

# Shared Care: What Mix of Generalist and Specialist Care Optimizes Patient Outcomes?

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The interface between specialty care and primary care has received limited study despite its importance to the effective functioning of the health care system. Both types of practice have benefits. Specialty care has been shown to improve the disease-care process<sup>1-3</sup> and patient outcomes,<sup>4</sup> while primary care results in similar health outcomes,<sup>5,7</sup> lower mortality,<sup>8,9</sup> less resource usage, and lower costs.<sup>8,10,11</sup>

Increased understanding of the unique roles of specialists and generalists is particularly important now, because both groups are feeling undervalued and beleaguered. The high costs and limited improvement in broad health care measures under the specialist-dominated US health care system fueled the growth of managed care. Efforts by managed care plans to control costs by limiting access to specialists has raised concern<sup>12,13</sup> about the quality of care for diseases requiring specialized expertise, and has led some plans to pay for direct access to specialists,<sup>14,15</sup> despite the potential benefit of generalist-guided access to specialist care.<sup>16</sup>

The current backlash against managed care<sup>17</sup> has led to a concurrent backlash against primary care.<sup>18</sup> This is because managed health care systems have emphasized primary care for its costs savings and the public relations value of the personal physician, rather than for the unique added value of broadly focused health care provided in an ongoing relationship with a generalist physician.<sup>18</sup> Although the requirement of most managed care plans that each patient have a primary care physician has fostered some new and enduring relationships between patients, families, and personal physicians, the annual bidding for managed care contracts has led to increasing discontinuity<sup>19</sup> and lower quality of care.<sup>19,20</sup> When primary care physicians are required to serve as the first contact for patients with whom they have not had the opportunity to develop a trusting relationship, they are more likely to be seen as hated gatekeepers<sup>21</sup> than as valued gateways to high-quality health care.

The articles by Diller and colleagues<sup>22</sup> and Valenstein and coworkers<sup>23</sup> in this issue of the *Journal* reframe the issues surrounding generalist and specialist care. Their concepts of shared care and comanagement provide a useful framework for determining the best mix of care from physicians with generalized and specialized expertise. Referral and consultation are appropriate ways to think of specialist involvement in the treatment of illnesses for which narrowly defined expertise is needed

for a limited time, such as an acute surgical illness.<sup>24</sup> However, chronic disease management and mental health care are 2 areas in which treatment may be shared between generalists and specialists not merely as a commodity, but as an ongoing relationship among the patient, generalist, and specialist.<sup>25</sup>

A rational discussion of shared care begins with the premise that most Americans benefit from an ongoing relationship with a primary care physician.<sup>26,27</sup> During the course of a lifetime, the best care will also require the involvement of physicians with specialized expertise. A small percentage of people may derive additional benefit from getting the majority of their care from a specialist. These are predominantly patients whose health care needs are dominated by a single severe illness.<sup>28</sup> The extent to which these patients also need a primary care physician will depend on whether the specialist can provide some of the unique facets of family practice and primary care,<sup>18</sup> such as care for other acute and chronic illnesses, integrated mental health care, and preventive services.

The studies by Diller and Valenstein and their colleagues inform discussions of the most appropriate models for shared care by describing the current state of comanagement. These studies also provide important observations of the process of shared care, and set the stage for future work that will identify the different mix of patients, physicians, and health systems that will result in the best patient outcomes. The studies by these authors are methodologically rigorous, but they are restricted to primary care patients who are comanaged with specialists. The recent growth of point-of-service health plans with direct access to specialists<sup>14,15</sup> fuels the need for additional studies of patients who primarily see specialists for their care. These patients have the benefit of specialized expertise but may lack the advantage of broad-based prioritized care from a primary care physician. Future studies of the appropriate mix of specialist and generalist care will need to move beyond disease-specific quality measures and focus on the broad array of patient outcomes that may be sensitive to the mix of general and specialized care.<sup>29</sup>

## COMANAGEMENT AND CHRONIC HEART FAILURE

The study by Diller and colleagues suggests that cardiologists are more likely to be involved in comanagement relationships with family physicians for the treatment of patients with more severe disease. This is an expected finding if family physicians are being appropriately selective in referral and consultation or if severely ill patients develop a relationship with a cardiologist through an emergency department visit or hospitaliza-

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tion. This study also shows a surprisingly high percentage of comanagement of patients with early-stage congestive heart failure (CHF) and found that comanaged patients receive more intensive treatment. In light of studies showing a lower rate of use of potentially life-saving treatments by primary care physicians,<sup>3,4,30</sup> this comanagement may provide access to the best cardiac care. However, other research recently published in the *Journal*<sup>31</sup> showed that family physicians who do not follow guidelines are often tailoring care to individual patient characteristics. Thus, the best mix of specialist and generalist care is still not clear, but it is likely to partially depend on the skill of the primary care physician in offering optimal first-line diagnosis and treatment.

