AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

When to Refer to a Specialist

Quick Reference Guide

2026

Table of Contents

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]

*Naming the track at the point of referral operationalizes value-based principles: it clarifies **who owns each decision**, **prevents redundant workup** and **conflicting orders**, and ensures that when specialist involvement ends or shifts, the recommendation is **cleanly reconciled back into one accountable care plan**.*[2,5]

Pre-Referral Decision Framework for High-Value Specialty Referrals

DECISION DOMAIN	PCP QUESTION[7–9]	VALUE PROTECTED[10–12]
Clinical complexity	Does diagnosis, risk, treatment failure, or procedure need **exceed primary care scope**?	Earlier definitive care **without reflexive transfer**
Risk stratification	**Will early specialty input prevent**: deterioration, hospitalization, disability, or diagnostic delay?	Capacity directed to **rising-risk patients**
Patient value	**Can the patient complete the referral**, and does the expected benefit justify travel, copay, and burden?	Adherence, equity, and goal-concordant care
Care ownership	**Is the specialist being asked to**: advise, co-manage, perform a procedure, or assume care?	**Fewer contradictory plans** and duplicate therapies
Completion	**Who tracks**: scheduling, attendance, note return, action, and transition back?	**Fewer open-loop (uncompleted)** referrals and **fewer missed recommendations**

CLINICAL PEARL: A COMPLETE REFERRAL FOR OLDER ADULT PATIENTS

A referral is not complete when the order is signed. It is complete when the patient is seen or advised, the recommendation is received, the PCP acts on it, and ownership of next steps is explicit.[13,14] In older adults, this loop must be viewed through a **geriatric lens**: frailty, cognition, hearing, vision, mobility, caregiver support, and polypharmacy **change both the urgency and the route of referral**, while Medicare network constraints, prior authorization, transportation, specialist copay, and durable medical equipment access determine **whether the plan is actually executable**.[15–17] Accordingly, a high-value referral in this population may call for **early co-management** rather than fewer referrals, particularly when **delay would increase the risk** of hospitalization or functional loss.[18]

DIAGNOSTIC PRECISION: THE SOS REFERRAL

SOS ELEMENT	WHAT TO DOCUMENT[9,19,20]	EXAMPLE[4,19,20]
S | Status	**Current severity**, **trajectory**, key positives and negatives, functional impact, and **urgency**	**Stage 3 CKD**; eGFR declined **from 45 to 32 mL/min/1.73 m^2** in 3 months; no obstruction
O | Optimization	**What PCP care has already addressed**, duration, response, adherence, and contraindications	**ACE inhibitor optimized**; BP 128/74 mmHg; medication and NSAID review completed
S | Specific question	**One** actionable request with **desired role** and **return plan**	Please advise on **renal-safe medication adjustment** and **whether biopsy evaluation is indicated**

ABBREVIATIONS: SOS = Status, Optimization, Specific question; CKD = chronic kidney disease; eGFR = estimated glomerular filtration rate; mL/min/1.73 m^2 = milliliters per minute per 1.73 square meters; PCP = primary care physician; ACE = angiotensin-converting enzyme; BP = blood pressure; mmHg = millimeters of mercury; NSAID = nonsteroidal anti-inflammatory drug

Vague vs. Value-Based Referral

SPECIALTY	VAGUE REFERRAL	VALUE-BASED REFERRAL[4,9,21]	AVOIDED CASCADE[22–24]
Cardiology	Palpitations. Please evaluate	Rare transient palpitations; ECG normal; echocardiogram shows preserved EF. **Is ambulatory monitoring indicated before exercise clearance?**	**Unfocused stress imaging or invasive testing**
Gastroenterology	Abdominal pain	Three months of intermittent LLQ pain and loose stools; celiac serology and fecal calprotectin normal. **Does this fit IBS-D, and is endoscopy indicated?**	**Repeat CT and broad laboratory panels**
Orthopedics	Chronic knee pain	Advanced medial-compartment OA; daily functional limitation despite 6 months of PT, NSAID trial, and injection; weight-bearing radiographs attached. **Assess surgical candidacy**	**Soft-tissue MRI or diagnostic arthroscopy**

ABBREVIATIONS: ECG = electrocardiogram; EF = ejection fraction; LLQ = left lower quadrant; IBS-D = irritable bowel syndrome with diarrhea; CT = computed tomography; OA = osteoarthritis; PT = physical therapy; NSAID = nonsteroidal anti-inflammatory drug; MRI = magnetic resonance imaging

CLINICAL PEARL: DEFINE THE SPECIALIST'S ROLE BEFORE YOU REFER

Name the specialist's job: advise, confirm, co-manage, perform a procedure, or assume care. Ambiguous ownership is a major source of **duplicate testing** and **contradictory prescribing**.

ROUTE SELECTION: PCP MANAGEMENT, E-CONSULT, OR VISIT

ROUTE	BEST FIT[25–27]	AVOID WHEN[25,26,28]
PCP management	Stable condition **within primary care scope**; guideline-directed first-line plan; no red flags; measurable follow-up	Progression, major uncertainty, procedure need, or inability to monitor safely
E-consult	**Focused question** answerable from existing history, labs, images, or medication data; **PCP can implement response**	Hands-on examination, procedure, rapidly progressive symptoms, complex consent, or unstable patient
In-person specialist	**Diagnostic ambiguity requiring examination**; treatment failure; high-risk co-management; procedure or advanced therapy	An emergency requiring immediate acute evaluation
Emergency pathway	**Threat** to life, limb, vision, airway, spinal cord, organ function, or acute psychiatric safety	Do not wait for routine referral authorization or e-consult response

