

Impact of a Simple Intervention to Increase Primary Care Provider Recognition of Patient Referral Concerns

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Objective: To determine whether a brief previsit questionnaire about referral concerns can improve primary care provider (PCP) recognition of patient concerns and satisfaction with care.

Design: Sequential prospective study in the internal medicine clinic of an academic medical center providing primary care to patients enrolled in a gatekeeper-model managed care plan.

Participants and Methods: Twelve faculty internists serving as PCPs for 1495 consecutive patient visits. Patients were given a previsit questionnaire asking about referral need and rationale and a postvisit questionnaire asking about discussion of referral concern and visit satisfaction. Providers were given a postvisit questionnaire asking whether a referral was discussed and made and about visit satisfaction. In the control phase, patient previsit questionnaires remained confidential, whereas in the intervention phase PCPs were shown the pre-visit questionnaires at the time of encounter.

Results: The intervention significantly increased PCP referral recognition from 61% to 81% ($P < .001$) and was associated with increased visit satisfaction ($P = .05$). Satisfaction of PCPs with the referral discussion, overall rate of referral, and visit duration were not affected by the intervention.

Conclusions: Using a brief previsit questionnaire about patient referral concerns increases PCP recognition of such concerns. The intervention does not adversely affect PCP satisfaction with the referral discussion or the overall referral rate and may enhance patient visit satisfaction.

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access can be limited in a manner that minimizes the risk of undertreatment, conserves resources, and maintains patient satisfaction.¹⁻⁷

A major function of PCPs in gatekeeper-model systems is control of referrals for specialty care. Referral regulation by PCPs affects the healthcare system, the PCP, and the patient differently. From the healthcare system standpoint, specialist referrals can be exceptionally costly.⁵⁻⁷ From the PCP standpoint, gatekeeping may result in an adversarial relationship with the patient and may impair patient-physician communication and quality of care.^{2,8,9} From the patient perspective, desire for specialist referral is high,¹⁰⁻¹⁵ and failure to meet patient referral desires is a major determinant of patient satisfaction, continued plan enrollment, and likelihood that the PCP will be recommended to friends.^{4,14,16}

In a recent study,¹⁷ we found that, depending on the PCP, 27% to 56% of patient referral concerns were not recognized by internist PCPs working in an academic gatekeeper-model managed care plan. In view of the reported negative impact of unmet referral desire on patient satisfaction,^{4,14,16} we undertook the present study. The primary objective of our study was to ascertain whether a simple intervention, a brief pre-visit patient questionnaire asking about referral concern, could improve PCP recognition of patient referral concerns. Secondary objectives were to ascertain whether enhanced PCP recognition of patient referral concerns affected patient satisfaction with the visit or the number of referrals.

Many primary care providers (PCPs) work in a "gatekeeper"-model healthcare delivery system. In gatekeeper models, PCPs are often responsible for authorizing access to specialty, emergency, and hospital care.¹⁻⁴ The assumptions of a gatekeeper model are that free access increases the risk of overtreatment and the cost of care and that

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... METHODS ...

Patients, Providers, and Setting

The study population consisted of 1495 consecutive patients seen at the University Medical Group Practice (Denver, CO) from February 1, 1998, through May 31, 1998. All patients were enrolled in a University of Colorado managed care program (CU Gold) that uses PCPs as gatekeepers for specialty access. Patients in this plan seen at the study site included approximately 3000 state employees, healthcare workers, physicians, nurses, academic-based employees, and their family members. Patients enrolled in the study were presenting to the clinic for new patient, return patient, or episodic patient visits. Patients seeking referral for emergency or urgent care, pregnancy, cancer, mental health concerns, AIDS, an annual eye examination, or continuing therapy for any referral issued in the previous 6 months were excluded. The 12 PCPs were board-certified general internists and were aware of the research study but were unaware of the study objectives. All patients were seen by a faculty physician without involvement of medical students or housestaff. The study was approved by the Colorado Multiple Institutional Review Board.

