

Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration (2022)

[Beyond the Referral](#) is an American College of Physicians position paper that makes recommendations for more effective collaboration between primary care and specialty physicians to improve patient care.

The below document is Appendix 1 of the position paper, an accompanying playbook that defines what is needed for each specific role or working relationship when more than one clinician is involved in the care of a patient.



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**An American College of Physicians
Position Paper**

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Appendix I: Playbook

Preface

The following playbook will define what is needed for each specific role or working relationship when more than one clinician is involved in the care of a patient. Ideally, these are in addition to the critical elements of a high value referral request and referral response as defined within the HVCC Toolkit. These include:

Critical Elements of a High-Value Referral Request:

- Prepared Patient
- Patient Demographics and Scheduling Information
 - Include any special considerations, such as language needs, vision/hearing/cognitive impairments, need for caregiver assistance, etc.
- Referral Information
 - Clinical question/detailed reason for referral
 - Summary of pertinent details
 - Patient goals
 - Urgency (referral priority status)
 - Supporting pertinent data
 - Referral type (role for SC)
- Patient's Core Data Set
 - Active problem list
 - Medical and surgical history
 - Medication list
 - Medical allergies
 - Preventive care (e.g., vaccines and diagnostic tests)
 - Family history
 - Habits/social history
 - List of providers (clinician and care team) (other specialists caring for patient)
 - Advance directives
 - Overall current care plan and goals of care
 - Any pain agreement; care management and/or behavioral health contacts
- Care Coordination/Referral Tracking
 - Referral request sent, logged and tracked, and acted on

Critical Elements of a High-Value Referral Response:

- Answer the clinical question/address the reason for referral—summary (include some thought process)
- Agree with or recommend type of referral/role of SC
- Confirm existing, new, or changed diagnoses; include “ruled out”

- Medication/equipment changes
- Testing results, testing pending, scheduled, or recommended (including how/who to order)
- Procedures completed, scheduled, or recommend
- Education completed, scheduled, or recommended
- Any "secondary" referrals made (confer with and/or copy PC clinician on all)
- Any recommended services or actions to be done by the PC clinician/PCMH
- Follow-up scheduled or recommended

It is also understood that all of the following specific roles abide by the fundamental principles, shared expectations, and critical or helpful elements defined in the preceding policy paper.

Cognitive Consultation

Definition: Formal consultation limited to one or a few visits or rounds of communication focused on answering a discrete question.

- A detailed report and discussion of management recommendations and anticipatory guidance is provided to the referring clinician. However, the SC clinician does not manage the problem on an ongoing basis.
 - Cognitive consultations can be via a direct assessment of the patient, or entirely as a direct clinician-to-clinician interaction.
 - Direct assessment of the patient can be carried out through a face-to-face in person visit or as a telehealth (video) visit.
 - Direct clinician-to-clinician interactions are usually in the form of e-consults.
 - An e-consult is an asynchronous communication between clinicians that occurs within a shared EHR or secure web-based platform consultation.¹

Principles:

- The SC clinician primarily provides expert guidance while the requesting/sending clinician is responsible for delivering care.
- A cognitive consultation includes a detailed discussion of management recommendations and anticipatory guidance.

Shared Expectations:

- Sending/PC Clinician and Care Team:
 - Provide a clinical question that is clear and specific.²
 - Are responsible for carrying out the SC clinician's recommendations as appropriate to the patient and practice context.
 - The sending clinician can indicate discomfort with taking on the recommendations (whether beyond their scope of practice or for other reasons). This can be remedied by:
 - More information and resources/explanations from the SC clinician.
 - Transition role in care to co-management with the SC clinician.

- Determine when the referral response is sufficient for concluding the consultation.
- For e-consults, review the consultation recommendations with the patient/caregiver either face-to-face, by telephone, or via the patient portal and ensures recommendations are enacted as appropriate or clarified if needed.
- If the e-consult communication platform is not automatically a part of the EHR, the requesting clinician is responsible to make sure the recommendations from the SC clinician and the referring clinician's follow-up are incorporated into the patient's medical record.
- Receiving/SC Clinician/Care Team:
 - For all cognitive consultations, the SC clinician should address the specific clinical question.
 - For face-to-face cognitive consultations with an in-person or telehealth encounter, the SC clinician should communicate recommendations to both the patient/family and the requesting clinician, whereas for e-consults, the SC clinician should communicate recommendations to the referring clinician who will then communicate with the patient/family.
 - The SC clinician can indicate that the case is too complex for a cognitive consultation and can propose a form of co-management for the condition.
 - Provide a consultation response note that guides the requesting clinician to take the next step in care when appropriate and provides an explanation of the recommendations to the patient/caregiver.
 - Face-to-face consult notes should include the elements in the HVCC Toolkit. E-consults should additionally include:
 - Review of the data provided and requests for clarification or more data as appropriate.
 - Make note of the amount of information available to the SC clinician on which the recommendations were based (e.g., "based on the information provided in the consultation referral" or "after review of the EHR")
 - Specific recommendations.
 - The reasoning behind those recommendations.
 - Anticipatory guidance around "if-then" scenarios, when appropriate.
 - Guidance on when to reconsult with the SC clinician or when a face-to-face visit with the SC clinician is indicated.
 - Instructions for how to handle follow-up questions.

If the requesting clinician is not the PC clinician, the SC clinician report should go to both the requesting clinician and the PC clinician.

- Patient and Family:
 - Express preferences or concerns about electronic interprofessional consultation vs. in-person consultation to the referring clinician and understand what your involvement will be. (Will the consultation require an appointment to meet with the SCC or will it be clinician-to-clinician only?)

- Understand what is the clinical question to be answered and why.
- Understand what specialty type and/or which SC clinician is being consulted.
- Understand that the SC clinician is being asked for advice and not to manage the care.
- Establish how you (the patient) will receive the results of the consultation.
 - Actively close the loop with the referring clinician if recommendations from SC clinician electronic (interprofessional) consultations have not been communicated to you within an established time frame.
- Find out what to do if you have questions and/or concerns.

Critical Elements:

- For e-consults, a secure platform to exchange information is needed.

Helpful Elements:

- Establishment of a cognitive e-consult virtual relationship.
 - For e-consults, use of SC clinicians who already have a strong relationship with the referring clinicians initially helps ensure the successful establishment of virtual care relationships.
 - Within a health care system, it is very useful to have agreement about best practices for the evaluation and management of common problems (e.g., subclinical hypothyroidism or headache). This would be subject to local control and specific to each system and practice area.³ Creation of standardized report formats is especially helpful for e-consults, to both identify them as potential e-consults and expedite the process.^{1, 4, 5}
 - Creation of standardized information sheets or infographics to help patients/family understand the nature of a cognitive consultation, especially for e-consults, to help manage expectations optimizing quality in cognitive consultations.
 - The ideal SC clinician for cognitive consultations is an excellent teacher and has the utmost respect for the referring clinicians.⁶
 - Consistency of cognitive consultation requests to a SC clinician in a given referral catchment area allows for the development of a relationship between referring clinicians and SC clinicians if it does not already exist.
 - An ongoing system of easy and real-time feedback between clinicians on the adequacy of referral information and usefulness of the consultative response allows for continued improvement.⁷ This can be done via formal rating but can also be done through the dialogue itself.⁵
 - With most care situations, access to shared medical records (interoperative EHR or and health information exchange) is important but is even more crucial with e-consults. Without access to the full medical records, the SC clinicians do not otherwise have the opportunity to fully complete the history as one would with a face-to-face consultation with the patient.

Illustrative Cases

Request for Unspecified Cognitive Consultation:

A PC clinician notes that her patient's potassium level has remained elevated despite some initial management steps. She sends a referral request for a cognitive consultation, indicating no specific preference for e-consult vs. in-person consultation. She provides a clinical question along with the pertinent history that this is a 64-year-old male with history of hypertension, supraventricular tachycardia (SVT), alcohol misuse in sustained remission, now with serum potassium levels of 5.2 to 5.3 mEq/L, despite discontinuation of angiotensin-receptor blocker therapy. He has no history of chronic kidney disease (eGFR >60 mL/min/1.73 m², but blood urea nitrogen 23 mg/dL), and this is a new problem. Serial laboratory results for potassium were as follows: 23 October 2020, 5.2 mEq/L; 3 February 2021, 5.3 mEq/L; and 16 February 2021, 5.3 mEq/L. He was previously on losartan, 50 mg daily, for many years for hypertension. On 4 January 2021, hydrochlorothiazide, 12.5 mg, was added for blood pressure and to help lower serum potassium. On 4 February 2021, losartan was discontinued and hydrochlorothiazide was increased to 25 mg daily. What are your recommendations for further work-up and management of the hyperkalemia?