The authors' finding of sex-based differences in comanagement may help to explain recent studies showing that women are less likely to receive aggressive cardiac care than men.<sup>32,33</sup> The lower rate of hospitalization for comanaged patients, despite their apparently more severe disease, shows the potential added value of comanagement of patients with CHF. However, as the authors point out, this difference in hospitalization rates could be due to unmeasured and uncontrolled differences in other factors affecting hospitalization. In addition, the findings might be different in nontraining primary care practices, in which the longevity of the physician-patient relationship and continuity of care may be higher than in a residency practice. Indeed, the comanaged patients in the study had an average relationship with their cardiologist of 2.5 years, which is nearly the duration of a resident's entire practice time at his or her training site. Nonetheless, the value of the early involvement of a cardiologist<sup>13</sup> for at least some patients with CHF is supported by these data.

### COMANAGEMENT AND DEPRESSION

The study of comanagement of patients with depression by Valenstein and coworkers is particularly timely because of the recent common practice of mental health carve-outs by third-party payers. Mental health carve-outs have rapidly achieved popularity among managed care organizations, because they cause a short-term reduction in utilization and costs.<sup>34-36</sup> However, the family physicians in this study reported a higher degree of difficulty in collaborating with mental health consultants for patients with managed care insurance. This finding is a result of the researchers' integration of qualitative research methods<sup>37,38</sup> to develop a quantitative survey that was grounded in the concerns of practicing family physicians. The study's finding of the facilitative effect of co-location of primary care and mental health professionals indicates a potential health care organizational mechanism to foster communication. Such co-location has previously been found not to influence the threshold for referral,<sup>39</sup> and thus may potentially increase the integration of care without increasing costs. Despite moderately high rates of reported communication between family practice and mental health clinicians, the low rate

of role definition for a host of important patient management issues illustrates the need for enhancement of communication in collaborative models of care.

### INTEGRATION AND COMMUNICATION

The need for enhanced communication between clinicians sharing the care of patients bucks the recent trend toward carving out care not only for mental health, but also for chronic disease management.<sup>40</sup> Separating, rather than integrating, diverse aspects of care represents a quick-fix approach to quality improvement. These divisive attempts at quality improvement are the result of blind spots engendered by a reductionistic quality-improvement paradigm and limitations in our ability to adequately measure the process and outcome of broad prioritized generalist care. Conceptualizing and measuring quality, one disease at a time, is not necessarily best for the health and well-being of patients and their families.

Future research should recognize the rationality of shared care approaches that involve universal access to primary care, and access to specialty care that is guided by an ongoing relationship among primary care physicians, patients, and families. This shared care process requires greater emphasis on the definition of roles and goals on the basis of the unique skills of the clinicians and the needs and desires of the patient. Research by a number of investigators has identified opportunities to enhance the quality of this shared care communication. These include negotiating a mutual understanding of roles and identifying the focus, process, and goals of shared care, as well as communicating information and values.<sup>41-47</sup>

Most patients should expect to develop a relationship with a primary care clinician and should see that physician for most of their care.<sup>27,48</sup> Patients should encourage their health care providers to communicate with one another, and should share their understanding of the care provided by other clinicians. Primary care clinicians and specialists should be explicit in communicating their expectations of each others' roles,<sup>42</sup> and should negotiate these roles on the basis of the patient's needs and their own ability to meet those needs. This communication must involve respect for the value of the narrow expertise of the specialist and the broad, relationship-centered role of the generalist. Those administering health systems and third-party payment should work toward systems that foster this type of communication,<sup>44</sup> rather than add additional burdens. Flexibility, not a rigid guideline, is necessary, since the best mix of care depends on many patient, physician, and system factors. Health-services researchers should define their questions on the mix of care not in terms of either specialist or generalist care,<sup>28</sup> but in terms of the mix and process of care that optimizes patient outcomes, including functional health and cost.<sup>26</sup>

Shared care makes sense. We need to understand which patients benefit from shared care, when that care is advantageous, where it should be provided, and how to maximize the effectiveness of generalist and special-

ist comanagement. Diller, Valenstein, and their colleagues have given us a good start.

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