Patient Questionnaire

Selected demographic data were obtained from the computerized scheduling system used in the clinic. Patients were contacted just after clinic check-in and completed a 1-page, self-administered previsit questionnaire (**Appendix**). All patients were asked to rate their overall health (poor, fair, good, very good, or excellent) and to respond to the statement "I am worried about my overall health" (strongly disagree, disagree, not sure, agree, or strongly agree). Patients were also asked whether they needed a referral to a specialist that day (yes, possibly, or no); those indicating definite (yes) or possible desire for specialist referral were also asked to respond (yes or no) to 4 additional statements regarding their referral concern ("I need to have a test or procedure done," "I need to be seen for ongoing care, treatment, or diagnosis," "I have tried other treatment plans that are not working," and "I have a new medical concern/problem that I feel merits a referral").

After the visit, patients were asked to respond to the following statement: "Overall, I am satisfied with this visit" (strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree). Patients were also asked to respond to the query "Did your

provider discuss all of your referral concerns?" (yes, no, or I had no referral concerns). Finally, patients were asked whether their provider seemed "rushed" during the visit (yes or no).

Provider Questionnaire

Providers were asked to complete a brief, self-administered questionnaire immediately after each patient visit, responding (yes or no) to the following questions: "Did the patient have a referral concern?" and "Did you make a referral?" Providers were asked whether they believed that they addressed the patient's referral concerns (all, some, or none) in patients in whom they recognized a referral concern. Providers were also asked to rate their satisfaction with any referral discussion (very unsatisfied, unsatisfied, somewhat unsatisfied, satisfied, or very satisfied).

Study Design

Our primary hypothesis was that a brief questionnaire that included information on patient referral concern would enhance PCP recognition of this concern. To evaluate this hypothesis, we used a sequential, prospective intervention. We believed that this was the most practical approach in view of the fact that we previously found that PCP recognition of referral desire was relatively constant in our clinic over several months of observation¹⁷ and because our study population consisted of a small number of PCPs. Such sequential intervention thus avoids contamination by the PCP. If different patients of the same PCP were assigned to the control or intervention groups in a traditional randomized controlled trial, the small number of study physicians would soon know the objectives of the study. Patients were entered into the study for only 1 visit, and patients who were seen in follow-up during the control phase or the intervention phase were excluded from participation.

Providers were asked to conduct their office visits in their usual manner throughout the study. During the first 2-month (control) phase of the study, patient previsit questionnaires were not made available to the PCPs at the patient encounters. During the second 2-month (intervention) phase, PCPs were given the patient previsit questionnaire at the time of the encounter. Patients were unaware, in both phases, of whether their PCPs would be shown the previsit questionnaire. In the intervention phase, patient previsit questionnaires were placed on top of the encounter form given to the PCP before the visit.

To ascertain whether the studied intervention affected visit time, a trained professional research assistant (S.A.) timed approximately 100 visits during each phase of the study. Neither patient nor PCP was aware that the visit was timed. Timing occurred by direct observation from 1 or more administrative stations within direct view of the examination room. The visits were selected using random numbers, and an attempt was made to time approximately 10 visits of each PCP during each study phase.

Statistical Analysis and Definitions

For questions related to overall health, a numerical score was obtained by assigning a score of 1 for poor, 2 for fair, 3 for good, 4 for very good, and 5 for excellent. For the statement about worry, a numerical score was obtained by assigning a score of 1 for strongly disagree, 2 for disagree, 3 for not sure, 4 for agree, and 5 for strongly agree. For the patient statement on visit satisfaction, a numerical score was obtained by assigning a score of 1 for strongly disagree, 2 for disagree, 3 for neither agree nor disagree, 4 for agree, and 5 for strongly agree. For the PCP question regarding satisfaction with the referral discussion, a numerical score was obtained by assigning a score of 1 for very unsatisfied, 2 for unsatisfied, 3 for somewhat unsatisfied, 4 for satisfied, and 5 for very satisfied. For this study, we defined physician recognition of a patient referral concern as a physician notation that a referral was discussed when patients indicated concern (yes or possibly) for a referral. Analyses were performed using a statistical software program (SPSS-PC version 4.2; SPSS Inc, Chicago, IL). Initially, continuous variables were tested using *t* tests and analysis of variance where appropriate, and categorical variables were compared using χ^2 tests. Because a relatively small number (*n* = 12) of physicians were

involved in this study, we did additional analyses. To account for possible clustering by physician, a mixed-effects linear model was used. Such a model is more statistically conservative because it takes into account the clustering of patients by physician. These analyses were conducted using the Proc Mixed procedure in the SAS statistical package (version 6.12; SAS Institute Inc, Cary, NC). The *P* values for the variables given in the tables are expressed in terms of this mixed-effects linear model; *P* < .05 is considered statistically significant. For *P* > .25, not significant is denoted by NS.