The SC nephrologist reviews the referral request and sends an e-consult response that clearly answers the question and provides some anticipatory guidance about need for subsequent in-person cognitive consultation as follows: "Thanks for the consultation. After brief review of his chart, it is interesting that he never had an issue in the past with hyperkalemia (serum potassium values between 2016 and 2019 were all within normal limits). This may have been masked from poor nutrition in setting of alcohol misuse, for which he is now in remission. As a first step, I would ensure that he is not taking any over-the-counter nonsteroidal anti-inflammatory drugs (NSAIDs) for chronic pain (noted in a recent PC clinician note), as these can cause hyperkalemia, especially if volume depleted at the same time. Next, if NSAID use not the cause, I would obtain some urine studies to evaluate whether this is a problem with renal handling/excretion of potassium. This is not urgent given his mild hyperkalemia, but at your/his next convenience, please obtain the following:

- Serum renal panel
- Serum osmolarity
- Serum creatine kinase (CK) (unlikely to be an issue but I note that he is on a statin, so would be good to rule out rhabdomyolysis, especially since he has a slightly elevated creatinine since 10/2020)
- Serum renin-aldosterone ratio
- Spot urine sodium (Na), potassium (K), chloride (Cl), creatinine, and spot urine osmolarity

Let me know when those are back and when you clarify the NSAID history so that I can help guide with next steps. If there is evidence of poor renal excretion of potassium, then best if he sees a nephrologist in person for a few visits to initiate management."

The PC clinician discusses the recommendations with the patient, confirms he has been taking over-the-counter NSAIDs on a frequent basis and rarely drinks water during the day. She works with him to find alternative ways to manage his

chronic pain, encourages better hydration and schedules a follow-up check of the potassium level in 4 weeks.

Cognitive Consultation by E-Consult:

48-year-old-male is new to the PC clinic. He has a remote history of thyroid cancer and was getting yearly neck ultrasonography but missed most recently due to other demands. Current laboratory results show he is thyrotoxic with a thyroid-stimulating hormone (TSH) level <0.01 mU/L and a free thyroxine (T₄) of 1.89 ng/dL on levothyroxine, 200 mcg daily, suppressive therapy. The PC clinician received his outside records with his transfer of care. The PC clinician requests an e-consult with endocrinology with clinical questions: What ongoing testing and care does this patient need for his history of thyroid cancer? Does he still need an annual neck ultrasound? Should we reduce his dose of levothyroxine? The past records and current laboratory results are available in the shared EHR. (Though otherwise they could have been sent with or attached to the e-consult request.)

The SC endocrinologist reviews the records and sends a response with recommendations the next day. The response indicates "I was able to review the outside records including the surgical pathology report, ultrasound reports and most recent endocrinology notes. Thanks for getting those. I see he had a total thyroidectomy in 2007 for a 1.2-cm papillary thyroid cancer with no high-risk features and no positive lymph nodes. He was treated with 100 millicurie (mCi) of I-131. Subsequent neck ultrasound studies have all been negative (including most recently in 2019) and he has had repeatedly undetectable thyroglobulin in the past. He received a more aggressive treatment with the radioactive iodine than we would currently do for a low-risk papillary thyroid cancer. He is over 10 years out from his initial surgery and follow-up studies have shown no evidence of persistent or recurrent disease. Therefore, there is no reason to continue with levothyroxine suppression. I would recommend decreasing his levothyroxine dose with an ultimate goal TSH level of between the lower limit of normal to 2 mU/L. Once you are at the goal TSH, I would check a thyroglobulin. If it remains undetectable, there is no need for further ultrasound. You can continue to check a yearly thyroglobulin. If it is detectable or increases in the future, please re-refer and we can see if an ultrasound would be warranted at that time. Also please re-refer if you notice any new mass or lymphadenopathy on exam. In addition, if the annual thyroglobulin remains negative, please check back since thyroid cancer guidelines are constantly being updated and further ongoing monitoring may be determined to be unnecessary. And of course, let us know if he or you have any questions.

The PC clinician reviews the recommendations with the patient, titrates down the levothyroxine and checks thyroglobulin, which remains undetectable. The PC clinician then explains the good news that he has no evidence of any cancer remaining or recurring and based on that there is no longer a need for annual neck ultrasonography unless a new problem arises.

Face-to-Face Cognitive Consultation:

A 35-year-old man with obesity presented to his PC clinician with symptoms of fatigue and low libido. His PC physician completed evaluations for depression, thyroid dysfunction, and obstructive sleep apnea. The patient had no depression or thyroid dysfunction. Continuous positive airway pressure was prescribed for treatment of newly diagnosed obstructive sleep apnea and the patient tolerated

this well. Six weeks later, symptoms persisted. The PC clinician checked a total and free testosterone, follicle-stimulating hormone, and luteinizing hormone. All of these values came back low, and after discussion with the patient, the PC clinician put in a referral to an endocrinologist. The PC clinician's office used a standardized referral report, which included recent clinic notes, relevant laboratory results, and a clear request for the specialist to evaluate the patient, complete any needed laboratory work-up, and convey recommendations back to the PC clinician for further management. The specialist completed additional laboratory tests and imaging, which revealed no additional contributors to the hypogonadism outside of obesity. The specialist's report back to the PCP acknowledged that this was a cognitive consultation. The report described the salient aspects of the history, work-up, and interpretation of the laboratory results. The primary recommendation was for weight loss to improve gonadal function, with a suggestion to re-refer should there be no improvement with weight loss, or if medications to support weight loss were of interest after a period of lifestyle change, diet, and exercise.

Discussion/Explanation:

Cognitive consultations involve a SC clinician in an episode of care that either includes a patient visit to the SC (face-to-face or virtual) or proceeds directly between clinicians (e-consult). The SC clinician role is mainly to provide guidance for ongoing care by the PC clinician. For e-consults, it is critical to have a clear clinical question and provide sufficient historical information, because the SC clinician will not have the opportunity to clarify details with the patient before offering recommendations. E-consults offer an educational opportunity for PC clinicians.⁸ E-consults also improve timely access to SC expertise while avoiding unnecessary patient travel and potentially improving access in clinics to patients requiring face-to-face evaluation.¹

Procedural Consultation

Definition: A procedural consultation is requested by a referring clinician to a procedural consultant to consider performing a technical medical procedure for purposes of screening, to aid diagnosis, cure a condition, identify and/or prevent new conditions, or palliate symptoms.⁹ It is an episode of care that includes the SC clinician's responsibility to evaluate the need for the procedure, assess risks and benefits, obtain patient informed consent, perform the procedure safely, and provide timely communication of procedure findings.

Principles:

- The referral for procedural consultation can be requested by a PC practice/clinician (PCC) or by a SC clinician (SCC) to a specialty procedural clinician (SPC) for a diagnostic or therapeutic procedure. This is a request for an episode of care that encompasses all periprocedural care.
- A request for a procedural consultation may or may not require initial cognitive consultation (face-to-face or e-consult) before the procedure, to help determine the appropriateness of the procedure for the given patient, condition, and/or clinical context.
- Clarity around who (which clinical team) will be responsible for components of the patient's periprocedural care is critical. This includes management of the underlying condition, any comorbidities, and any

- procedure-related management such as pain control. It addresses pre-procedure preparation as well as intra- and postprocedural care.
- The procedural consultant ensures that the benefits of a procedure outweigh its risks, assesses potential therapeutic alternatives, and then if indicated, safely executes the procedure, and communicates results to the referring physician and patient.
 - It does not include ongoing care/co-management, but co-management by the clinician performing the procedural consultation can be requested as a subsequent role in care. The request for this subsequent role can be made at the time of the request for the procedural consultation or after the results of the procedure are determined. A request for a subsequent role in care to help manage/co-manage the condition can be to the same SPC or to another clinician.

Shared Expectations:

- Agreement exists as to how both procedure-related care and concurrent medical issues are to be managed periprocedurally and postprocedurally and by whom.
 - It is crucial then, that the PCC and the SCC proceduralist each have a clear understanding and agreed-on expectation of the role each is to play in the patient's care. These roles will vary with not only factors related to the patient and the condition, but also with the exact procedure being contemplated and performed.
- Sending/PC Clinician and Care Team:
 - Ensure procedure is appropriate before referral request for the procedure—may require preprocedure (cognitive) consultation with SCP
 - Clarify indication and goals
 - Ensure patient goals are considered and patient/family understand the expectations and the limitations of the procedure
 - Provide information in addition to the elements of a high-value referral request
 - Any information about the patient's intellectual, emotional, or social situation, including their ability to understand the risks of the condition and the procedure, that may help the clinicians work more effectively with the patient
 - Information about other clinicians with relevant management roles (e.g., PC clinical referring patient with type 1 diabetes mellitus on insulin pump co-managed by endocrinologist; patient with coagulopathy managed by hematologist, etc.)—also who should notify these relevant clinicians—the requesting clinician, the proceduralist, or the patient
 - Known risk factors for complications from the procedure and/or any anesthesia or sedation
 - Relevant updates on changes in the patient status in interim between referral and the procedure and/or after the procedure
 - Indicate preferences and/or limitations regarding providing care
 - What conditions/issues they will manage perioperatively (or who will manage; see above) or if need someone to manage, such as patient going to remote location for procedure
 - Are responsible for addressing SCP recommendations

