

The Referral Dance: Improving the Interface Between Primary Care Practitioners and Specialists Caring for Patients With Dementia

Sid Feldman, MD, FCFP

Patients must sometimes feel a bit like a football passed back and forth between primary care physicians and specialist colleagues when referrals are sought, advice is provided, interventions are tried with inconsistent success, further referrals are requested, and so on.

The questionnaire-based practice audit of Canadian neurologists by Chow and colleagues¹³ identifies a number of significant issues related to referrals of patients with dementia from primary care practitioners (PCPs) to neurologists. Although the sample size was small (only 25 neurologists documented referral data for analysis, 24% of those invited to participate), there was a mix of practitioners in private and academic university practice, with both specialty memory clinic physicians and general neurologists, practicing in urban settings of various sizes, geographically distributed across Canada. This sample therefore likely approximates true referral patterns across Canada, assuming a lack of bias related to the cholinesterase-prescribing criterion. A total of 79% of referrals were from family physicians, followed by other neurologists (9%), with the remaining 12% from geriatricians, psychiatrists, emergency physicians, and others. Common symptoms for referral included memory loss (89%) and poor concentration (23%); mood and behavioral symptoms were listed on 44% of referral requests.

Prior to referral, patients had received a number of investigations, including laboratory investigations

(49%) and imaging with computed tomography and magnetic resonance (CT and MR; 55%) though, disturbingly, only 13% had received basic standardized cognitive testing with Mini-Mental State Examination (MMSE) or other instruments.

Neurologists, not surprisingly, performed objective mental status testing and functional assessment of instrumental activities of daily living in the vast majority of referrals and formulated a diagnosis in 99% of patients after 1 visit. Dementia syndromes (Alzheimer's disease [AD], vascular dementia [VaD], dementia with Lewy bodies [DLB], frontotemporal dementias [FTD]) were diagnosed in 62.5% of referrals, mild cognitive impairment (MCI) in 15%, depression in 5.7%, and Parkinson's disease in 4.9%. No cognitive impairment was found in approximately 6% of patients referred for assessment.

Caring for patients with cognitive impairment is one of the great challenges in primary care. This appears to be an almost universal phenomenon.^{1,2} A focus group of 20 family physicians opining on care for cognitively impaired versus nonimpaired seniors identified challenges related to both the process of medical care, such as impaired history leading to less diagnostic certainty, as well as changes in the doctor-patient relationship, such as the need to involve third parties in care. Caring for patients with cognitive impairment led family physicians to feel "deep overtones of frustration and uncertainty."³ Because of the complexity of these patients, even experienced family physicians, professing good knowledge of dementia, desired specialist input in the care of their patients with dementia.¹ In particular, determining the diagnosis of dementia is a common referral from primary care practitioners (PCPs) to specialist colleagues. The international survey of caregivers revealed that patients were initially seen by a general

From the Baycrest Geriatric Health Care System, Department of Family and Community Medicine, University of Toronto, Toronto, Ontario.

Address correspondence to: Sid Feldman, Baycrest Geriatric Health Care System, Department of Family and Community Medicine, University of Toronto, Toronto, ON M6A 2E1; e-mail: sFeldman@baycrest.org.

practitioner or a family physician in the majority of cases, ranging from 55% in Italy to 93% in Australia, yet AD was diagnosed by the primary care physician in, on average, only 13% of the cases. Diagnoses were made by neurologists 52% of the time, with the remainder of patients diagnosed by geriatricians and psychiatrists.⁴ This echoes the findings of the current study by Chow et al.

Is it possible, though, to assist PCPs to improve practice and referrals to secondary care providers? Will clinical practice guidelines alone do the trick? Unlikely. Time pressures alone make it impossible for family physicians to adhere to the majority of recommendations from published guidelines.⁵ In fact, many family physicians experience an involuntary reflex, the “Got another guideline” or “gag” reflex, when yet another large group of recommendations arrives on their desk or computer. Many evidence-based clinical practice guidelines have been developed with the goal of improving care in a particular clinical domain, including dementia (eg, Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia and the Report of the Quality Standards Subcommittee of the American Academy of Neurology Practice Parameter on the Diagnosis of Dementia.^{6,7}), but simply printing and distributing these recommendations likely does little, if anything, to change actual patient outcomes.⁸ A recent Cochrane Review looked specifically at the issue of interventions to improve referrals from primary to secondary care. The authors provided the usual cautions on the limited numbers of rigorous studies on which to base conclusions. Ineffective interventional strategies included passive dissemination of local referral guidelines, feedback of referral rates to PCPs, and discussion with an independent medical advisor. Active local educational interventions involving secondary care specialists with primary care physicians and implementing the use of structured referral sheets were shown to affect modestly, but positively, the referral rates. The authors caution that specific referral sheets may lead to the potential for overload of PCPs if they are adopted for a wide range of conditions, but suggest that advances in informatics (eg, online booking systems with embedded referral management sheets) may address this issue in the future.⁹ In a separate systematic review, Faulkner et al similarly cautioned that methodological quality of studies reviewed was poor, but that in general, some interventions may be more useful than others. Of interest, the authors concluded that the interventions grouped as

professional, such as education or guidelines, affect clinical behavior but not necessarily referral patterns. In contrast, most studies that looked at organizational or system changes, such as the provision of “in-house” specialists or specialist outreach programs to primary care providers, did show an effect on referral outcomes.¹⁰