ABBREVIATIONS: PCP = primary care physician

Specialties Commonly Suited to E-Consult

SPECIALTY	COMMON BRIEF USE CASES[25,29–32]
Endocrinology	**Thyroid-panel interpretation**; osteoporosis sequencing; diabetes medication question
Hematology	**Stable mild cytopenia**; smear or gammopathy workup question; periprocedural anticoagulation
Psychiatry	**Medication cross-taper**; interaction review; augmentation question in a stable patient
Dermatology	**High-quality image review**; step-up topical therapy; stable lesion triage

SPECIALTY	COMMON BRIEF USE CASES[25,29–32]
Nephrology/ Cardiology	**Stable CKD medication dosing**; isolated ECG question; chronic disease optimization
Infectious disease	**Antibiotic selection**; latent infection interpretation; travel or prophylaxis question

ABBREVIATIONS: CKD = chronic kidney disease; ECG = electrocardiogram

CLINICAL PEARL: IN OLDER ADULTS, ACCESS FRICTION IS CLINICAL RISK

For older adults, access friction is clinical risk. If an e-consult can safely start treatment while transport, caregiver, or mobility barriers are resolved, **use it**; if an examination or procedure is necessary, **do not let digital-first policy become delay**.

FEE-FOR-SERVICE TENDENCY[33,34]	VALUE-BASED REFERRAL DESIGN[4,5]
Visit volume, fragmented data, proximity-based specialist choice, **broad handoff**	**Clinical necessity**, integrated data, specific question, high-value network, **defined transition back**

EXTENT OF REFERRAL: THE THREE CARE TRACKS

To prevent duplication of services and clarify who is writing orders, the PCP and specialist must **explicitly agree on one of three tracks for every referral**:[5,20]

- **Consultation (Short-Term):** The specialist evaluates the patient, provides a discrete diagnostic or treatment recommendation, and **immediately returns management to the PCP**[5,27]
- **Co-Management (Shared Track)**: The PCP manages **overall health** and **baseline chronic issues**, while the specialist manages the **specific organ system** or condition (e.g., PCP manages hypertension and diabetes, while the Nephrologist manages Stage 4 CKD)[5,6]
- **Principal Care (Total Transfer)**: The specialist takes over the **majority of the patient's care** for a critical, high-acuity period (e.g., an Oncologist during active chemotherapy)[27,35]

CARDIOLOGY AND ORTHOPEDIC SURGERY

Cardiology

ROUTE	OPERATIONAL GUIDANCE[36–40]
REFER	**New or worsening HF**, especially **reduced LVEF** or **NYHA II-IV symptoms**; apparent resistant hypertension on 3 agents including a diuretic; recurrent unexplained syncope with exertion or palpitations
PRE-REFERRAL WORKUP	CBC, CMP, TSH, lipid panel, BNP/NT-proBNP; 12-lead ECG and transthoracic echocardiogram
E-CONSULT/ PCP	**Stable asymptomatic sinus bradycardia**; nonspecific T-wave changes without symptoms; medication adjustment for **controlled AF**
OLDER ADULT/ MEDICARE	Document orthostasis, falls, frailty, renal function, cognition, anticoagulation, and the **desired cardiology role**

MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **atrial fibrillation**, **heart failure**, and **sick sinus syndrome**, as well as the **utilization management QRGs** on **heart failure medications**, **anticoagulants**, and **antiplatelets**

ABBREVIATIONS: HF = heart failure; LVEF = left ventricular ejection fraction; NYHA = New York Heart Association; CBC = complete blood count; CMP = comprehensive metabolic panel; TSH = thyroid-stimulating hormone; BNP = B-type natriuretic peptide; NT-proBNP = N-terminal pro-B-type natriuretic peptide; ECG = electrocardiogram; AF = atrial fibrillation

Orthopedic Surgery

ROUTE	OPERATIONAL GUIDANCE[41–44]
REFER	**Advanced hip or knee OA** with **daily functional impairment** after 3-6 months of conservative care; suspected **structural tear with mechanical symptoms**; radicular pain with progressive motor or reflex deficit
PRE-REFERRAL WORKUP	Document NSAIDs, PT, weight intervention, or injections; obtain weight-bearing radiographs; MRI for soft-tissue or spine concerns with neurologic deficits
E-CONSULT/ PCP	**Mild bunion or flat foot**; stable nondisplaced fracture after splinting; persistent lateral epicondylitis after initial care
OLDER ADULT/ MEDICARE	Frame benefit around mobility, falls, ADLs, caregiver burden, surgical risk, and prehabilitation **rather than pain score alone**

ABBREVIATIONS: OA = osteoarthritis; NSAID = nonsteroidal anti-inflammatory drug; PT = physical therapy; MRI = magnetic resonance imaging; ADL = activities of daily living

ENDOCRINOLOGY AND GASTROENTEROLOGY

Endocrinology

ROUTE	OPERATIONAL GUIDANCE[45–48]
REFER	**Type 2 diabetes with A1C above brief threshold** despite optimized multidrug therapy; type 1 diabetes; severe hyperthyroidism, pregnancy with thyroid disease, suspicious thyroid nodule; severe osteoporosis with fragility fracture or first-line failure
PRE-REFERRAL WORKUP	**Diabetes**: glucose data, A1C, BMP/eGFR, UACR. Thyroid: TSH, free T4/T3 and ultrasound report; **osteoporosis**: DXA, calcium, vitamin D, renal function, treatment history
E-CONSULT/PCP	**Mild subclinical hypothyroidism**; vitamin D titration; initial adrenal incidentaloma workup question
OLDER ADULT/ MEDICARE	Assess hypoglycemia, sarcopenia, falls, CKD, cognitive capacity, injection ability, and caregiver support **before escalating complexity**
MAKING CONNECTIONS: Consult the VBC-focused **coding QRG** on **diabetes mellitus**	