- Or indicate if prefer SCP to assume subsequent co-management role based on findings
 - Responsible for addressing reported secondary findings
- Patient and Family:
 - Clarify patient goals for the procedure
 - Express any concerns and questions clearly
 - Are an active participant in stating preferences (e.g., “I want to select the physician that I will work with for any postprocedure ongoing care”). Do not assume others know what you want.
 - Clarify pain management protocols for during and after the procedure and discuss any concerns
 - Offer suggestions specific to your personal situation, communicate your “ideal vision” of how things will go to see what can and cannot be accommodated, recognizing there are limitations (e.g., “In my experience, this is what helps/what works for me to tolerate procedures, if possible”)
- Receiving/SC/Specialty Procedural Clinician and Care Team:
 - Ensure procedure is appropriate
 - Elicit patient goals and ensure understanding of expectations and limitations.
 - If open access scheduling option, criteria for using open access processes should be transparent to the PCC and should contain hard stops that suggest a prior cognitive consultation, either by an in-office patient visit or by e-consult. The goal is to address in advance all patient care issues that will be critical to patient outcome and avoid procedural requests that are contraindicated for a given patient.
 - Clarify roles (who will do what) regarding periprocedural care
 - Are responsible for informed consent
 - Explain the proposed procedure in understood language to the patient with current benefits, risks, alternatives, and current limitations—shared decision-making approach
 - Ensure that the benefits of a procedure outweigh its risks and assesses potential therapeutic alternatives.
 - Perform procedure safely
 - Provide timely communication of procedure findings to both referral clinician and patient (and to PC physicians if PC physician is not the referring clinician)
 - Procedure report
 - Description of procedure and findings
 - Interpretation of results
 - Intraprocedural events or complications
 - including anesthesia events
 - Postprocedural events
 - Secondary findings/diagnoses
 - Recommendations
 - Direct communication of any urgent issues
 - Ensure the patient receives a report in an understood format (verbal and/or written)

Critical Elements:

- Shared decision making is made with the patient/family.
 - Indications for procedure: SPC confirms that the patient's expectation is the same as the PC reason for referral for the procedure.
 - Risks, contraindications, and alternatives to the procedure clearly shared with patient.
 - Patient goals clarified and negotiated.
 - Patient is given the ability to make an informed decision on their path forward.
 - Procedure to be performed is mutually agreed on by patient, SPC primarily.
- Comorbidities/conditions are identified with the patient's confirmation and plan for peri-procedural medical clearance or further imaging is clearly agreed on between SPC and patient. This plan is clearly conveyed/communicated to PC physician.

Helpful Elements:

- Referral request instruments that guide PCCs in requesting appropriate referrals via imbedded decision support with hard stops that avoid contraindicated referral requests.
- Specialty-specific guidelines for patient evaluation and referral imbedded into the patient EHR for quick point-of-care referral by the PCC.
- An option with the initial request for the PC/requesting clinician to indicate if they want the SPC to assume co-management of a condition identified during the procedure (see discussion/explanation)

Illustrative Cases

Preprocedural Cognitive Consultation:

A 24-year-old female has her annual Pap smear with her PC. Her Pap smear reveals high-grade intraepithelial lesion of the cervix. Her PC sends a referral request for procedural consultation to SC gynecologist for potential diagnostic excision procedure, also alerting the SC gynecologist that the patient is concerned about her desire for future pregnancy. The SC gynecologist reviews her records and schedules an in-person consultation appointment. The SC gynecologist and the patient decide together to avoid the excision procedure and instead follow the patient every 6 months for a PAP smear and colposcopy. The SC gynecologist notifies PC of this decision. The patient sees PC 8 months later for a sore throat. The PC reminds patient she is overdue for her Pap and colposcopy with SC gynecologist. Patient makes her follow-up appointment.

Surgical Procedure:

A 49-year-old female sees her PC to follow-up for her chronic pain and opioid management and reports her menstrual cycles seem to be becoming heavier and last longer. The PC physician orders a complete blood count and a pelvic ultrasonography, which confirm iron deficiency anemia and a small submucosal fibroid. A referral is made to SC gynecologist for potential hysterectomy.

The SC gynecologist reviews referral and schedules the patient to discuss potential surgery. At the consultation appointment, the patient expresses her desire to proceed with total hysterectomy and the surgery is scheduled. The SC

gynecologist decides with the patient that it is most appropriate for the patient to consult with her PC physician regarding postoperative pain management. The patient makes a preoperative appointment with her PC to create a plan for and receive appropriate prescriptions for her pain management.

Diagnostic Procedure:

A 36-year-old woman with persistent diarrhea is referred to a SPC for a colonoscopy. Her PC clinician had done the recommended testing for stool cultures and celiac panel, and these were negative. The patient and PC clinician discuss the possibility of inflammatory bowel disease and the likely need for SC help in managing the condition. The referral to the gastroenterology practice requests both the diagnostic colonoscopy and management if inflammatory bowel disease is confirmed. The colonoscopy reveals ulcerative colitis. The SPC sends a copy of the report to the PC clinician along with a note indicating the assumption of principal care co-management of the ulcerative colitis. The SPC schedules a follow-up appointment with patient to discuss the findings and establish a treatment plan, using shared decision making as part of the process.

Diagnostic Procedure:

A 71-year-old woman has had persistent iron deficiency anemia and is referred to a SPC for a diagnostic colonoscopy. The referral request is for the diagnostic procedure with the request for the SPC to notify the patient and PC clinician of any findings before any subsequent management or referrals. The SPC notes a large colonic tumor in the right colon during the procedure. The SPC calls the PC clinician with the results. The SPC discusses the results with the patient and her partner. The PC clinician arranges a follow-up visit with the patient the next day to arrange for referral to a surgeon and oncologist.

Diagnostic Procedure:

A 67-year-old man is referred to urology for cystoscopy because of microscopic hematuria. His PCC followed the urology clinic's referral guidelines by obtaining a midstream urine specimen to confirm the hematuria before the referral. Because of co-existing diabetes and cardiovascular disease, the urology clinic, at the time of scheduling, informs the patient and the PCC that antibiotic prophylaxis is recommended within 1 hour of cystoscopy and provides instructions for the PCC to provide the antibiotic prescription to the patient.

Cystoscopy revealed no significant urologic findings. The urologist (SCC) provides a report of the evaluation to the patient and PCC explaining that the patient has idiopathic microscopic hematuria and recommending a plan for follow-up. Communication is given to the PC clinician to recheck microscopic urinalysis annually. If 2 consecutive annual urinalyses are negative, no further urine testing is needed. For persistent or recurrent asymptomatic hematuria, consider urine cytology, and consider repeat evaluation in 5 years, especially in patients with a smoking history or family history of bladder or kidney cancer.

Discussion/Explanation:

Some procedures are for screening purposes, some diagnostic, some therapeutic, some palliative. A screening or diagnostic procedure might reveal a condition that then needs either an additional procedure or procedures (such as the need for surgery after a biopsy) or a condition that requires SC co-management (such as the finding of inflammatory bowel disease during a colonoscopy). The patient/family and requesting/PC clinician may or may

not prefer the same SC clinician who performed the screening or diagnostic procedure to perform the next procedure or to assume co-management of the condition. This will likely depend on several factors, including those related to the condition, to the SC clinician, to local culture and local facilities, and to the patient and patient preferences.

A PC clinician may want to establish a standing agreement with a SPC that whenever a patient is referred to that SPC for a screening or diagnostic procedure that the PC clinician intends for that SPC to also assume management of any identified conditions. Or a PC clinician may establish a standing agreement for only certain procedures or certain diagnoses/conditions. However, many PC clinicians and/or patients and families may indicate a preference to receive and review the findings from the initial procedure and then determine next steps, including selection of a SC clinician for any subsequent roles in care. This can be addressed at the time of the initial request for the procedural consultation by including an indication such as

- I am referring the patient for a procedural consultation for XXX. Please also assume management of any condition diagnosed with the procedure.
- I am referring the patient for a procedural consultation for XXX and prefer to determine next steps with the patient before any subsequent management.

Co-Management With Shared Care

Definition: A SC clinician shares long-term management of a referred disorder or set of disorders with a PC clinician (or other requesting clinician) for a patient's referred health condition, with the PC clinician providing a medical home, serving as the first point of contact, and assuming most responsibility for the elements of care for the co-managed disorder, along with the SC clinician providing intermittent input as needed for the disorder or set of disorders. Input from SC can be provided directly to the requesting clinician (e.g., via telephone or e-consult) and/or may require intermittent in-person assessment of the patient via a televisit or clinic visit.

Principles:

- PC is responsible for all or most elements of care for the disorder or set of disorders that is being co-managed with shared care, while SC remains engaged, updated, and provides input/recommendations, contributing to the management of the same disorder or set of disorders.
- Mutual/two-way information sharing in a consistent timely way is critical for co-management by shared care to be effective.

