

Referring for knowledge base: What is the case for referral?

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DO SPECIALISTS TREAT ALLERGY PATIENTS BETTER THAN OTHER DOCTORS?

We assume that as specialists, we treat our patients better than other doctors, and that should be the reason to refer to us. Some data support this assumption. At least six studies have addressed the question of how seeing an allergist makes a difference. Although the methodologies vary greatly, all of the studies suggested improved outcomes when patients with allergies were treated by a specialist. There were decreased emergency room visits and hospitalizations for allergy and asthma, fewer disease-related absences from school or work, and lower overall health care costs. In addition, two of the six studies reported increased patient satisfaction when they were treated by specialists. This last point may be subjective, but it is an important factor in patient choice regarding health plans.

If allergy care makes a difference, a reasonable question to ask is, "What do allergists do to make a difference in patient care?" Some of the studies attempted to address this issue. Six key areas potentially contribute to differences in care and outcomes from allergists versus nonspecialists: (1) environmental control; (2) compliance, which can be attributed to better patient education and to seeing the patient more often; (3) self-management skills for the patients (i.e., treating exacerbations early and monitoring with peak flow meters); (4) correct use of spacers, peak flow meters, and delivery devices; (5) differences in the types of medications used to treat the disease; and (6) immunotherapy. Some of these could just as well be covered in a primary care setting, but for many reasons, they are often not being done there.

A MODEL FOR REFERRAL

Referral is sometimes viewed as a source of aggravation rather than a source of solace for patient care. For the most part, this is because the referring physician may not understand the specialist's knowledge base. Also, in the evolving health care environment in the United States, there are increasing incentives for primary care physicians not to refer patients unless the illness is classified as "severe."

One example of appropriate referral within a managed care environment is provided by the allergy department of Kaiser Permanente in San Diego, Calif. This staff model managed care organization has six allergists for a population of approximately 350,000. The allergy department in this setting is an integral, accepted, and appreciated department that does four things for the health maintenance organization (HMO). First, the allergists teach the primary care and allied health professionals in the organization how to manage allergy/immunology-related illnesses. This specifically includes identifying the point of referral, that is, that point at which patients need to see the allergist. It also includes teaching primary care residents. Second, the allergists are the physicians for the special problems, the sicker patients. They actively call and see all patients who go to the emergency room or the hospital with asthma. Third, the allergy group provides primary care to many patients with rhinitis and sinusitis and to patients with asthma and urticaria as well. Finally, the group is involved in some research projects. This model may not be generalizable to all primary care settings, but it works well in a staff model HMO and can provide some guidance for developing a partnership between primary care providers and allergy/immunology specialists.

ISSUES TO CONSIDER

Several issues should be considered in a discussion of when patients should be referred to the allergist. Specific questions include the following: (1) How can allergists become involved in refereeing the medical dollar? (2) Will there be extra cost for specialist referral? (3) What are the guidelines for referral? (4) What health care value does allergist care offer to the patient (and organization) beyond primary care? (5) Which patients will benefit most from allergist care? (6) What will be the impact of decreasing profitability on specialist care? Shared vision, including both value and risk, between the allergists and the primary care gatekeepers will determine the referral base for allergy in the future.

REFERRING FOR KNOWLEDGE BASE: DISCUSSION

Wasserman. Outcome studies are done by a particular organization, like Zeiger's study, showing that allergy referrals for asthma are valuable at Kaiser. Does that necessarily translate into a HMO in Boston or Baltimore buying allergy care for their patients with asthma? Or does each unit locally need to demonstrate their value to a particular purchaser?

Venable. I think right now it is local first. However, there is a move toward national guidelines. Clinical indicator panels for primary care are looking to idealized national standards to see what physicians are doing. Right now you can demonstrate local value and publish it in a national forum. Health reform was nothing more initially than the government trying to get control of the health care dollar. In the future we are going to see foundation and provider equity models where physicians will be in charge of their own destiny. You will see quality by outcomes and by patient ratings in the twenty-first century. There already is a report card project that the National Business Coalition on Health is doing with the National Association of Managed Care Physicians. Specialty societies can help educate employers about managed care and about what is appropriate in terms of rating health care. For example, hospital admission rates for asthma may be a very good initial indicator. That may open the door for the specialty.

Austen. What is the provider equity model? Who owns it?

Venable. The doctors.

Wasserman. Mullikan is among the biggest. It is a wholly owned corporation. The physicians own the HMO; they own the system.

Venable. What happened is that Mullikan outgrew its abilities to grow. Physicians in planning have to get some other partners. Provider equity models of the future will be employers, physicians, hospitals, and perhaps health plans. The prediction for the twenty-first century is that the insurers will still control two thirds of the market, and one third will be reconfigured as a provider equity-driven model.

Anderson. The phenomenon that I see emerging relates to the individual credentialing processes for each of the HMOs, preferred provider organizations, etc. They seem to use board certification as a criterion for specialists, and increasingly they seem to exclude people who did not pass the boards. A physician might have gone through a training program and been practicing for 15 years in the community but now cannot join the vehicle.

Venable. That is true. In fact there are concerns about inconsistencies in credentialing. In California, we are working with the California Medical Association, National Business Coalition of Health, Health Care Financing Administration, and some other groups to put together a credentialing process that will be more performance based.

Kaliner. Data show that the quality of care is proportionate to the training of the provider. Board-certified

American and Canadian physicians apparently provide better medical care than physicians who have not been board certified.

Lockey. Where do you see physician assistants (PAs) and nurse practitioners in the evolutionary scheme? What role will they play? How will they replace the primary care physician?