ABBREVIATIONS: A1C = hemoglobin A1c; BMP = basic metabolic panel; eGFR = estimated glomerular filtration rate; UACR = urine albumin-to-creatinine ratio; TSH = thyroid-stimulating hormone; T4 = thyroxine; T3 = triiodothyronine; DXA = dual-energy X-ray absorptiometry; CKD = chronic kidney disease

Gastroenterology

ROUTE	OPERATIONAL GUIDANCE[49–52]
REFER	**GERD persistent after 8 weeks of optimized PPI**; diarrhea beyond 4 weeks or bleeding with inflammatory markers; persistent unexplained AST/ALT elevation per brief pathway
PRE-REFERRAL WORKUP	CBC, CMP, iron studies, CRP, celiac serology; fecal calprotectin, *C. difficile* testing, and O&P when diarrhea context supports it
E-CONSULT/ PCP	**Classic mild IBS without alarms**; average-risk colonoscopy routing; mild asymptomatic steatosis evaluation
OLDER ADULT/ MEDICARE	Flag anemia, weight loss, dysphagia, anticoagulation, frailty, prior imaging/endoscopy, bowel-prep risk, and transport for sedation
MAKING CONNECTIONS: Consult VBC-focused **coding QRS** on **chronic hepatitis**, **Crohn's disease**, **chronic pancreatitis**, **ulcerative colitis**, **colorectal cancer**, and **small intestine cancer**	

ROUTE	OPERATIONAL GUIDANCE[49–52]

ABBREVIATIONS: GERD = gastroesophageal reflux disease; PPI = proton pump inhibitor; AST = aspartate aminotransferase; ALT = alanine aminotransferase; CBC = complete blood count; CMP = comprehensive metabolic panel; CRP = C-reactive protein; O&P = ova and parasites; IBS = irritable bowel syndrome

PULMONOLOGY AND GENERAL SURGERY

Pulmonology

ROUTE	OPERATIONAL GUIDANCE[53–56]
REFER	Asthma uncontrolled with exacerbations **despite high-dose ICS/LABA**; advanced COPD with recurrent hospitalization or oxygen evaluation; suspected ILD, fibrosis, or sarcoidosis
PRE-REFERRAL WORKUP	Complete PFTs with spirometry, lung volumes, and DLCO; PA/lateral chest radiograph; attach prior CT images and exacerbation history when available
E-CONSULT/ PCP	**Isolated mild DLCO reduction**; low-risk solid nodule below 6 mm; chronic cough after common causes addressed
OLDER ADULT/ MEDICARE	Document inhaler technique, oxygen saturation at rest/exertion, smoking exposure, cognition/dexterity, affordability, and pulmonary rehabilitation need

MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **severe asthma**, **COPD**, **cystic fibrosis**, **lung cancer**, **pulmonary fibrosis**, and **pulmonary hypertension**

ABBREVIATIONS: ICS = inhaled corticosteroid; LABA = long-acting beta-agonist; COPD = chronic obstructive pulmonary disease; ILD = interstitial lung disease; PFT = pulmonary function test; DLCO = diffusing capacity of the lung for carbon monoxide; PA = posteroanterior; CT = computed tomography; VBC = value-based care; QRG = quick reference guide

General Surgery

ROUTE	OPERATIONAL GUIDANCE[57–60]
REFER	Symptomatic cholelithiasis; painful or function-limiting nonincarcerated hernia; rapidly growing, deep, or painful soft-tissue mass requiring surgical assessment
PRE-REFERRAL WORKUP	**Gallstones**: RUQ ultrasound, LFTs, lipase; **hernia**: reducibility and exam; ultrasound or CT only if diagnosis is uncertain; attach imaging
E-CONSULT/ PCP	**Small asymptomatic reducible umbilical hernia**; stable lipoma; imaging review for drainage question
OLDER ADULT/ MEDICARE	Emergency escalation overrides routine referral for strangulation, obstruction, peritonitis, sepsis, or rapidly progressive mass concerns

ROUTE	OPERATIONAL GUIDANCE[57–60]

ABBREVIATIONS: RUQ = right upper quadrant; LFT = liver function test; CT = computed tomography

HEMATOLOGY AND ONCOLOGY

Hematology

ROUTE	OPERATIONAL GUIDANCE[61–65]
REFER	Persistent unexplained anemia, leukopenia, or thrombocytopenia at brief thresholds; monoclonal protein or abnormal free-light-chain ratio; **unprovoked VTE** when specialist input is needed
PRE-REFERRAL WORKUP	CBC with smear, reticulocytes, iron/ferritin, B12, folate, CMP; SPEP and serum free light chains when gammopathy suspected; **include trends and medications**
E-CONSULT/ PCP	**Stable iron-deficiency pattern**; mild isolated neutrophilia or erythrocytosis linked to smoking or sleep apnea
OLDER ADULT/ MEDICARE	Escalate urgently for blasts, pancytopenia, active bleeding, hemolysis, severe symptomatic anemia, thrombosis instability, or suspected TTP

MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **DVT/PE**, **sideroblastic anemia**, and **sickle cell anemia** as well as **utilization management QRGs** on **anticoagulants**, **antiplatelets**, and **thrombocytopenia medications**

ABBREVIATIONS: VTE = venous thromboembolism; CBC = complete blood count; CMP = comprehensive metabolic panel; SPEP = serum protein electrophoresis; TTP = thrombotic thrombocytopenic purpura; VBC = value-based care; QRG = quick reference guide