... RESULTS ...

Complete data were available for 781 patients in the control phase and 714 in the intervention phase. Approximately 80% to 90% of patients approached agreed to participate in the study. Information on patients electing not to participate was not obtained. As noted in **Table 1**, the 2 study populations were similar.

Table 2 demonstrates the effect of the intervention on selected aspects of PCP-related referral behavior. The intervention increased PCP recognition of

Table 1. Characteristics of the Study Population

Variable	Control Phase (N = 781)	Intervention Phase (N = 714)	P
Established patient, % of visits	71.3	69.0	.34
Females, %	65.0	65.5	.89
Patient age, %			
<20 y	1.0	2.0	.13
20-60 y	73.0	73.0	.99
>60 y	25.0	25.0	.96
Self-rated overall health score, mean \pm SD*	3.16 \pm 0.04	3.28 \pm 0.04	.09
Self-rated worry about health score, mean \pm SD*	2.70 \pm 0.04	2.61 \pm 0.01	.12
Patient self-perceived referral need, % of visits			
No	50.8	53.7	.28
Possibly	32.0	33.0	.67
Yes	17.2	13.3	.06
Patient rationale for referral, %			
Procedure needed	42.6	47.5	.06
Ongoing care, diagnosis, treatment	49.6	44.8	.07
Tried other plans	20.2	26.4	.005
New issue	46.5	55.7	.003

*Rated on a 5-point Likert scale. See the "Statistical Analysis and Definitions" subsection for more information.

patients with a self-perceived referral concern. However, PCP recognition of patient self-perceived referral concern did not reach 100%, indicating that in some visits PCPs elected to either not review the questionnaire or not explicitly address the referral concern. Although the intervention was associated with enhanced PCP recognition of patient referral concern, there was no effect on total number of referrals. We assessed the effect of the intervention on PCP recognition of patient self-perceived definite and possible need for referral (Figure). The intervention had its greatest impact in patients expressing a possible rather than definite need for referral.

Table 3 depicts patient-level outcomes in the 2 phases of the study. There was a very modest increase in patients rating their visit satisfaction at the highest level in the intervention phase compared with the control phase.

The mean ± SD duration of the observed visits in the control (24.1 ± 1.1 minutes, n = 86) and intervention (22.7 ± 1.2 minutes, n = 88) phases did not differ. Also, the percentages of patients indicating that they perceived that their PCP was “rushed” were comparable in the control and intervention phases: 3.7% and 2.1%, respectively.

... DISCUSSION ...

Up to 64% of unselected patients in a primary care setting have a self-perceived need for specialist referral,^{10-13,15} and this self-perceived referral concern is often not recognized by PCPs.^{11,13,17,18} In our previous study in a gatekeeper-model managed care environment, we found that patient self-perceived need for referral averaged 45%.¹⁵⁻¹⁷ Moreover, individual PCP nonrecognition of patient referral concerns ranged from 27% to 56%.¹⁷

There are significant implications of PCP failure to recognize and address patient referral concerns. For example, Kerr et al¹⁶ analyzed a large California managed care database and found that patients who wanted to see a specialist but did not were significantly less satisfied, wanted to disenroll, and were more likely not to recommend their plan to a friend than those who saw a specialist. Marple and collaborators¹⁴ found that residual desire for specialty referral was a powerful, independent correlate of lack of patient satisfaction 2 weeks after an ambulatory encounter (adjusted odds ratio, 2.9; 95% confidence interval, 1.5-5.4; *P* < .001). Finally, Grumbach et al⁴ reported that patients who had difficulty obtaining specialty referrals were more likely to have low trust in (adjusted odds ratio, 2.7), low confidence in (adjusted odds ratio, 2.2), and low satisfaction with (adjusted odds ratio, 3.3) their PCP.