Venable. There are plenty of nurse practitioners and PAs out there. There is an American Association of Managed Care Nurses and now a PhD program for advanced practice nurses called the Nurses-as-Doctor. Half of what family doctors do today, specifically in the semirural and semiurban settings, will be controlled on a day-to-day basis by nonphysicians. We should embrace the fact that we are an integrated delivery system.

Lockey. Do you think they will become independent of physicians?

Kaliner. In Washington, DC, they will be able to set up independent clinics without any MD allegiance. The question is whether they will be able to prescribe.

Platts-Mills. We have a nurse practitioner who is licensed to prescribe.

Austen. Dr. Weiss, we talked a little bit about practicing allergy in a staff model setting. We have talked a lot about the year 2000. I want to be sure we answered the question about referring for knowledge base, and I wondered if you would challenge your two colleagues.

Weiss. In Chicago I am in the process of setting up a center for health services research within an integrated hospital system called Rush Health Systems, which used to be Rush Medical Center, and is now an eight-hospital network and is in partnership with Rush Prudential, as in Prudential Insurance. This is one of these new complex models. I am the person who will be building out their health services research, the clinical epidemiology, the health economics, all of these new developmental, clinical scholar-type of activities. This week I met with three different groups of people, each of whom reflects different ways managed care is practiced in different parts of the country. In terms of specialty, even for asthma, and even in the mature markets, managed care is not homogeneous but is a very heterogeneous activity.

I think you are avoiding the hard questions. The referral-base question is really one of the points; the other question is the academic nature of your specialty. If you do not struggle with those questions, you will not be prepared for the twenty-first century. With regard to referral base, we can discuss for a long time the need to do the types of studies to prove that allergists provide care that is very different care from that provided by primary care physicians for the types of illnesses that they treat. We could do some studies to improve that knowledge base. What is more important is to begin to ask the question on a conceptual level: that is, what is the appropriate level of referral? I do not think you have answered that question. Someone suggested managing the severely ill patient, and in fact that is where the resting point will be for referral. What defines severe

illness still is an open question. This needs to be made very clear so that the managed care providers and the other decision makers who are not physicians know exactly what the product of service is that you are providing to them. The academic agenda will follow from that. For the academic agenda, you also must decide what piece will move forward into the twenty-second century. Who are the scientists who are going to develop your discipline? They will have a role, but it will be a much more confined role than that defined by the marketplace. How many fellows are needed annually to really move the biomedical portion of the science forward? How many are needed to move the clinical research agenda forward? Those are tough questions. They need to be addressed in terms of how much of a referral base the discipline needs to survive. To what degree do you feel that the clinical syndromes around which you gather yourself need ongoing support? I have heard one allergist for every 60,000 population is a rough estimate.

Wasserman. Right now the population is about one per 65,000, and the HMOs use about one per 90,000.

Weiss. That is about 1% of the physician manpower. You have to ask whether 1% of the physician manpower dedicated to these diseases is enough.

Another question would be, "What percentage of your practice is being supported by allergy shots?" That is something you are going to confront head-on as cost-effective clinical effectiveness becomes paramount. Science is moving on and will likely provide better or alternative medicines. If "shots" drift away, your whole referral base is going to shift.

Austen. Dr. Weiss, do you want to say something about your quality assessments and outcomes?

Weiss. One of the things that I am working on is for the National Asthma Education Project, specifically, the task force on cost-effectiveness, quality, and financing of asthma care in this country. I struggled with the question of what the National Institutes of Health (NIH) and the biomedical industry need to do and know about cost-

effectiveness and financing. That has been the work of three wonderful subgroups. John Eisenberg, Head of the Department of Medicine at Georgetown, helped me look at the issue of cost-effectiveness. In financing I drew on Jen Falls, who works at Park Nicolett, and for quality on Mark Young, who does much of the quality improvement work at the Henry Ford system. One of the outputs is that the National Heart, Lung, and Blood Institute, in developing one of its new initiatives asked about the cost-effectiveness as part of a new clinical trial. However, I am not sure that the NIH in its biomedical agenda can afford to also address this additional agenda. In the pharmaceutical industry, if you have not addressed the issue of an agent's cost-effectiveness, you may be off the target for what you are planning to market. We are producing societal goods. The NIH does science for the year 2020 as opposed to science for the year 1997. New forces may say look to the year 1998 to be relevant for funding.

One of the things I noticed in talking to several medical directors of HMOs during the past 12 to 14 months is that the consumers, the patients, want "shots." There must be a mechanism for shots. At least for the short-term solution, that is something you will have to fold into your mix.

Bloch. Many people smiled when I said that we should go back home and learn how to own the HMO business, but if we don't do something now, we will never get in on the business because it is changing now. Also, we look on these outcome studies as if they were ways of holding on to patients with allergies. That is a mistake. The key will be how the results are interpreted. If it turns out that the reason we do better is because we teach the patients how to use an extender on their inhaler, it is up to us to teach the deliverer of health care to do that. It is not necessary for us to keep all the patients to teach them how to use the extender. I think that the allergist of the future whom we will wish to train will be a scholar, an educator, and a teacher of the generalist.

Integrating a primary care role with allergy and immunology training

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In the emerging field of managed care, primary care physicians play a critical role. For the sake of our patients, who must come first, and for quality care, we need to have input. There are two ways to approach this question. First, we can assume that

primary care physicians will provide the primary care for patients with allergy and asthma. We then need to determine how well qualified they are to take on this task and how much time they will have for managing and "educating" the patients. Other