Ep #170: When to Refer vs When to Manage: A Primary Care Guide for NP Boards

Full Episode Transcript

With Your Host

Anna Miller

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Anna: Welcome to the *Real Deal Nurse Practitioner Club*, the podcast for nurses who are ready to pass their boards and thrive in their careers as real deal nurse practitioners. I'm Anna, and I'm the Director of Nursing Content at Blueprint Test Prep. Whether you're deep in exam prep or stepping into practice, I've got you. It is time to become the confident, knowledgeable NP that you're meant to be. Let's dive in.

Hello, hello everyone. Welcome back. As usual, I'm Anna.

Alex: And I'm Alex. Thanks for joining us today.

Anna: Yeah, today's episode is one that I think every NP student and really every new nurse practitioner really struggles with at some point. And that's when do you manage something yourself and when is it actually time to refer? Because if you have ever taken practice questions while studying, you've probably noticed that refer to XYZ specialist shows up as an answer choice all the time. And there's almost this, I feel like, test taking myth that's like if you're stuck, pick the answer that refers them.

Alex: Yes, I hear that from students constantly. And while a referral is definitely the correct answer sometimes, it's definitely not always the correct answer.

Anna: Yeah, so today I really want to talk about that like clinical judgment piece, right? Your exam, it is trying to determine whether you know what falls in the scope of a safe entry level primary care nurse practitioner. So Alex, let's just start there. What are the boards actually testing when they're asking these referral questions?

Alex: I think just like you mentioned that boards are really just testing your clinical judgment. So just be careful here because a lot of students will see refer to a specialist and think, that feels like the safest answer. But before you choose it, ask yourself, have I done everything that would be expected of an entry level NP first? And if the answer is no, it's probably too early to refer.

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Anna: Yeah, I love that. I mean, really, technically every patient could be referred, right? So really the better question to ask is, is a referral appropriate right now or appropriate today? Right? If someone is working through an exam question or they're in clinic seeing patients, what questions do you think Alex should be running through their mind?

Alex: I keep it really simple. There are a few questions I always ask myself. First, are there any red flags? Is this patient's condition unstable? Could something life threatening be happening? If the answer is yes, I'm not even thinking about a routine referral here. I'm thinking emergency department evaluation.

Second, if a patient's clinical status is stable, is their condition appropriate for primary care management? Or is it a complex presentation that likely requires specialist input? And if their clinical scenario is something I can handle within my scope, have I actually initiated the appropriate first line management? If it's within my scope and I haven't even tried evidence-based treatment, then why would I send them somewhere else?

Anna: Yeah, absolutely. So I want to go ahead and just work through a sample patient scenario together because I think that really helps people start to understand the difference. So let's just say we have a 52-year-old patient who comes into the primary care office for a routine visit. Their blood pressure is 168 over 96. And they actually feel fine. There's no headache, no chest pain, no shortness of breath, no neurologic symptoms. And this is the first time that they've ever been diagnosed with hypertension. So what's going through your head when you meet this patient, Alex?

Alex: Well, the first thing I'm thinking is, is this patient stable? And based on what you just told me, the answer is yes, if their physical exam is also unremarkable. So let's say there's no evidence of a hypertensive emergency or signs of end organ damage. This is a patient that falls into routine primary care management.

So this is where we'd start guideline directed care. We'd confirm the diagnosis appropriately. We'd start an antihypertensive if indicated. We'd talk about lifestyle changes like sodium reduction, exercise, weight management, and arrange close follow up to see how they're responding. So this is exactly the kind of patient the boards expect you to manage, not refer.

Anna: Yeah, and I think that's a really important point because I can almost hear some students thinking, you know, it's that high of a blood pressure reading, like do I need to send them to the emergency department? Are they going to have a stroke? Do I need to send them to cardiology? But they haven't even been treated yet, and like you said, they don't have any of those alarm signs that make me immediately refer them.

Alex: Exactly. We haven't given first line management even a chance to work. So referring immediately would actually skip over care that's completely within the primary care NP scope. And if you come from an inpatient background as an RN, this can be a really tough mindset shift. So in the hospital, it's common to see a specialist consulted for all kinds of things, right? Because those patients are often more complex and have multiple issues going on. But remember, the boards are testing outpatient primary care. Stable, uncomplicated hypertension is something they expect you to manage confidently before involving a cardiology specialist.

Anna: All right, now let's fast forward about six months. So we have the same patient. They've been really compliant with their treatment. They're taking multiple different blood pressure medications at appropriate doses. They're watching their sodium intake, they're exercising. And yet, after multiple medications, multiple follow ups, their blood pressure is still running in the 170s over 90s. And then on top of that, we do some lab work and today's lab work is going to show hypokalemia. So now, how does your thinking change here?

Alex: Yeah, so now I'm wondering if this is truly essential hypertension or if there's something else going on, right? The biggest clue here is that they're

on three different blood pressure medications and they still have high blood pressure, right? So when someone has resistant hypertension despite appropriate therapy, that's a big old red flag. When you add hypokalemia into the picture, now I'm thinking about a possible secondary cause like primary hyperaldosteronism or another endocrine or kidney disorder.