Shared Expectations:

- Sending/PC Clinician and Care Team:
 - Provide the elements of a high-value referral request
 - Take the lead in providing patient's care, including responsibility for the elements of care for the disorder or set of disorders being co-managed by shared care:
 - Order needed tests
 - Prescribe necessary medications
 - Arrange indicated consultations
 - Are the first point of contact for the patient/caregiver

- Communicate results and changes in the plan/patient's condition to the SC clinician, including:
 - All relevant laboratory, imaging, and/or other diagnostic or monitoring data
 - Changes in patient's status
 - Specific patient/caregiver goals
 - Clinician limitations or preferences regarding providing care
- If communications from SC use a separate platform, the PC team is responsible for incorporating these into the patient's medical record.
- Receiving/SC Clinician and Care Team:
 - Provide clear recommendations and expert guidance, including anticipatory guidance for common scenarios.
 - Clearly indicate what steps the requesting clinician needs to take and what the SC clinician will be handling.
 - Are available to provide ongoing care as needed, including with face-to-face visits (in-person or televisits) with the patient or clinician-to-clinician interprofessional consultations (synchronous or asynchronous).
 - Advise when the patient's care needs to be delivered via a different model (e.g., SC needs to assume principal care co-management for the condition, or the condition no longer requires SC co-management assistance and can be transitioned to PC for management).
- Patient and Family:
 - Work mainly through your PC team for monitoring of the condition, medication adjustments, refills, etc.
 - Clarify when and how to contact the SCC or team
 - Clarify the anticipated duration of the co-management with shared care arrangement and the expectation for what needs to happen for SCC input to no longer be necessary.

Helpful Elements:

- Guidance from SC clinician regarding what conditions are best suited to shared care.

Illustrative Case

Iron Deficiency–Co-Management

A 55-year-old woman presents to her PC clinician with fatigue and dyspnea and was found to have anemia with hemoglobin 8.5 g/dL, MCV (mean corpuscular volume, measures blood cell size) 72 fL and ferritin (blood protein that contains iron) 4 mcg/L. She was started on iron supplements but cannot tolerate them due to significant gastrointestinal upset. Referral was made to a hematologist who arranged for infusions with iron sucrose and suggested co-management with shared care. With the iron infusions, the patient's symptoms improved, and follow-up laboratory tests were ordered by the PC clinician, which showed hemoglobin 11.4 g/dL, retics 4% of total red blood count, and ferritin 200 mcg/L. The hematologist recommended that PC obtain a gastroenterology consultation for cause of the iron deficiency and that work-up showed an arterial venous malformation in the stomach, which was cauterized. Three months later the PC

clinician repeats the tests, with results showing hemoglobin 12.0 g/dL and ferritin 50 mcg/L. The results are shared with the SC/hematologist who recommends ongoing monitoring. Six months later the patient's fatigue and dyspnea return, and laboratory testing shows hemoglobin 9.0 g/dL and ferritin 5 mcg/L. Stool guaiac again positive. The hematologist is contacted and again arranges for iron sucrose infusions for the patient. The patient continues to be monitored by the PC clinician. Two years later iron deficiency anemia recurs. The hematologist provides the iron infusions and recommends that the gastroenterology evaluation be repeated, which again shows arterial venous malformations.

Discussion/Explanation:

This role in care is currently a less recognized and used option. It provides an "intermediate" option between the principal responsibility for the management of a condition residing completely with the PC clinician or completely with the SC clinician. In a co-management with shared care option, both the PC and SC "share" in the management of the same condition, with PC responsible for administering the elements of care and SC responsible for advisory input and/or recommendations based on ongoing involvement via updates from PC and, if needed, occasional direct assessment of the patient via face-to-face clinic visit or televisit. This role in care can be a "step down" from SC principal care co-management of a condition to shared care or a "step up" from a SC cognitive or procedural consultation role when some ongoing involvement of SC is desired.

The American Psychiatric Association's Collaborative Care Model for shared care co-management of behavioral and mental health conditions by a psychiatrist working with a PC team provides a nicely operationalized example of shared-care co-management.¹⁰

Co-Management With Principal Care of a Disorder or Set of Disorders

Definition: Both the PC and SC practice are concurrently active in the patient's ongoing/long-term/chronic (not just an episode of care) treatment (thus the term "co-management"), with the SC practice taking responsibility for the elements of care for a discrete disorder, set of disorders or set of problems for which they provide ongoing follow-up and management while PC continues to serve as the hub of care for the patient, managing other chronic, preventive, and acute issues.

Principles:

- All parties (PC clinician, SC clinician, patient/family) mutually agree on the disorder or set of disorders for which SC will provide care as principal co-management.
- SC clinician and team assume full responsibility for elements of care for the agreed on disorder or set of disorders and takes "first call" (primary contact) for the condition(s) they are managing.
- The PCC will manage other conditions, usual preventive care, and urgent care not related to the disorder or set of disorders being co-managed as principal care by the SC team.
- There is adequate on-going, two-way information sharing and communi-

ation between teams to ensure that each team knows what the other is doing and avoids unnecessary duplications or omissions.

Shared Expectations:

- Sending/PC Clinician and Care Team:
 - Provide information in addition to the elements of a high-value referral request
 - Should indicate at the time of referral the specific disorder(s) and which associated aspects of care that they want specialist to handle, especially in the case of patients with complex conditions (e.g., for a patient referred for principal care of diabetes—does PC want SC to manage only glycemia or also blood pressure and lipids).
 - Should indicate if they want all secondary referrals to go through their office or indicate which types of secondary referrals that they prefer the SC clinician to make to expedite management of the co-managed disorder or set of disorders.
- Receiving/SC Clinician and Care Team:
 - Should confirm with both patient and PC clinician which disorders they are managing.
 - Should explain to patient/family which issues they should contact the SC team with as well as how to best to contact them and when (urgent vs. routine).
 - Take the lead in providing patient's care, including responsibility for the elements of care for the disorder or set of disorders being co-managed by principal care:
 - Order needed tests and communicate results to patient/family.
 - Prescribe necessary medications and other treatments.
 - Obtain prior authorizations for treatments and tests ordered by the SC practice.
 - Provide appropriate related support and education for the patient/family.
 - Are the first point of contact for the patient/family for the defined disorder or set of disorders.
 - Communicate results and changes in the plan/patient's condition to the PC clinician, including:
 - Specific patient/caregiver goals
 - All relevant laboratory, imaging, and/or other diagnostic or monitoring data
 - Changes in patient's status or treatment plan
 - Timely notification of changes to the patient's status, condition, or treatment that necessitate a change in something that the PC clinician is managing (e.g., addition of glucocorticoid that will affect what is needed to manage diabetes)
 - If communications from PC use a separate platform, the SC team is responsible for incorporating these into the patient's medical record.
 - May make appropriate secondary referrals for additional care related to the condition(s) they are managing, such as referral to other specialties or services (PC team should be informed that referrals have been made) as agreed on with the referring clinician.

- Need to be aware of and honor PCP's preferred referral network or if PCP prefers that all secondary referrals go through their office.
 - Patient preferences regarding the secondary referral should be solicited and honored.
 - Any disputes or disagreements around secondary referrals should be handled by telephone call.
- Both Specialty and Primary Care Teams:
 - Understand how the ongoing co-management is being defined with clear understanding by both the SC and PC teams as well as the patient and/or caregiver understanding of who is doing what.
 - Will share pertinent information about the care they are providing with the other team(s) and ensure informing each other when there is:
 - change in patient status or
 - need for further action, to include secondary diagnoses that come to light during ongoing co-management.
 - Should provide both the other team and the patient with a medication list that includes any changes that have been made.
 - Should be prepared to facilitate hand-offs if patients contact their office about an issue being handled by the other.
 - Patient and Family:
 - Be informed on who to call for what and follow these guidelines (not calling the SCC for issues that PC should be attending to or vice versa).