Oncology

ROUTE	OPERATIONAL GUIDANCE[66–70]
REFER	**Pathology-confirmed cancer**; imaging strongly suspicious for malignancy; severe suspected paraneoplastic syndrome or rapid unexplained decline
PRE-REFERRAL WORKUP	**Pathology if obtained**; site-appropriate imaging; CBC/CMP and relevant organ tests; tumor markers only when indication-specific; send images, **not reports alone**
E-CONSULT/ PCP	Screening guidance for strong family history; genetics question or variant-of-uncertain-significance clarification
OLDER ADULT/ MEDICARE	**Do not let frailty obscure urgency**; document ECOG or functional status, weight trajectory, cognition, goals, caregiver support, and **simultaneous palliative need**

ROUTE	OPERATIONAL GUIDANCE[66–70]
MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **breast**, **lung**, **prostate**, **colorectal**, and **skin cancers**	

ABBREVIATIONS: CBC = complete blood count; CMP = comprehensive metabolic panel; ECOG = Eastern Cooperative Oncology Group; VBC = value-based care; QRG = quick reference guide

NEPHROLOGY AND NEUROLOGY

Nephrology

ROUTE	OPERATIONAL GUIDANCE[71–73]
REFER	**Accelerated eGFR decline or eGFR below 30**; persistent UACR above 300 mg/g or UPCR above 500 mg/g; refractory electrolyte or acid-base disorder
PRE-REFERRAL WORKUP	CMP and eGFR trend, electrolytes, calcium, phosphorus, PTH; urinalysis with microscopy and UACR; **renal ultrasound to evaluate obstruction**
E-CONSULT/ PCP	**Stable stage 3 CKD with minimal albuminuria**; medication-dose question in stable reduced eGFR
OLDER ADULT/ MEDICARE	**Include KFRE when available**, orthostasis, NSAIDs, volume status, SGLT2/RAAS therapy, cognition, and dialysis-goal discussions when relevant
MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **CKD**, **alcoholic hepatitis**, and **chronic hepatitis**	

ABBREVIATIONS: eGFR = estimated glomerular filtration rate; UACR = urine albumin-to-creatinine ratio; UPCR = urine protein-to-creatinine ratio; CMP = comprehensive metabolic panel; PTH = parathyroid hormone; CKD = chronic kidney disease; KFRE = Kidney Failure Risk Equation; NSAID = nonsteroidal anti-inflammatory drug; SGLT2 = sodium-glucose cotransporter-2; RAAS = renin-angiotensin-aldosterone system

Neurology

ROUTE	OPERATIONAL GUIDANCE[74–77]
REFER	**Seizures despite 2 appropriate antiseizure medications**; rapidly progressive cognitive decline; suspected demyelinating disease or persistent focal deficit
PRE-REFERRAL WORKUP	CBC, CMP, B12, RPR, HIV, TSH and targeted tests; **syndrome-appropriate MRI or EEG**; attach actual images and event description
E-CONSULT/ PCP	**Stable migraine after first-line failure**; initial evaluation of symmetric distal diabetic neuropathy

ROUTE	OPERATIONAL GUIDANCE[74–77]
OLDER ADULT/ MEDICARE	Sudden focal deficit, thunderclap headache, status epilepticus, acute cord compression, or delirium is an **emergency pathway**, **not routine referral**

MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **seizure disorders**, **Parkinson's disease**, and **dementia**

ABBREVIATIONS: CBC = complete blood count; CMP = comprehensive metabolic panel; B12 = vitamin B12; TSH = thyroid-stimulating hormone; MRI = magnetic resonance imaging; EEG = electroencephalogram

RHEUMATOLOGY AND PSYCHIATRY

Rheumatology

ROUTE	OPERATIONAL GUIDANCE[78–81]
REFER	**Persistent symmetric small-joint swelling and morning stiffness**; systemic features with specific autoantibodies; atypical or treatment-unresponsive PMR
PRE-REFERRAL WORKUP	CBC, CMP, ESR/CRP, ANA with reflex testing when indicated, RF, anti-CCP; baseline radiographs of symptomatic joints
E-CONSULT/ PCP	**Isolated low-titer ANA without systemic features**; stable gout maintenance question
OLDER ADULT/ MEDICARE	**Escalate urgently** for suspected giant cell arteritis, rapidly progressive vasculitis, pulmonary-renal syndrome, or organ-threatening autoimmune disease

MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **inflammatory polyarthropathy**, **rheumatoid arthritis**, and **systemic lupus erythematosus**

ABBREVIATIONS: PMR = polymyalgia rheumatica; CBC = complete blood count; CMP = comprehensive metabolic panel; ESR = erythrocyte sedimentation rate; CRP = C-reactive protein; ANA = antinuclear antibody; RF = rheumatoid factor; anti-CCP = anti-cyclic citrullinated peptide

Psychiatry

ROUTE	OPERATIONAL GUIDANCE[82–84]
REFER	**Depression after 2 adequate medication trials**; suspected bipolar or psychotic disorder; mental illness complicated by severe substance use **requiring integrated care**
PRE-REFERRAL WORKUP	TSH/free T4, B12, folate, CMP, CBC, targeted toxicology; PHQ-9, GAD-7, MDQ when appropriate; medication and substance history

ROUTE	OPERATIONAL GUIDANCE[82–84]
E-CONSULT/ PCP	**Cross-taper question in a stable patient**; low-dose augmentation or insomnia strategy
OLDER ADULT/ MEDICARE	Suicidality, homicidality, severe agitation, catatonia, delirium, inability to care for self, or dangerous withdrawal **requires crisis or emergency care**

MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **schizophrenia**, **personality disorders**, and **major depressive disorder**