In view of the implications of PCP nonrecognition of patient referral concern, we studied whether a simple intervention could improve this recognition. Previsit patient questionnaires have been used to describe patient concerns and desires, and the effects of these questionnaires on visit satisfaction have been described.^{11-13,19-24} These questionnaires have been valuable regarding characterization of length, content, and outcome of patient-PCP interventions.^{11-13,19-24} However, at least one of these studies¹² suggests that a modestly detailed questionnaire leads to more diagnoses discussed per visit, with significantly longer visit duration and decreased patient satisfaction.

Our study found that use of a brief questionnaire significantly increases PCP recognition of patient referral concerns. This recognition, however, still falls short of 100%, suggesting that even this simple intervention will not be uniformly used by busy clinicians. Our simple intervention increased PCP

Table 2. Effect of the Study Intervention on PCP-Related Referral Behavior

Variable	Control Phase (n = 781)	Intervention Phase (n = 714)	P
PCP recognition of patients expressing a referral concern, % of visits	61.4	80.6	<.001
PCP satisfaction with any referral discussion score, mean ± SD*	4.17 ± 0.03	4.10 ± 0.03	.09
Total referrals made, % of visits	27.7	27.4	.93
Referrals made when patient expressed no referral concern, % of visits	9.2	6.9	.10
Referrals made when PCP recognized patient referral concern, % of visits	74.3	63.8	<.05

PCP = primary care provider.

*Rated on a 5-point Likert scale. See the “Statistical Analysis and Definitions” subsection for more information.

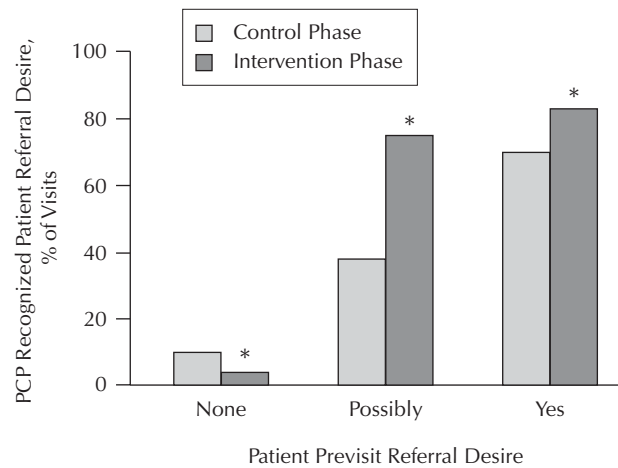
recognition of patient referral concerns, especially in patients who indicated possible rather than definite referral concerns. This confirms our previous observation¹⁷ that the strength of patient referral concerns is an important determinant of PCP recognition. Our intervention did not seem to have any negative impact on visit duration, patient perception of PCP being rushed, PCP satisfaction with the referral discussion, or number of referrals. The number of referrals in the intervention phase did not differ significantly compared with that in the control phase. We hypothesize that improved recognition of a referral concern leads to discussion of the symptom/concern and formulation of a treatment plan between the PCP and patient independent of referral. Longer-term studies using the referral questionnaire would be required to determine whether use of this instrument changes referral rates over longer periods.

It is more difficult to ascertain whether our intervention improved patient overall satisfaction. There are numerous determinants of overall visit satisfaction, and overall satisfaction scores were high in the control phase of the study. Nonetheless, we observed a modest percentage increase in patients rating their visit at the highest levels of satisfaction (4 or 5 on a Likert scale rated from 1 to 5).

There are some limitations to our study. Only a few PCPs in a single setting were studied. Thus, our results may not be generalizable. We did not differentiate between patient “desire” (what the patient wants) and “expectation” (what the patient feels they will get) because we asked about referral concern. Expectation rather than

desire has been demonstrated to affect patient satisfaction.¹¹ We used a simplistic instrument for measuring satisfaction and did not use any validated instrument that allows assessment of patient satisfaction with their physician or with their visit. Finally, we conducted a sequential before-after study rather than a randomized controlled trial. Given the nature of our study and the small number of PCPs involved, a randomized controlled trial could not have been done because PCPs would have quickly ascertained the nature of the intervention (see the

Figure. Effect of the Intervention on Primary Care Provider (PCP) Recognition of Patient Self-Perceived Referral Desire



*P < .05.