Illustrative Case

Co-Management With Principal Care of a Disorder or Set of Disorders:

A 62-year-old male with type 2 diabetes previously managed by diet and exercise returns to see his PCC after several years with no follow-up. His hemoglobin A_{1c} is 11.6%, blood pressure 168/100 mm Hg, creatinine 1.3 mg/dL, and urinary microalbumin-creatinine ratio 50. There is hyperlipidemia and elevation of alanine aminotransferase, and he complains of burning in his feet that is keeping him awake at night. A retinal image is obtained and sent to the contracted ophthalmologist. The PCC reviews his/her concerns with the patient and together they agree that endocrine assistance would be helpful. The PCC sends a referral request to the endocrinologist specifying that the endocrinologist assume principal management for glycemic, lipid, and blood pressure management to determine what medications are most appropriate and effective given the developing complications and comorbidities. The request indicates that the patient and PCC would prefer that once an effective care plan is established and the patient is stable, that the management be transitioned back to the PCC. The SC endocrinologist reviews the situation with the patient and clarifies what the patient's concerns and goals are, learning that the patient is especially concerned about avoiding a future amputation as well as dialysis. The SCC discusses what is needed to help avoid these issues and uses shared decision making to help select initial medications. The SCC prescribes these medications and monitors appropriately to see if they are both effective and well tolerated. The patient is also referred for diabetes education. The SCC explains that the patient should contact the endocrine practice for any concerns regarding these prescribed medications or side effects as well as with any issues with blood sugars or blood pressure. Regular follow-up with the SC team is

established with a report sent to the PCC after every visit. In the interim, the patient develops a severe bout of gout and treatment with NSAID and/or glucocorticoids is considered. The PC clinician calls the SC to alert them and discuss options that will be the least disruptive to the patient's other conditions. The SC team calls the patient to let them know that they are aware that he will be taking some medication for the episode of gout and asks him to let them know if his blood sugars or blood pressure exceed a certain level. After several more months and trials on different medications, they have found a combination on which the patient is doing well with hemoglobin A_{1c} of 6.9%, blood pressure of 120/80 mm Hg, and low-density lipoprotein cholesterol of 95 mg/dL. The SC and patient discuss that they have reached the point where management can be returned to the PC team.

Discussion/Explanation:

A key issue for principal care co-management is defining the extent of what SC is asked to manage and take responsibility for. For example, with a referral for principal care co-management for diabetes, it would be important to clarify if SC is to assist only with glycemia or if assistance is also desired for any diabetes-associated conditions, such as neuropathy pain, hypertension, and/or dyslipidemia, and to clarify which care team will ensure any needed diabetes-related screenings (such as diabetes eye examination, urinary microalbumin-creatinine ratio, foot examination).

Also, two-way updates, not just from SC to PC but from PC to SC, are essential for effective and safe principal care co-management. Even if there is a change in another aspect of health (not the condition managed by the SC clinician), it is important for the SCC to be notified as this impacts the overall patient well-being and health status and might also impact the management of the condition (e.g., glucocorticoid treatment of another condition in a patient with diabetes; cancer diagnosed in a patient with coronary artery disease, end-stage renal disease, diabetes, lupus, etc.).

Co-Management With Principal Care of a Consuming Illness

Definition: A consuming illness (CI) is a critical illness or a worsening of a chronic condition of high acuity that requires continuous care by a single SC clinician and care team. Often CIs are life-threatening events or are chronic illnesses characterized by intermittent life-threatening exacerbations. A CI becomes the highest priority of need for the patient's medical well-being and survival. Examples of a CI include care in preparation for and acute follow-up after a transplantation, care during chemotherapy, or an exacerbated state of a medical illness (e.g., Crohn disease or congestive heart failure).

During co-management with principal care of the patient for a CI for a limited period, the SC team managing the CI (SC-CI team) may need to provide not only the elements of care required to manage the condition but also temporarily become the patient's point of first contact for care because of the significant nature and impact of the disorder. The SC clinician serves as first contact, but the patient retains their PC clinician as medical home.

Principles:

- A single SC team (SC-CI team) should have primary responsibility for care coordination. It is a critical function to establish a team lead (SC-TL). While

anyone across the spectrum of care can be the team lead, the clinician managing the CI is leader of the care team during the CI.

- The SC-CI team assumes the lead for the elements of care and for overall first contact for the patient, not just for the disorder, until the CI resolves or abates.
- The patient's PC clinician and care team and other SC clinicians and care team members should be updated, consulted, and/or involved in care when appropriate to maintain care continuity. No clinician is expected to practice outside their scope emphasizing the importance of timely and effective communications between SC-CI team and SC and PC teams.

Shared Expectations

- Once a CI that requires principal care co-management by SC is identified, the appropriate SC team lead will need to be established.
 - See comments below (under explanation) regarding various routes of referral for CI
- PC Clinician/Care Team and Other "Preexisting" (SC) Clinicians:
 - The patient's preexisting clinicians and care teams should be willing to provide information to the SC-CI team/SC-TL and any other clinicians assisting in the care of the patient (e.g., patient on dialysis referred for management of cancer and another nephrologist needs to assist with dialysis during the CI, the patient's original nephrologist should provide needed information).
 - Including mental health and behavioral health condition and clinicians.
 - Collaborative information sharing from PC and other SC team members will improve the quality of decision making around goals of care throughout the CI and at the end of life.
 - Resume care after the CI has resolved:
 - PC clinician/team resumes the general role of overall management, care coordination and first contact.
 - Preexisting SC clinicians resume or continue their role in care for co-management of co-existing (noncritical illness) conditions (comorbidities) unless modifications are required due to changes in condition(s) or patient status.
 - Resuming management of the condition underlying the critical illness will depend on the status of that condition:
 - If the condition was a preexisting chronic illness co-managed by a SC clinician who became the SC-TL during the CI, the role in care for that SC clinician can transition back to co-management with principal care of the disorder (e.g., Crohn disease).
 - If the condition was a preexisting chronic illness co-managed by a SC clinician who transitioned care to a different SC-TL during the CI (e.g., patient with cirrhosis/end-stage liver disease having for a liver transplant), transition back to the original/preexisting SC may or may not be required. The patient/condition may instead need follow-up with the new team for co-management via shared care or principal care of the disorder (e.g., transplant check-ups).

- If the CI condition was a newly diagnosed condition, the appropriate follow-up depends on the status of the condition after the CI has abated whether any SC co-management is still required. Decisions regarding follow-up should be discussed with the PC clinician.
- SC-TL and/or SC-CI Care Team:
 - Will be first call (patient contacts them first for any concerns) and will manage the elements of care for the CI.
 - Distinguish principal care of the patient from principal care of a disorder; in these principles, the SC-CI team assumes both.
 - Will establish with the patient/family a clear understanding of who is to be called for urgent care.
 - Will notify other clinicians involved in the patient's care (the patient's "preexisting" clinicians/team) of the CI and the SC-TL for the CI.
 - Will establish best methods of contact for all parties.
 - Will communicate with the patient's PC and other SC team members regarding the most appropriate arrangements for co-management of any non-CI conditions (during the interim of CI).
 - If the PC or other SC clinicians are not comfortable with the complexity or other demands of managing these conditions during the CI if it is geographically not feasible or if insurance coverage and/or regulatory requirements mandate specific clinicians, then the SC-CI care team will take on the responsibility of arranging for the needed consultations and/or co-management.
 - Will communicate with the patient's PC and other SC care teams (including surrogate decision makers) for additional information and existing and evolving decision making around goals of care, especially at the end of life.
 - Will coordinate with insurance/payers (third-party case manager) to safeguard against financial toxicity risk for patient and practices involved in care of patient with CI.
 - Will communicate with PC and other SC team members regarding significant change in status of the patient's condition and evolving major medical/life events.
 - Where feasible, it is expected that the PC or SC team members will be involved in decision making and/or care when appropriate.
 - PC must be kept informed of patient's status and evolving health care needs.
 - The SC-CI team should inquire regarding the preference of the PC and other relevant SC clinicians regarding shared information to define optimal delivery, frequency, and content (for example, whether they prefer to receive status reports vs. every detail of results).
 - Communications need to be stratified by action/non-action and level of acuity.
 - Treatment summaries and care plans as part of standard practice can be a communication tool from the SC-CI team to the PC and any other SC team(s). These tools have been used successfully in oncology and should be considered a standard of care.
 - Discharge from SC-CI team to PC and/or SC team care is done with the understanding that the PC or SC team is functioning

within scope of practice and can provide the necessary care for dignity and comfort of the patient.

- At the time of transition/discharge from SC-CI team, it must be clear to patient, PC, and any other SC team that the patient's team lead has changed.
- Patient and Family:
 - Patient/caregiver should understand who is responsible for which aspects of their care and who to call in the event of a need, especially for urgent or emergent issues.
 - Patient/caregiver should expect to be informed when the lead physician transitions from SC-CI back to PC or when there are any other transitions in the team lead for their care.

Critical Elements:

- Advanced care directives, if available, included with information from PC clinician or other preexisting SC clinicians.
- List of all clinicians involved in the patient's care and what condition(s) they helped co-manage before the CI.
- Determine at onset if preexisting team members are comfortable handling comorbidities in conjunction with the SC-CI (e.g., diabetes during liver transplantation) (when local and ambulatory care is needed).
- Information regarding any mental health or behavioral health needs that were preexisting.
- Documentation of which specific aspects of patient care become the responsibility of the SC-CI and which remain the responsibility of the PC and/or other preexisting clinicians.
- Specify secondary referrals that CI team needs to manage for optimal outcome for the patient.
- Deliberate communication (vs. information dumping):
 - Communication and process algorithms. It is critical to identify systems-based tools available to promote communication between SC-CI and PC.
 - The development of shared care pathways, guidelines, and/or protocols to define communication between SC-CI and the rest of the team.
- Opportunities for shared decision making.