ABBREVIATIONS: TSH = thyroid-stimulating hormone; free T4 = free thyroxine; B12 = vitamin B12; CMP = comprehensive metabolic panel; CBC = complete blood count; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = Generalized Anxiety Disorder-7; MDQ = Mood Disorder Questionnaire

DERMATOLOGY AND ALLERGY/IMMUNOLOGY

Dermatology

ROUTE	OPERATIONAL GUIDANCE[85–89]
REFER	Lesion suspicious for **melanoma or squamous cell carcinoma**; psoriasis above 10% body surface area or severe refractory dermatitis; nodulocystic acne or hidradenitis needing systemic therapy
PRE-REFERRAL WORKUP	**Document**: topical therapy potency, duration, adherence, and response; include **high-quality images** and **any existing biopsy report**
E-CONSULT/ PCP	Stable benign-appearing rash image review; step-up therapy for localized eczema
OLDER ADULT/ MEDICARE	In older adults, **lower the threshold** for rapidly changing, bleeding, ulcerated, or nonhealing lesions and document immunosuppression and prior skin cancer

MAKING CONNECTIONS: Consult the VBC-focused **coding QRG** on **melanoma**

ABBREVIATIONS: PCP = primary care physician

Allergy/Immunology

ROUTE	OPERATIONAL GUIDANCE[90–93]
REFER	**Anaphylaxis to food**, **venom**, or **unknown trigger**; uncontrolled asthma/rhinitis despite optimized therapy; recurrent unusual sinopulmonary infections suggesting immune deficiency

ROUTE	OPERATIONAL GUIDANCE[90–93]
PRE-REFERRAL WORKUP	**Asthma/rhinitis**: spirometry and environmental-control history; **immune concern**: CBC with differential, SPEP, quantitative IgG/IgA/IgM, total IgE as directed by phenotype
E-CONSULT/ PCP	**Environmental-test interpretation**; remote mild penicillin-rash delabeling pathway question
OLDER ADULT/ MEDICARE	**Ensure epinephrine access and teach-back**; distinguish drug intolerance from allergy; delabeling can widen antibiotic choices and reduce avoidable broad-spectrum use
MAKING CONNECTIONS: Consult the VBC-focused **coding QRG** on **severe asthma**	

ABBREVIATIONS: CBC = complete blood count; IgG = immunoglobulin G; IgA = immunoglobulin A; IgM = immunoglobulin M; IgE = immunoglobulin E

UROLOGY AND OTOLARYNGOLOGY

Urology

ROUTE	OPERATIONAL GUIDANCE[94–97]
REFER	**Unexplained gross hematuria or persistent microscopic hematuria**; refractory retention, recurrent UTI, or severe LUTS despite medical therapy; confirmed concerning PSA pattern
PRE-REFERRAL WORKUP	Creatinine/eGFR, microscopic urinalysis, culture when indicated, repeat PSA when indicated; Prostate MRI, PVR and renal/bladder ultrasound for selected LUTS presentations
E-CONSULT/ PCP	**Small uncomplicated stone without infection or obstruction**; mild nonbothersome overactive bladder
OLDER ADULT/ MEDICARE	Anticoagulation does not explain away hematuria; **escalate**: fever plus obstruction, anuria, clot retention, testicular torsion, or sepsis **immediately**
MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **bladder cancer** and **prostate cancer**	

ABBREVIATIONS: UTI = urinary tract infection; LUTS = lower urinary tract symptoms; PSA = prostate-specific antigen; eGFR = estimated glomerular filtration rate; PVR = post-void residual

ENT/Otolaryngology

ROUTE	OPERATIONAL GUIDANCE[98–101]
REFER	Asymmetric sensorineural hearing loss or pulsatile tinnitus; chronic rhinosinusitis beyond 12 weeks with objective disease after medical therapy; dysphonia beyond 4 weeks or sooner with red flags
PRE-REFERRAL WORKUP	**Formal audiogram**; sinus CT after maximal therapy when indicated; focused head/neck exam; **laryngeal visualization precedes CT/MRI for isolated dysphonia**
E-CONSULT/ PCP	**Recurrent uncomplicated otitis externa**; mild positional vertigo before vestibular therapy
OLDER ADULT/ MEDICARE	Prioritize hearing access, falls, swallowing, aspiration, weight loss, tobacco history, neck mass, stridor, and caregiver communication

ABBREVIATIONS: CT = computed tomography; MRI = magnetic resonance imaging

GYNECOLOGY AND VASCULAR SURGERY

Gynecology

ROUTE	OPERATIONAL GUIDANCE[102–104]
REFER	**Abnormal uterine bleeding failing first-line therapy or concerning for pathology**; symptomatic fibroid or adnexal mass; high-grade cervical dysplasia or persistent abnormal screening requiring colposcopy
PRE-REFERRAL WORKUP	Pregnancy test when relevant, CBC, TSH and targeted coagulation testing; current cervical report; transvaginal/transabdominal ultrasound
E-CONSULT/ PCP	**Contraceptive switch for breakthrough bleeding**; uncomplicated recurrent candidiasis question
OLDER ADULT/ MEDICARE	Postmenopausal bleeding **requires prompt evaluation**; acute heavy bleeding with instability, chest pain, dyspnea, or syncope **is an emergency**

MAKING CONNECTIONS: Consult VBC-focused coding QRGs on **uterine cancer**, **ovarian cancer**, and **cervical cancer**

ABBREVIATIONS: CBC = complete blood count; TSH = thyroid-stimulating hormone; PCP = primary care provider; CT = computed tomography; MRI = magnetic resonance imaging

