AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

When to Refer to a Specialist

Quick Reference Guide

2026

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WHEN TO REFER TO A SPECIALIST

OBJECTIVE: Help PCPs decide when to manage, e-consult, refer, or escalate; send a clinically ready referral; retain care-plan ownership; and close the loop after specialty input.

USE THIS GUIDE TO	DO NOT USE THIS GUIDE TO
Define a **specific consultation question;** assemble relevant data; select urgency and route; track completion and return plan	Delay emergency care; replace clinical judgment; impose payer rules; or require low-value tests that do not fit the presentation

AAVBC PERSPECTIVE

Value-based referral *begins when the PCP, acting as the "quarterback" of the patient's care, determines that the* ***expected benefit of specialist expertise exceeds what can be achieved safely within primary care****.*[1,2] *In this role,* ***the PCP owns responsibility across the entire care trajectory****—selectively connecting patients with higher-cost specialty visits while maintaining the bulk of care in lower-cost, more accessible settings.*[1,3] *The referral relationship continues* ***until the specialist recommendation is reconciled into one longitudinal care plan****.*[4] *A narrow clinical question, relevant pre-workup, appropriate urgency, high-value network selection, and closed-loop follow-up are the core controls that let the PCP direct (rather than relinquish) the care of the patient.*[4,5]

Because the PCP remains the accountable quarterback even when specialists are on the field, an explicit, ***upfront agreement on the extent of the referral*** *is equally essential. Before the visit, the PCP and specialist should define* ***which of three care tracks applies****, so that ownership of orders is unambiguous, services are not duplicated, and the patient is directed to the appropriate level and cost of care:*[5]

- ***Consultation (Short-Term)****: The specialist evaluates the patient, delivers a discrete diagnostic or treatment recommendation, and immediately returns management to the PCP. This track pairs naturally with a* ***narrow clinical question*** *and closed-loop follow-up*[5]
- ***Co-Management (Shared Track)****: The PCP retains overall health and baseline chronic disease management while the specialist manages a specific organ system or condition (e.g., the PCP manages hypertension and diabetes while nephrology manages Stage 4 chronic kidney disease).* ***Reconciliation into a single longitudinal plan is the critical control here****, since two clinicians are writing orders concurrently*[5,6]
- ***Principal Care (Total Transfer)****: The specialist assumes the majority of care during a critical, high-acuity period (e.g., an oncologist during active chemotherapy), with a* ***defined trigger for returning management to the PCP*** *once the acute phase resolves*[2]