Helpful Elements:

- Electronic templates for CI plan of care and status updates should be drafted and used to facilitate communication between clinician care teams.
- Patient-centered team conferencing.
- Using readily available web conferencing technology, telementoring, or other technology to facilitate knowledge transfer among all parties to achieve continuity of care for patients.
- During a CI, the focus on the management of the CI risks obscuring other health care needs. Establishing connection and communication with the patient's preexisting clinicians/care teams can help ensure that the full spectrum of a patient's health care needs continue to be met.

Illustrative Cases

Co-Management With Principal Care of a Consuming Illness:

A 56-year-old male was previously well and received routine care from his PC. He was noted to have diet-controlled hyperglycemia. He presented to the PC for evaluation after a 2-month history of progressive back pain and new-onset fatigue. Routine laboratory testing was performed, noting the patient had anemia, and he is referred to a hematologist (SC). The SC physician evaluates additional laboratory results that demonstrate a monoclonal gammopathy and lytic bone lesions. The patient is diagnosed with multiple myeloma. The SC hematologist communicates the diagnosis to the PC clinician and the patient indicating that a rigorous schedule of weekly chemotherapy including pulses of steroids will be needed for the foreseeable future. The hematologist will assume the role of SC-CI team lead and the patient is instructed to contact the SC-CI hematologist/team for any issues, such as fever, bleeding, and increased pain, instead of his PC team.

However, the patient's glucose management will likely require close monitoring and the addition of at least temporary medication to manage the hyperglycemia associated with the pulses of steroids. The SC-CI contacts the PC to assess the patient for glucose management and recommendations. The PC team instructs the patient on self-blood glucose monitoring (SBGM) and sliding scale insulin as indicated by the glucose values. The PC clinician asks the patient to call them with his SBGM values and will help ensure the insulin coverage is appropriately controlling the blood glucose levels. The PC communicates this plan to the SC-CI. The SC-CI continues weekly visits with the patient to administer chemotherapy. The SC-CI hematologist keeps the PC team informed of the patient's response to treatment and any changes in his status or care plan.

Co-Management With Principal Care of a Consuming Illness:

A 45-year-old woman was referred by her PCC to see a nephrologist for evaluation of chronic kidney disease. The nephrologist (SCC) identified that the patient has stage 5 chronic kidney disease from diabetic kidney disease and communicates the diagnosis to the PCC and the patient indicating that a frequent schedule of nephrology clinic visits and monthly laboratory testing will be needed to monitor the patient's clinical status that might indicate a need to start kidney replacement therapy. The nephrologist assumes the role of SC-CI team lead and the patient is instructed to contact the nephrologist with issues such as metallic taste in the mouth, shortness of breath, and increasing lower extremity edema. The nephrologist will also make referrals to other SC related to the patient's kidney care, to include kidney transplantation evaluation referral and vascular surgery referral for arteriovenous fistula placement. The nephrologist will communicate to the PCC that these referrals have been made. The PCC will continue to follow the patient closely with visits every 3 months, making changes to her diabetes management plan as her kidney disease progresses. The PCC also provides relevant preoperative evaluation of the patient before vascular access surgery and shares medical records important for kidney transplant evaluation and listing. After 6 months of this management course, the patient initiates peritoneal dialysis at home. As the condition stabilized, the role of the SC clinician transitions to co-management with principal care of a disorder or set of disorders. The SCC manages the patient's dialysis care, blood pressure medications, anemia, and bone/mineral disease. The patient continues close

follow-up with the PCC, who manages the patient's diabetes and preventive care. The SC-CI nephrologist keeps the PCC informed of the patient's dialysis-related medication regimen and any changes in her status or care plan.

Discussion/Explanation:

Currently a major concern when a patient requires principal care co-management for a CI is the PC clinician and other SC clinicians ("preexisting" team members) involved in the patient's care before the consuming illness being "left out of the loop" once patient comes under SC for the CI. This includes a lack of communication and updates regarding the CI and the patient status as well as a lack of soliciting background information about the patient and preexisting conditions and input around critical decisions.

Referral to SC for principal co-management of CI can occur in variety of ways: The patient might be referred to the SC clinician (SC-TL) by their PC clinician or by another SC clinician (gastroenterologist referring to liver transplant team; oncologist referring to bone marrow transplant clinician) or a SC clinician already caring for the patient may assume SC-TL if a chronic condition exacerbates (gastroenterology SC clinician managing Crohn disease assumes SC-TL role during crisis; oncologist managing quiescent multiple myeloma assumes SC-TL role during intense chemotherapy (but may refer to bone marrow transplant team for CI if necessary) or may be referred to the SC-TL via an emergency situation.

Discharge from SC-CI team care may return co-management to preexisting PC and SC clinicians and care teams for ongoing care or may require a change in the clinician and care team types. Some patients may need fewer SC clinicians after recovery or resolution of a condition that led to a CI, others may need additional or different clinicians or care teams. For example, some may benefit from the addition of palliative care or transition to hospice care.

Transfer of Care From One Practice to a Similar Practice

Definition: Transfer of the current role in care from one clinician/care team to another clinician/care team. This includes transfer from pediatric PC practice to adult PC practice and transfer from pediatric SC to adult care SC for same problem. It also includes patients transferring care due to a move/change of locations or health plans. This includes transfer of care from the patient's (sending) PC practice to a new (receiving) PC practice and from any of the patient's SC clinicians/practices (sending) to another SC clinician/practice for the same condition.

The discussion here does not apply to patients who transfer without informing their previous clinician(s). However, there is still value in the receiving practice receiving prior medical records. The receiving clinician should discuss the benefits of prior records with the patient and, if the patient permits, reach out to the previous clinician. The previous clinician(s) should cooperate with efforts to provide these records.

Principles:

- A planned or proactive approach should be used to ensure care continuity during the transfer process (vs. waiting to request records after a move to a new practice).

Shared Expectations:

- Sending Clinician/Care Team:
 - Provides a transfer summary as well as copies of medical records to the receiving clinician/practice when identified.
 - These records should be identified as a “transfer-of-care” document.
 - If a receiving clinician is not identified until later (has not been identified by the time the patient departs), once the sending practice is notified of the receiving practice, the sending practice is accountable for providing the medical records promptly (and before the initial appointment of the patient with the receiving clinician if possible).
 - Provides a copy of transfer summary to patient and/or family.
 - The transfer summary should include:
 - Current/sending care team contact information;
 - Other extended care team members, such as SC clinicians including behavioral health clinicians, physical therapists, occupational therapists, etc;
 - Time frame for completion of transfer request (urgency/acuity);
 - Need for any interim testing, treatments, and/or appointments during the transfer interim (red flag items);
 - Patient goals and preferences/individual circumstances (social determinants of health, language preferences, and barriers) and how being addressed;
 - Any information about the patient' intellectual, emotional, or social situation, including the patient's understanding of their health status or care plan, that may help the clinicians work more effectively with the patient;
 - Major medical (health) conditions, disorders, or diagnoses;
 - Conditions and treatments that have been managed by the sending clinician and are being transferred for management by the receiving clinician;
 - Conditions (and treatments) managed by other clinicians;
 - Uncontrolled and/or “in-process” issues, and next steps needed to assess/manage them;
 - What to do in interim if condition deteriorates (alarm signs or symptoms and what to do);
 - Updated list of all active medications, including reference to the prescriber (e.g., PC clinician, SC clinician) who is best equipped to refill them until transfer of care has fully occurred;
 - Medical allergies, intolerances, or contraindications;
 - Critical test results (e.g., usual creatinine is 2.1 mg/dL or usual hemoglobin is 10 g/dL or usual electrocardiogram shows right bundle branch block); and
 - Immunization and health maintenance details.
 - Provides updated information on any significant changes or events that occur during the transfer process (e.g., patient has laboratory

- testing that results in change of medication dose by sending clinician following last appointment with sending clinician but before first appointment with the receiving clinician) as an addendum to the transfer summary and ensures that the patient/caregiver and receiving clinician receive the updated summary).
- Assumes initial first-call contact for transfer process questions for the agreed on time frame unless the receiving clinician opts to take responsibility (during the transfer interim).
 - For pediatric-to-adult care transfers, this time frame may benefit from being extended (a longer time frame may be allowed) until the patient is “anchored” in an adult care practice to ensure that the young adult has a constant connection (continuity of care) with a health care clinician.
- Ensures patient has enough medication and supplies during the transfer process, until care is established with the new clinician/practice. The sending clinician should inform patient how long they are willing to continue to monitor and/or refill medications.
- Care navigation through the transfer process may enhance the success of the transfer if the patient:
 - Is transferring from a pediatric practice to an adult care practice.
 - Requires urgent follow-up on medical needs/care.
 - Has complex care needs or situation (circumstances).
- Receiving Clinician/Care Team:
 - Should review the transfer summary and/or medical records to determine if their practice is appropriate for the patient’s needs in advance of accepting the transfer/scheduling initial encounter (e.g., patient with type 1 diabetes mellitus transferring care to an endocrinologist in new location, if that endocrinologist only treats thyroid and pituitary but not diabetes, then not appropriate for the patient’s needs).
 - Assumes care once the transfer of care is complete.
 - If there are elements of care that the receiving clinician is not comfortable assuming, work with patient/family to identify appropriate SC and provide referral.
 - Communicates completion of transfer of care to sending clinician (close the loop) for:
 - Patients transferring from pediatric to adult care.
 - Patients with critical medical issues.
 - Patients with other complex care situations.
- Patient and Family:
 - Ensure that the sending practice is aware of the patient’s need or intent to transfer to another similar practice in advance of the time to transfer to allow time to adequately prepare transfer summary and interim care.
 - If the transfer is from pediatric to adult care:
 - The patient and family will plan the timing of transfer with the pediatric clinician/care team after having completed the transition readiness processes.^{11 12}
 - Work with the pediatric clinician/care team to locate an appropriate adult care clinician.
 - Pediatric patients transitioning to adult care should understand whether they are transitioning to an adult

PC physician who will generate new SC referrals as needed or whether there will be direct referral to an adult SC practice from the managing pediatric SC practice(s).