Vascular Surgery

ROUTE	OPERATIONAL GUIDANCE[105–107]
REFER	**Lifestyle-limiting PAD** despite structured therapy or any rest pain/tissue loss; AAA at diagnosis and repair-range or symptomatic disease; symptomatic carotid stenosis
PRE-REFERRAL WORKUP	**PAD**: ABI and arterial duplex; **AAA/carotid**: recent ultrasound or CT with exact dimensions/stenosis; include antiplatelet, statin, smoking, wound, and walking-program status
E-CONSULT/PCP	Surveillance interval for **stable small AAA**; mild uncomplicated varicose veins
OLDER ADULT/ MEDICARE	Acute limb ischemia, ruptured/symptomatic AAA, blue toe with progression, or infected ischemic wound **requires immediate escalation**

MAKING CONNECTIONS: Consult the VBC-focused **coding QRG** on **peripheral arterial disease** as well as the utilization management QRG on **antiplatelets**

ABBREVIATIONS: PAD = peripheral arterial disease; AAA = abdominal aortic aneurysm; ABI = ankle-brachial index; CT = computed tomography; PCP = primary care provider

NEUROSURGERY, COLORECTAL SURGERY, AND OPHTHALMOLOGY

Neurosurgery

ROUTE	OPERATIONAL GUIDANCE[108–111]
REFER	Progressive myelopathy or radiculopathy with motor, gait, or sphincter change; symptomatic intracranial lesion; disabling stenosis after conservative care
PRE-REFERRAL WORKUP	Recent high-resolution **syndrome-appropriate MRI**; detailed PT, injection, analgesic, and functional history
E-CONSULT/ PCP	**Stable incidental small meningioma or tiny aneurysm**; mild degenerative disc bulge without compression
OLDER ADULT/ MEDICARE	New bowel/bladder dysfunction, saddle anesthesia, progressive weakness, acute cord compression, or sudden severe headache **bypasses routine referral**

MAKING CONNECTIONS: Consult the VBC-focused **coding QRG** on **brain cancer**

ABBREVIATIONS: MRI = magnetic resonance imaging; PT = physical therapy

Colorectal Surgery

ROUTE	OPERATIONAL GUIDANCE[112–115]
REFER	Grade III/IV hemorrhoids, complex fistula, or chronic fissure after medical therapy; severe fecal incontinence after conservative care; full-thickness rectal prolapse, **colorectal cancer**
PRE-REFERRAL WORKUP	**Relevant endoscopy if indicated**; pelvic/anorectal examination; document fiber, stool regulation, topical therapy, and pelvic-floor treatment
E-CONSULT/ PCP	**Early hemorrhoid management**; mild pruritus ani after common causes addressed
OLDER ADULT/ MEDICARE	**Consider**: frailty, continence-related falls, skin injury, caregiver burden, anticoagulation, and whether bowel preparation or surgery is tolerable
MAKING CONNECTIONS: Consult the VBC-focused **coding QRG** on **colorectal cancer**	
ABBREVIATIONS: Grade III/IV = grade three/four	

Ophthalmology

ROUTE	OPERATIONAL GUIDANCE[116–119]
REFER	**Unexplained vision loss or metamorphopsia**; elevated IOP or optic-disc change; proliferative retinopathy, macular edema, or severe nonproliferative disease
PRE-REFERRAL WORKUP	Visual acuity per eye, red reflex and symptom onset; most recent A1C and BP trend **when retinopathy is relevant**
E-CONSULT/ PCP	**Chronic mild dry eye after artificial tears**; stable chalazion under 2 months
OLDER ADULT/ MEDICARE	Sudden vision loss, painful red eye with visual change, retinal-detachment symptoms, acute angle closure, or chemical injury **requires same-day emergency eye care**
MAKING CONNECTIONS: Consult VBC-focused **coding QRGs** on **age-related macular degeneration** and **diabetic eye disease**	
ABBREVIATIONS: IOP = intraocular pressure; A1C = hemoglobin A1c; BP = blood pressure	

VALUE-BASED REFERRAL DECISION WORKFLOW

In VBC, referrals are treated as **accountable episodes in which the PCP retains responsibility** for total cost, outcomes, and loop closure, **rather than a one-way handoff** that ends once the specialist is contacted.[120,121] This means each step below **adds an explicit quality**, **network**, and **coordination check** that traditional **fee-for-service referral practices typically omit**.[4,5]

STEP	PCP ACTION[5,20,21,122,123]	REQUIRED OUTPUT
1 | Red flag screen	**Identify threats to**: life, limb, vision, airway, spinal cord, organ function, or psychiatric safety	Emergency route selected without referral delay
2 | Optimize scope	Apply evidence-based PCP care and **define what remains uncertain or refractory**	Treatment trials and response documented
3 | Assemble data	**Complete**: clinically relevant labs, imaging, medication reconciliation, and trend review	Actionable package; avoid indiscriminate panels
4 | Choose route	PCP management, e-consult, urgent visit, routine visit, or procedure pathway	Urgency and reason recorded
5 | Select specialist	Use quality, access, network, patient preference, and episode performance	Named receiving service and backup plan
6 | Write SOS question	Status + Optimization + Specific Question, **including desired specialist role**	One narrow, answerable request
7 | Close access	**Confirm**: authorization, scheduling, transport, language, caregiver, and copay needs	Appointment or e-consult acceptance confirmed
8 | Close the loop	Receive note, reconcile recommendations, contact patient, and **define transition back**	Unified plan, owner, timeframe, and monitoring

ABBREVIATIONS: PCP = primary care provider; SOS = status, optimization, specific question

CLINICAL PEARL: PREPARE THE REFERRAL, DON'T RITUALIZE IT

Pre-referral completion should **make the first specialist interaction actionable**. It should **not** become a barrier that forces every patient through the same tests regardless of presentation.