So at this point, we've done everything we're supposed to do in primary care. We've started treatment, we've optimized medications, we've reassessed, and now it's appropriate to involve a specialist because the clinical picture has become more complicated.

Anna: Yeah, I think that's a really really good distinction to make, right? Our diagnosis has not changed here. It's still hypertension in both cases, but really the difference is the context that we're looking at it through.

Alex: Exactly, and NP boards love that. Always look at the context that you are given in the question.

Anna: All right, let's do another one because diabetes is one of those diagnoses you'll see all of the time in primary care, and a lot of times you can manage it in primary care. So we have a 58-year-old, they come in after routine lab work, and their A1C comes back at 7.2%. Kidney function is normal, they're otherwise healthy, and this is a brand new diagnosis of type two diabetes. So just starting out here, what's your plan, Alex?

Alex: So this is another patient that we should absolutely feel comfortable managing in primary care. We're going to talk about nutrition, exercise, and weight management if warranted. We'll discuss diabetes education and typically start first line medication, like metformin, if there aren't any contraindications, of course. We'll monitor their A1C over the next several months and adjust treatment based on how they respond, right? So no endocrinology referral is needed here yet.

Anna: All right, but now let's change the story. Let's say it's been over a year. They have been incredibly motivated. They're taking metformin.

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You've added a GLP one receptor agonist. Later, you've added an SGLT two inhibitor, and despite all of that, their A1C is still climbing or, let's say maybe they're having frequent hypoglycemia.

Alex: So now we've reached the point where another set of eyes would be really beneficial to the patient. So this is where endocrinology can help with advanced insulin management or even further evaluation if we're questioning the diagnosis, right? So again, the referral isn't because we gave up. It's because we've appropriately managed everything within our primary care scope, and now the patient's complexity has outgrown the routine primary care.

Anna: Yeah, I think another place where students tend to get tripped up is they confuse what warrants an outpatient referral versus what needs like an emergency care or an urgent referral.

Alex: Absolutely. So not every patient who needs a higher level of care gets referred to a specialist, right? Sometimes they just need the emergency department. Chest pain with diaphoresis, that is not a cardiology referral, that is EMS, right? A patient who is pregnant with severe hypertension, headache, vision changes, that is not an outpatient OB referral. They need immediate evaluation in labor and delivery, right? So a patient with saddle anesthesia, urinary retention, severe low back pain, that's not neurosurgery next month, folks. That's the emergency department for possible cauda equina syndrome.

Anna: Yeah, and I'm going to say, I think this is something that evolves as you gain more experience, right? As a new NP, there's always that fear of either referring too much or not referring enough. And one thing I always tell new clinicians is this: use your guidelines. If you're practicing evidence-based medicine within your scope and you've appropriately initiated first line management, you are practicing safely. And so don't feel you have to refer just because you're new. But at the same time, don't be afraid to refer when a patient scenario becomes more complicated.

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Specialists are part of the healthcare team, and good clinicians know when to manage independently, but they also know when collaboration benefits the patient. And remember that you can also go ahead and get a second opinion from another provider in the office if you're unsure. You never have to be in this alone. So Alex, if listeners remember one thing from this episode today, what do you hope it is?

Alex: I'd want them to remember that a referral isn't about confidence, right? It's about clinical judgment. If the patient is stable, the clinical picture is within your scope, and the current guidelines support outpatient management, then that's your role as a primary care clinician. But once those red flags appear or treatment fails or the clinical picture becomes complicated, that's when a referral becomes the safest and smartest decision. So that's exactly the type of thinking your boards are trying to assess.

Anna: Yeah, I love that. You are not trying to prove that you can manage everything yourself, right? That is not expected of you. But you are trying to show that you know when routine primary care ends and when another level of expertise will improve the patient care. That is what makes someone a safe nurse practitioner. We're all about what is best for our patient.

All right, if you enjoyed today's episode, we cover referral decisions, red flags, and tons and tons of board style clinical judgment cases inside our review courses, our live review, our question bank. And we don't just teach you the right answer. We're going to be teaching you how to think through the question like a practicing NP.

Alex: And if you're looking for more free resources, come join our Facebook community and follow us on Instagram. We are always posting clinical pearls, practice questions, and study tips. We even have a TikTok account where we post frequently.

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Anna: Yeah, and definitely follow us on TikTok and Instagram because we do sometimes randomly go live and do little like free lives on there. And another little tidbit here, we are going to be starting a little mini series here soon in the next few weeks over some of those red flags that do warrant a more immediate or urgent referral. But thank you for joining us today. Remember, you don't have to know everything. You just have to know how to think like a safe, competent new nurse practitioner to pass your exam. We'll see you next time.

Thanks for listening to another episode of the *Real Deal Nurse Practitioner Club*. If you want more information about the different types of support that we offer to students and new nurse practitioners, you can visit npreviews, with an S, dot com. We'll see you next week.