- Ensure that they receive a copy of the transfer summary to take with them and understands/is aware of the schedule for any needed testing or treatments (red flags).
 - Share the transfer summary with other clinicians as needed for any interim care, such as an acute issue requiring urgent or emergency care.
 - Provide copy to new (receiving) clinician as needed while awaiting records from the sending clinician.
- If the patient/family has not established a receiving clinician by the time they depart/move, they should:
 - Clarify with sending clinician any expectations and time limits for ongoing care (medication refills, monitoring, etc.) until established with the new clinician.
 - Notify the sending clinician/practice of the receiving practice as soon as they have been accepted into the new practice to have the transfer summary, medical records, and any additional information sent by the sending practice and/or any other communication accomplished.

Critical Elements:

- Ancillary team member (e.g., physical therapy, nutrition, behavioral health) recommendations should be included for pertinent medical issues.
- Sending clinician recognizes and communicates vulnerabilities that may impair patients' ability to adequately manage disease, including but not limited to:
 - Low health literacy/cognitive or intellectual disability, or difficulty navigating health system
 - Language and/or cultural barriers
 - Social isolation
 - Food insecurity
 - Homelessness
 - Physical handicaps
 - Mistrust of health system
 - Financial insecurity
- An identified accountable team member in the sending practice who is responsible for ensuring that the transfer summary and medical records are sent to the receiving practice and ensures any addendums to the transfer summary are added and sent as well as helps with any additional information or communication needs related to the transfer.
- An identified accountable team member in the receiving practice who is responsible for ensuring the transfer summary and medical records are received and delivered to the receiving clinician in advance of the patient's initial appointment and helps coordinate receipt of additional information and/or communications.
- Pertinent medical records sent to the receiving clinician in addition to a transfer summary—avoid "data dumps."
- "Red flag" mechanism to call out testing or other elements of care that require attention or timeliness.

- For young adults transitioning from pediatric to adult care, the process is more involved than just transferring care when the young adult reaches a certain age. There needs to be an established preparation for the move from pediatric model of care to the adult model of care, including training for appropriate self-management skills (transition readiness assessment and education). There also needs to be a process for integration into adult care following the transfer. We refer you to Got Transition and their 6 core elements, as well as the ACP pediatric to adult care toolkit.

Helpful Elements:

- The sending clinician and care team can prepare the transfer summary and prepare prescriptions and refills during a clinic/office visit (the final clinic visit) with the patient/family with time designated specifically to this task and to ensuring patient/family has what they need for the transfer.
- Use of a template for transfer summary.¹³
 - www.gottransition.org has vetted templates for transfer summaries for pediatric to adult care transitions.
- A joint virtual visit with sending clinician, receiving clinician, and patient and/or family can help provide a warm hand-off. This can be especially important for pediatric to adult care transfers.
- Assistance from employer (Human Resources department), health plan (medical insurance company rep), hospital partnerships, and other resources to help locate appropriate clinician(s) in new location.
- For a patient who is relocating to a new community, the new/receiving PC clinician/care team can help patient find any SC clinicians that the patient requires in their new location so that the SC clinicians are in the patient's required network and work well with their new PCP (vs. having their sending PCP refer to new PCP and sending SC clinicians refer to new SC clinicians).
- Patient navigator to assist medically and/or socially complex patients and/or with the pediatric to adult care transitions.¹⁴
 - Help locate receiving clinician/practice to transfer to:
 - Ensure information transfer (transfer summary and medical records).
 - Ensure interim continuity of care for the patient.

Illustrative Cases

Pediatric-to-Adult Care Transfer:

An 18-year-old male with panhypopituitarism and diabetes insipidus is ready for transfer of care from his pediatric endocrinologist to an adult care endocrinologist. He will maintain his PC with his family physician. With his pediatric endocrine team, he has been prepared for transition to the adult model of care through their transition readiness program. His pediatric endocrinologist has prepared a transfer summary and sent a copy to the patient's new adult care endocrinologist along with copies for both the patient and, with his permission, his parents. The patient will be going to college in a town 3 hours away. The patient's appointment with the adult care endocrinologist is scheduled for 4 months from now. The pediatric endocrinologist has ensured that the patient has adequate refills of his medications and has let the patient know to contact the pediatric endocrine team with any needs in the interim. The patient has a

lab order for a free T4 and a testosterone level in 2 months and the pediatric endocrinologist will update the transfer record with those results and any changes to the patient's pituitary hormone replacement doses. The pediatric endocrine nurse care manager will follow-up with the patient a few days after his scheduled new patient appointment with the adult endocrinologist to ensure all went well. The adult care endocrinology team has reviewed the transfer summary and has also received a copy of pertinent medical records. They accepted the patient into their practice and will help ensure further support with his transition to adult care.

Transfer to New PC Practice Due to a Location Change:

A 53-year-old male is moving with a job promotion. He notified his PC physician that he would be moving but had not yet located a new PC practice in his new city. His PC physician prepared a transfer summary and provided a copy to the patient. He also provided 6 months of refills on the patient's medications for hypertension and hyperlipidemia. He highlighted in the summary as well as reminded the patient that he will need a follow-up test for prediabetes and a follow-up colonoscopy due to colon polyps in the next year. When the patient found a new PC practice, he gave them a copy of the transfer summary before his first appointment. He also notified his previous PC practice of the new PC practice and requested medical records be sent.

Discussion/Explanation:

Currently when patients must transfer care from one practice to another due to a relocation, a change in health plan networks or aging out of pediatric care, most of the efforts to obtain necessary health care information are after the fact—that is, the patient has moved, located a new physician, and then sends a request for medical records, often with a long delay in those records being forwarded. The effects of this are obvious. Along with the health and financial impacts of missed care and duplicated care are the frustrations and potential risks for both the sending and receiving practices. Creating more of a "hand-off" in care with a planned transfer is better for everyone involved. This is especially critical when a young adult is transferring from pediatric to adult care (a vast literature details the adverse effects of gaps in this transition). The pediatric-to-adult care transition ideally includes a progressive preparation process (transition readiness) that begins well before the time of the transfer and continues as needed after the transfer. More details on this process can be found elsewhere.^{11, 12} Here, we want to emphasize the importance of a good hand-off approach with the actual transfer between practices.

As those in clinical practice will readily recognize, there can be several variations or permutations of care transfers. For example, a patient might transfer to a new cardiologist in the same town (but not change their PC or other SC clinicians) due to an insurance network change or personal reasons. Then the only transfer is from the initial (sending) cardiologist to the new (receiving) cardiologist. Or a patient with a PC physician along with many SC clinicians might move from Tulsa to San Diego so that they need to transfer from all of the clinicians to new clinicians. There are several possible approaches to this latter scenario, but probably the least fragmenting approach would be for all of the sending clinicians (PC and SC) to provide a transfer summary to the patient and to the new (receiving) PC practice and have that practice help with referrals to the appropriate SC practices.

Sometimes a move to a new location must occur during managing critical medical conditions and time-sensitive treatments (such as radiation therapy, chemotherapy, or dialysis). Obviously, making advance arrangements for continuation of these of treatments or services is preferred and optimal for continuity of care.

The ideal processes for improving the transfer of care are:

- The sending practice is made aware of transfer in advance so it can prepare a transfer summary and prepare a plan with the patient along with any needed supplies or medications, etc.
- The patient is prepared for the transfer and provided copy of the transfer summary as well as adequate medications, supplies, and refills. Care needs that are urgent are identified and prearranged (patient needing dialysis or needing chemotherapy on schedule). If patient is not able to navigate this by themselves, arrangements with family or a care navigator need to be made.
- Appropriate and timely information is shared, ideally a transfer summary as well as medical records, and the receiving clinician can review records in advance of the initial appointment for the transfer of care.
- For pediatric-to-adult care transfer, closing the loop is a critical step so the pediatric clinician/care team knows the patient made it to the adult care appointment and is willing to continue care to become established in adult care or if alternative arrangements need to be made.