EHR implementation tips

- Embed **specialty-specific SmartSets** with **conditional** rather than universal **data requirements**
- Require a specific clinical question and urgency selection **before submission**
- Create **exception buttons** for emergency escalation, contraindication, unavailable testing, and specialist-requested direct referral
- Route **unresolved referrals** to a work queue with named ownership and aging alerts

EHR-READY REFERRAL CHECKLIST

The EHR is the **operational backbone of a value-based referral**, structuring and transmitting complete patient data so the specialist receives an **actionable package** rather than a bare request, which **reduces duplicate testing**, **shortens wait times**, and **prevents lost or open-loop referrals**.[12,124] For the PCP, embedding these checklist fields directly in the EHR workflow **standardizes referral quality** and **closes the coordination gaps** that account for most referral breakdowns.[125]

SECTION	REQUIRED FIELD OR CONFIRMATION[9,20,21,126]
Patient and referral metadata	Patient; DOB; MRN; referring PCP; target specialty; named specialist/group; routine, urgent, or emergency route
Clinical gatekeeping	**Top-of-license care** reviewed; conservative treatment trial documented when applicable; red flags excluded; **e-consult considered for stable questions**
Specific question	**One narrow consultation goal**; expected specialist role; action PCP can take while waiting; **desired transition back**
Diagnostic package	Relevant current labs; trend data; imaging reports and image access; medication reconciliation; treatment failures; key progress notes
Network and financial	**Medicare plan/network status**; prior authorization; quality and access review; **out-of-network exception rationale when necessary**
Patient readiness	Transportation; caregiver; mobility; language; hearing/vision accommodations; copay; understanding of purpose and next step

ABBREVIATIONS: DOB = date of birth; MRN = medical record number; PCP = primary care provider

Referral Order Fields

FIELD	ENTRY[5,9,20]
STATUS	**Diagnosis or syndrome**; severity; trajectory; functional impact; **relevant positive and negative findings**
OPTIMIZATION	Tests and treatments completed; duration; adherence; response; contraindications; prior specialist input
SPECIFIC QUESTION	What **decision**, **confirmation**, **procedure**, or **co-management** action is requested?
URGENCY	Routine/urgent/emergency; reason and latest safe appointment date

FIELD	ENTRY[5,9,20]
OWNER WHILE WAITING	Named clinician/team and monitoring or contingency plan
RETURN PLAN	**Information expected from specialist**; PCP responsibilities after response; **transition criteria**

ABBREVIATIONS: PCP = primary care provider

TEACH-BACK: **Ask the patient or caregiver**: “What is the specialist being asked to decide, what should you do while waiting, and whom will you call if symptoms worsen?”

CLOSED-LOOP TRACKING AND PATIENT ACCESS

Closed-loop tracking assigns **explicit ownership** and **completion evidence** to every milestone from referral acceptance through the patient's transition back to primary care, so **no referral is lost in the common failure points** of scheduling, attendance, and note return.[12,125] Because **a large share of referrals are never completed or never return a usable specialist note**, this accountability structure is what converts a referral order into a **finished**, **safe**, and **coordinated episode of care**.[12]

MILESTONE	OWNER	EVIDENCE OF COMPLETION	ESCALATION TRIGGER
Referral accepted	Referral team	Receiving service **confirms complete package**	Rejected, redirected, or no response
Appointment scheduled	Scheduler/care coordinator	Date, location, modality, and preparation **confirmed**	**No appointment** within urgency window
Patient ready	Care coordinator	Transport, caregiver, interpreter, copay, and instructions **closed**	**Access barrier** threatens completion
Attendance confirmed	Referral team	**Claims**, **scheduling**, or **direct confirmation**	**No-show** or **cancellation without reschedule**
Consult note received	Referral team	Note and test results **available in EHR**	**No note** within local SLA
PCP review	PCP	**Recommendations reconciled**; duplicates and interactions resolved	Conflicting, unclear, or **unsafe plan**
Patient contacted	PCP team	**Teach-back**; medication and monitoring plan updated	Patient **cannot explain** or **access plan**
Transition established	PCP + specialist	Consult-only, shared care, or transfer role **documented**	**Indefinite specialty follow-up** without purpose

MILESTONE	OWNER	EVIDENCE OF COMPLETION	ESCALATION TRIGGER

ABBREVIATIONS: EHR = electronic health record; SLA = service level agreement; PCP = primary care provider

Four Checks Before SEND

CHECK	QUESTION[9,127,128]
RED FLAG	Does the patient need **emergency** or **same-day escalation** rather than referral?
DUPLICATE TEST	Are relevant prior results and image access attached so they are **not repeated**?
TOP OF LICENSE	Has **safe evidence-based primary care been attempted** or explicitly bypassed for a valid reason?
NETWORK + ACCESS	Is the selected route **clinically appropriate**, **covered**, **accessible**, and **acceptable** to the patient?

CLINICAL PEARL: DIAGNOSE THE ACCESS FAILURE BEFORE LABELING NONADHERENCE

A missed referral may reflect hearing loss, cognitive impairment, transportation, caregiver strain, or cost **rather than refusal**. Diagnose the access failure **before labeling nonadherence**.

