines-policies/guidelines-referral-consultation.pdf>. Accessed 15 Nov 2013.
- <sup>4</sup> College of Physicians & Surgeons of Alberta. The Referral Consultation Process. Available at: [http://www.cpsa.ab.ca/Libraries/standards-of-](http://www.cpsa.ab.ca/Libraries/standards-of-practice/the-referral-consultation-process.pdf?sfvrsn=0)

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[practice/the-referral-consultation-process.pdf?sfvrsn=0](http://www.cpsa.ab.ca/Libraries/standards-of-practice/the-referral-consultation-process.pdf?sfvrsn=0). Accessed 16 Sep 2014.

<sup>5</sup> College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada. Guide to enhancing referrals and consultations between physicians. Available at: <http://www.cfpc.ca/ProjectAssets/Templates/Resource.aspx?id=3448>. Accessed 27 Nov 2013.

<sup>6</sup> Rapid Access to Specialist Expertise. Available at: [www.raceconnect.ca](http://www.raceconnect.ca). Accessed 27 Nov 2013.

<sup>7</sup> Liddy C, Rowan MS, Afkham A, Maranger J, Keely E. Building access to specialist care through e-consultation. *Open Med.* 2013 Jan 8;7(1):e1-8. Available at: <http://www.openmedicine.ca/article/view/551/492>. Accessed 27 Nov 2013.

<sup>8</sup> Wilson M. Rapid Access to Consultative Expertise: An innovative model for shared care. Available at: <https://www.cma.ca/Assets/assets-library/document/en/advocacy/RACE-Overview-March-2014.pdf>. Accessed 16 Sep 2014.

<sup>9</sup> Afkham A. Champlain BASE project: Building Access to Specialists Through e-Consultation. Available at: <https://www.cma.ca/Assets/assets-library/document/en/advocacy/Champlain-BASE-Dec2013-e.pdf>. Accessed 16 Sep 2014.

<sup>10</sup> Alberta Health Services, University of Calgary Department of Medicine. Medical Access to Service (MAS). Available at: <http://www.departmentofmedicine.com/MAS/> Accessed 15 Nov 2013.