Transition of Management of a Condition Back to PC From SC

Definition: The transition of co-managed care of a disorder or set of disorders from SC back to PC for a patient with a stable problem and treatment plan that can be safely, reasonably, and effectively managed by PC.

- Same principles and expectations may be used in the hand-off of co-management from one SC clinician to another. (Examples: radiation oncologist to medical oncologist; electrophysiologist to general cardiologist; or surgical specialist to medical specialist, such as cardiovascular surgeon to cardiologist, surgical oncologist to medical oncologist, or thyroid surgeon to endocrinologist.)

Principles:

- The decision regarding the transition is shared among all parties (PC, SC, and patient/family) with common agreement.
- There is support available for the PC team and/or the patient/family to assist with the transition of management and a mechanism for reestablishing SC assistance where needed or requested.

Shared Expectations:

- The preference of the PC clinician/care team to resume management of the referred condition once stable or to have SC continue long-term (ongoing) co-management of the condition should be communicated at the time of the initial referral for SC co-management.
- If a condition has been co-managed long-term by SC with no prior indication regarding the preference of PC to resume management and if the

condition can be safely and effectively managed by PC, then any party (patient/family, PC clinician, or SC clinician) can suggest transition of management back to PC and ensure that all other parties are comfortable with this transition.

- SC Clinician/Care Team and Transition Care Team:
 - Set patient/family expectations regarding eventual transition of management of the condition back to PC.
 - Include transition back to management by PC as part of treatment plan goals, ideally beginning with the initial visit with SC (e.g., “once we have a plan and your condition is stable, it is likely that your PC clinician/team can take over the management”).
 - Define what is or will be considered as stable (based on factors related to the patient, the condition, and the treatment expectations).
 - If the patient/family prefers to return management of the condition to PC before SC considers the condition acceptably stable for transition or before PC is comfortable resuming full responsibility for management:
 - Educate the patient/family regarding the need for ongoing SC co-management.
 - Accommodate patient/family as much as possible (consideration of shared-care co-management in place of principle care co-management, televisits in place of in-person visits, etc.).
 - If the patient/family is reluctant to have the management of the condition transitioned back to PC despite their condition being stable and the transition being acceptable to both PC and SC:
 - Address any misperceptions with appropriate reassurance, including a clear path back to SC if needed.
 - If patient continues to prefer ongoing SC follow-up, consider an intermediate form of co-management, such as in-person and or virtual shared-care co-management with check-ins with SC rather than SC principal care co-management.
 - Once the condition is stable and acceptable for transition of management back to PC and/or the decision to transition agreed on by all parties, SC should notify PC regarding the timing of the transition.
 - Prepare the patient/family for transition of management of their health condition:
 - Consider individual patient factors regarding timing of the transition.
 - SC team should engage the patient/family in the preparation for transition and ensure patient/family has knowledge and understanding of the condition and care plan, needed monitoring, warning signs/symptoms and how to handle.
 - Ensure patient/family is educated on who to call for what and when during the actual transition (between the final SC appointment and first PC appointment to resume management of the condition).
 - Ensure adequate quantities of medication refills, supplies, oxygen, durable medical equipment, etc., to cover the transition period.
 - Provide adequate information for continuity of care to both PC team and the patient/family.
 - Provide a summary of care, including events and procedures, pro-

gression, response to or tolerability of (or lack of) treatment options, current status of the condition. Use of a standardized template has been shown to improve completeness of data.^{13, 14}

- Provide a recommended care plan: current treatment; any recommended titrations; indicated monitoring; alarm signs and symptoms; and contact info for questions, advise, and reestablishing care.
 - When possible, adapt the documents provided to patient/family for their level of health literacy.
 - Provide patient/family with contact information to call with concerns if transition does not occur or if return to SC is required.
 - Provide PC with contact information for additional information/explanations as needed to assist with transition and be available to clarify any confusion or if referral back (return) to SC co-management is required.
- PC Clinician/Care Team:
 - Indicate their preference for resuming management of the condition once stable or not.
 - Acknowledge receipt of a notice of timing of transition from SC that transition of care back to the PC is planned (close-the-loop response back to SC to ensure that PC is aware and accepting of, and is anticipating, the transition).
 - Ideally with this acknowledgment, indicate date of appointment for the patient and the date that PC will resume management of the condition.
 - For certain patients SC clinician/care team may ask to be notified if the patient does not follow-up with the PC practice for the condition.
 - If uncomfortable or unclear regarding the care summary or care plan, contact SC clinician/care team for additional information.
 - If the transition is a “stepped” transition from co-management with principal care of the disorder to co-management with shared care, acknowledge acceptance of this change in the role in care for the SC clinician and willingness to assume responsibility for the elements of care for the condition and any anticipated SC encounters.
 - Patient and Family:
 - Be willing to ask if the condition managed by SC is stable enough for management to be transitioned from SC back to PC.
 - Be willing to consider transitioning management of a health condition from SC back to PC if either the SC and/or PC clinician suggests it.
 - Learn what treatments, medications, and/or follow-up monitoring, if any, are needed for the condition once transition takes place.
 - Learn about any alarm signs or symptoms that would suggest a need to contact SC or return to SC management for the condition.
 - Learn how to contact the SC clinician with concerns, if necessary.
 - Be sure to have enough medication refills and/or supplies to last until a follow-up appointment with PC.
 - Be sure there is a scheduled appointment with PC for any needed follow-up.
 - Once transition has occurred, understand that the PC team is now

managing the condition and direct requests for medication refills, testing, and questions to them instead of the SC team.

Critical Elements:

- Identification of the PC clinician/care team's need for information and/or resources.
 - Including, if appropriate, the need for and benefits of ongoing participation with cancer registries, prior authorization assistance/ needed data.
- Pathway back for SC assistance if needed.
 - Who/how to contact to reengage (contact info in summary note).

Helpful Elements:

- Normalize transition back to PC management (use of supportive messaging regarding confidence in PC clinician/team and use of terms such as "graduation").
- Mechanisms for incorporation of preference options (for transition of management back to PC or not) with the initial referral request.
- Ideally, incorporate into technology. For example:
 - Dropdown options built into the EHR referral request form, such as:
 - "I am referring the patient for principal co-management of this condition."
 - "I prefer to resume management of this condition once stable."
 - "I prefer that you assume ongoing co-management of this condition."
 - Prescribed messages regarding:
 - Request to resume management of a condition
 - Recommendation from SC that transition back to PC is planned
- Develop the transition plan and documents with the patient/family during an office/clinic visit devoted to the transition of care.
- Utilize standardized forms to help ensure completeness of and easy access to information.¹⁵
- Establish mechanisms for the transition as part of a care coordination agreement.
- The SC and PC clinicians can work together to identify which conditions are usually suitable or not suitable for transition of management back to PC, recognizing that these need to be adapted and individualized to the PC clinician and patient/family.

Illustrative Case

A 76-year-old female with previous obesity and obstructive sleep apnea (OSA) requiring continuous positive airway pressure (CPAP). She lost 50 pounds and has kept the weight off. The OSA resolved, and she has not required CPAP for the past 4 years but returns annually to sleep clinic for routine follow-up.

At the next annual follow-up visit, she has continued to keep the weight off and has no evidence of OSA. The sleep clinic physician suggests to the patient that her PC care team could follow her going forward. If she regains weight

or develops signs/symptoms of OSA, she can always return to the clinic. The physician reassures the patient that her PC clinician is comfortable with and very capable of monitoring for any recurrence and has agreed to assume follow-up of similar cases. The patient is very anxious that recurrence of OSA might be missed. The sleep clinic clinician suggests that they can be available to the PC clinician to review any concerns and that if the patient notes things that worry her, begin by asking the PC clinician to address with the sleep clinic. If for some reason she (the patient) does not then hear back regarding the recommendations from the sleep clinic, she can contact the sleep clinic herself at XXX-XXX-XXXX. The clinician spends the remainder of the appointment creating the transition documents with the patient. The clinician reviews with the patient signs and symptoms to watch for and provides the patient a copy of the transition documents (summary of care and recommended treatment plan).

Discussion/Explanation:

Many patients continue to be followed in SC that could easily be followed by PC. One reason this has occurred is the lack of a process for returning the management of a co-managed condition back to PC.¹⁶ These appointments for stable conditions can reduce access to the SC clinic for both established patients with acute issues and new patients with unaddressed issues, often leading to otherwise preventable emergency department visits or hospitalizations. In addition, these visits add to fragmentation of care and extra time and financial costs for the patient. Many patients indicate a great appreciation for the SC clinician and the care that was provided when needed, but as long as there is a route back to SC if it is again needed, are very comfortable with and appreciative of the opportunity to transition from SC back to PC management. If patients are overly reluctant to forgo SC follow-up, an intermediate option would be to transition their care from “principal co-management” by the SC clinician and team to “shared care co-management” between SC and PC, with the PC clinician and team attending to the elements of care and SC reviewing updates and test results and providing recommendations as needed.

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