PCP REFERRAL PERFORMANCE SCORECARD

Referral effectiveness and appropriateness are increasingly tracked, often continuously and through proprietary logic embedded in EHR referral modules and health-plan claims analytics, yet the specific targets and case-mix adjustments used are frequently invisible to the referring clinician.[5,129] The table below translates these **commonly measured domains** into transparent, realistic benchmarks that a primary care physician can act on directly. Rather than treating raw referral volume as a quality signal, these metrics span **network stewardship**, **referral preparation**, appropriate use of **e-consultation**, **downstream cost**, and **closed-loop follow-up**. The listed targets are pragmatic aim points for typical primary care panels; local peer means and health-plan definitions may differ, so they are best used to identify outliers and **guide workflow improvement** rather than as absolute pass/fail thresholds. Consistent pre-referral workup, appropriate in-network and e-consult routing, and reliable loop closure are the **levers most within a PCP's control** and tend to improve several of these measures simultaneously.[130]

METRIC	DEFINITION	TARGET	DATA SOURCE
In-network referral rate	In-network referrals/total outpatient referrals	**At least 85%**	Claims/EHR

METRIC	DEFINITION	TARGET	DATA SOURCE
Pre-workup completion	Referrals with brief-specified package/total referrals	**At least 90%**	EHR audit
E-consult utilization	E-consults/e-consults plus face-to-face referrals for nonurgent questions	**At least 25%**	Referral module
Risk-adjusted referrals	Annual specialty referrals per 1,000, adjusted for case mix	**Within 10% of peer specialty mean**	Claims/risk model
90-day specialty TCOC	Downstream specialty cost/ completed referral episode	**At or below peer median**	Claims
Referral conversion	Completed specialist visits/ authorized referrals	**At least 80%**	Scheduling/claims
Loop closure	Notes reviewed and acted upon/ completed consultations	**Local target**	EHR workflow

ABBREVIATIONS: EHR = electronic health record; TCOC = total cost of care

CLINICAL PEARL: USE THE PCP-TO-SPECIALIST RATIO AS A SIGNAL, NOT A SCORE

A PCP-to-specialist visit ratio of approximately **2:1 to 3:1** may **indicate PCP-led longitudinal care**, with primary care managing preventive, behavioral, and multisystem needs while **specialists address defined complex issues**.[33,131] **An inverted ratio** may signal fragmented care, duplication, polypharmacy, or excessive specialty dependence.[5,33] However, referral ratios should be interpreted with case mix, clinical outcomes, access, and patient needs because a **low ratio may also reflect under-referral**.[132] The goal is **appropriate** and **effective specialty use**, not simply fewer referrals.

Weighting Model

The following tables show how the individual referral metrics can be **combined into a single weighted performance score** and how PCPs are then grouped into **action-oriented performance bands**. The domain weights emphasize the factors most **within a clinician's control**: documentation readiness, network alignment, and appropriate e-consult use; banding translates a composite score into concrete recognition, coaching, or workflow-support pathways rather than punitive ranking.[125,133]

DOMAIN	WEIGHT	INTENDED SIGNAL
Clinical readiness and documentation	30%	First specialty interaction is actionable
In-network alignment	25%	Data continuity and contracted access

DOMAIN	WEIGHT	INTENDED SIGNAL
E-consult adoption	20%	Stable questions resolved digitally
Risk-adjusted volume	15%	Panel complexity considered
Episode cost efficiency	10%	High-quality, lower-cost specialist selection

PERFORMANCE BAND	PROFILE	ACTION
High-value partner	**Top 25%**; strong readiness and network retention	**Shared-savings recognition**; consider gold-card status
Opportunity zone	**Middle 50%**; moderate leakage or low e-consult use	**Peer coaching** and **specialty directory support**
High-variance provider	**Bottom 25%**; incomplete packages or high leakage	Focused review, **workflow redesign**, and clinical support

TEN KEY TAKEAWAYS FOR PCPS

1 Screen for emergency red flags first

Before any referral, screen for threats to life, limb, vision, airway, spinal cord, organ function, or psychiatric safety and route these to emergency care without delay.

2 Structure every referral with SOS

Frame each request as Status, Optimization, and Specific Question. A single, narrowly answerable clinical question paired with the relevant clinical status and prior optimization is what lets the specialist address the actual need without repeat workup or a wasted visit, which is the core determinant of a high-value referral.

3 Name the specialist's role, unambiguous ownership

State whether the specialist should advise, co-manage, perform a procedure, or assume care, so order ownership is unambiguous.

4 Use e-consults for stable, focused questions

In a US national sample, eConsults avoided or corrected a referral in 26.3%, avoided unnecessary testing in 26.1%, and improved the care plan in 75%.

5 Attach the data that make the first visit actionable

Send relevant labs, trends, medication reconciliation, and image access; structured referral sheets measurably improve appropriateness.

6 Preserve PCP ownership of the integrated care plan.

The PCP remains the accountable coordinator of one longitudinal plan, reconciling specialist input rather than relinquishing the patient.

7 Close Medicare barriers

Confirm transport, copay, language, mobility, cognition, and caregiver needs, since these determine whether referrals are completed.

8 Close the loop and track every step

Track acceptance, scheduling, attendance, note return, PCP action, and transition back; active closed-loop tracking with defined ownership at each milestone is what prevents referrals from being lost at the well-documented failure points of scheduling, attendance, and consult-note return, and enhanced EHR-based referral management measurably improves completion over ad hoc processes.

9 Measure appropriateness, not simply fewer referrals

Judge referral quality by appropriateness, completeness, and outcomes, not volume. Track risk-adjusted process and outcome measures (referral appropriateness, adequacy of pre-referral workup, loop closure, avoidable duplicate testing, and episode outcomes) rather than raw counts.

10 Select specialists on total episode value

Combine quality, access, network alignment, patient preference, and downstream cost, not proximity or volume alone.

AAVBC SUMMARY AND CONCLUSION

The highest-value referral is the **right patient**, routed at the **right urgency**, to the **right specialist**, with the **right question and data**, followed by **one reconciled plan** and a **defined return of ownership**.

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