Table 3. Effect of Study Intervention on Patient-Related Outcome Variables

Variable	Control Phase (n = 781)	Intervention Phase (n = 714)	P
Patient rating of visit at highest Likert score (4 or 5), % of visits	62.3	68.6	<.05
Patient satisfaction rating, %			
Very unsatisfied	0.1	0.4	
Unsatisfied	0.1	0.1	
Neutral	5.8	2.8	
Satisfied	73.3	82.0	
Very satisfied	20.6	14.0	
Satisfaction rating, mean ± SD*	4.51 ± 0.03	4.57 ± 0.03	.19

*Rated on a 5-point Likert scale. See the “Statistical Analysis and Definitions” subsection for more information.

“Methods” section). Although other temporal trends could have produced similar findings, no other interventions by the clinic or the healthcare plan were instituted during the study. Thus, we believe that our results are reasonably accurate because our present and previous studies have demonstrated constancy in patient referral need and in PCP recognition of this referral need over several months.¹⁷

Several limitations also apply to our patient population. Data on the patient’s education and race/ethnicity were not collected, which may limit application of the results to other patient populations. However, data from a previous study¹⁷ indicate that healthcare professionals were not more likely to have a referral desire compared with non-healthcare professionals. Approximately 80% to 90% of patients approached during the control and intervention phases participated in the study; however, we did not collect data on the remaining 10% to 20% who declined enrollment. This subset may represent a population with different referral expectations. Also, we did not collect data as to type of visit, thus limiting interpretation of our results. Finally, exposing patients to a form requesting data on referral expectations could, per se, affect our results.

In summary, we found that using a simple intervention can increase PCP awareness of patient self-perceived referral concern. This intervention did not affect the total number of referrals or total visit duration and may have enhanced patient satisfaction. We recommend adding questions about referral concerns to the traditional new patient information sheet.

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Appendix.

<p>PATIENT PREVISIT QUESTIONNAIRE</p> <p>Thank you for taking the time to answer this questionnaire. This questionnaire will be used to provide confidential information to our clinic. Our goal is to improve the quality of your visit and your healthcare.</p> <p style="text-align: right;">Thank you, UMGP</p> <p>Please check the best answer.</p> <p>1. How much time do you EXPECT to spend with the doctor today?</p> <p><input type="checkbox"/> less than 10 min <input type="checkbox"/> 10-20 min <input type="checkbox"/> 21-40 min <input type="checkbox"/> 41 min - 1 hour <input type="checkbox"/> more than an hour</p> <p>2. How would you rate your OVERALL HEALTH?</p> <p><input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> good <input type="checkbox"/> very good <input type="checkbox"/> excellent</p> <p>3. I am WORRIED about my overall health.</p> <p><input type="checkbox"/> strongly disagree <input type="checkbox"/> disagree <input type="checkbox"/> not sure <input type="checkbox"/> agree <input type="checkbox"/> strongly agree</p> <p>4. AGE (in years):</p> <p><input type="checkbox"/> less than 20 <input type="checkbox"/> 20-39 <input type="checkbox"/> 40-59 <input type="checkbox"/> 60 or older</p> <p>5. SEX: <input type="checkbox"/> female <input type="checkbox"/> male</p> <p>6. Do you need a REFERRAL to a specialist today?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY <input type="checkbox"/> YES (stop here) (continue) (continue)</p> <p>STOP here if your answer is NO to question #6. Please return this form to the manila envelope labeled "PATIENT QUESTIONNAIRES" on the wall of the examination room. CONTINUE if your answer is YES or POSSIBLY.</p> <p>Please check the reason you need to see a specialist:</p> <p>7. I need to have a test or procedure done. <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>8. I need to be seen for ongoing care, treatment, or diagnosis. <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>9. I have tried other treatment plans that are not working. <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>10. I have a NEW medical concern/problem that I feel merits a referral. <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>10a. Please list your new concerns or problems:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>A. Study# _____ B. Date ___/___/___</p> <p>C. Dr. # _____ D. MA _____</p> <p>E. Ins: Tricare <input type="checkbox"/> Select <input type="checkbox"/> Gold <input type="checkbox"/> Blue Adv <input type="checkbox"/> Other <input type="checkbox"/></p> <p>F. V type: RPV <input type="checkbox"/> NPV <input type="checkbox"/> NAD <input type="checkbox"/> RAD <input type="checkbox"/> RGY <input type="checkbox"/> RHA <input type="checkbox"/> Other <input type="checkbox"/> ___/___</p>
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