Perhaps then, 2 approaches are needed. Carefully designed educational interventions, developed conjointly by family physicians and specialists, as well as targeted use of structured referral forms may help family physicians in identifying who does and who does not require referral. Patients with normal Montreal Cognitive Assessment (MoCA) scores¹¹ and no functional decline, for example, can certainly be considered for primary care management without support. In addition, we need to look for creative models of care for complex patients with dementia, involving primary care providers and specialists, in a more interactive and mutually responsive relationship. Callahan and colleagues have published a promising randomized controlled trial of a collaborative care management model for older adults with AD compared with usual care (augmented with educational materials). Collaborative care patients were followed regularly by a family physician and advanced practice nurse, supported by weekly meetings with a geriatrician, geriatric psychiatrist and psychologist, and a web-based informatics system to ensure that all the team members were aware of the patients' current clinical status. Patients in the intervention group experienced significant improvements in total Neuropsychiatric Inventory (NPI) scores (adjusted group difference of 5.6), reflecting fewer behavioral symptoms, accompanied by lower ratings of caregiver stress. Unfortunately, no significant differences were found in time to nursing home admission, activities of daily living (ADLs), or differences in the rate of cognitive decline, suggesting that collaborative care as described may not be a panacea, though appears very promising.¹²

With the enormous burden of care to come in future decades by the increased number of patients with dementia, it will be even more important to improve the effectiveness of referrals between primary care providers and specialists. The current article by Chow et al adds to our understanding of referrals to neurologists from primary care physicians, reinforcing the need to assist PCPs in improving care for patients with dementia and also emphasizing the need to think more broadly about models that will enhance our ability to care for these complex individuals and their families.

References

1. Yaffe M, Ozreck P, Barylak L. Family physicians' perspectives on care of dementia patients and family caregivers. *Can Fam Physician*. 2008;54:1008-1015.
2. Turner S, Iliffe S, Downs M, et al. General practitioners' knowledge, confidence and attitudes in the diagnosis and management of dementia. *Age Ageing*. 2004;33:461-467.
3. Adams W, McIlvain HE, Geske JA, Porter JL. Physicians' perspectives on caring for cognitively impaired elders. *Gerontologist*. 2005;45:231-239.
4. Wilkinson D, Stave C, Keohane D, Vincenzino O. The role of general practitioners in the diagnosis and treatment of Alzheimer's Disease: a multinational survey. *J Int Med Res*. 2004;32:149-159.
5. Pimlott N. Who has time for family medicine? *Can Fam Physician*. 2008;54:14-16.
6. Chertkow H. Introduction: Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia. *Alzheimers Dement: J Alzheimers Assoc*. 2007;3:262-265.
7. Knopman DS, DeKosky ST, Cummings JL, Chui H, Corey-Bloom J, Relkin N, Small GW, Miller B, Stevens JC. Practice parameter: diagnosis of dementia (an evidence-based review). Report of the quality standards subcommittee of the American Academy of Neurology. *Neurology*. 2001;56(9):1143-53.
8. Farmer AP, Légaré F, Turot L, Grimshaw J, Harvey E, McGowan JL, Wolf F. Printed educational materials: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev*. 2008; CDC004398.
9. Akbari A, Mayhew A, Al-Alawi MA, Grimshaw J, Winkens R, Glidewell E, Pritchard C, Thomas R, Frasesr C. Interventions to improve outpatient referrals from primary care to secondary care. *Cochrane Database Syst Rev*. 2008;CD005471.
10. Faulkner A, Mills N, Bainton D, et al. A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. *Br J Gen Pract*. 2003;53:878-884.
11. Nasreddine ZS, Phillips NA, Bédirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *J Am Geriatr Soc*. 2005;53:695-699.
12. Callahan CM, Boustani MA, Unverzagt FW, et al. Effectiveness of collaborative care for older adults with Alzheimer Disease in primary care: a randomized controlled trial. *JAMA*. 2006;295:2148-2157.
13. Chow T, Binder C, Smyth S, et al. 100 years after Alzheimer: contemporary neurology practice assessment of referrals for dementia. *Am J Alzheimers Dis Demen*. In press.