E-Consult Workgroup Webinar

December 19, 2018
12-1 PM

blue of california foundation

BluePath HEALTH

Agenda

Agenda Topic	Time
Introductions and Agenda Review	10 minutes
Presentation by Daren Anderson, MD, Weitzman Institute	15 minutes
Summary of November E-Consult Workshop	5 minutes
DHCS 2019 Telehealth Manual and E-Consult	15 minutes
E-Consult Workgroup Efforts in Conjunction with DMHC	5 minutes
Next Steps	10 minutes

Reduced Cost Of Specialty Care Using Electronic Consultations For Medicaid Patients

Daren Anderson, MD
Director, Weitzman Institute
Community Health Center, Inc.

weitzman institute
inspiring primary care innovation

The December 2018 issue of *Health Affairs*, available beginning today, details a study led by the Community Health Center's Weitzman Institute showing dramatic cost savings to Medicaid when electronic consults (eConsults) are used for specialty care. The study found that linking primary care providers with specialist via eConsults for dermatology, endocrinology, gastroenterology and orthopedics resulted in average savings of $82 per patient per month over six months.

weitzman institute

A Learning and Innovation Center
Supporting Practice Transformation for Safety Net Practices Nationwide

Reduced Cost of Specialty Care Using eConsults for Medicaid Patients

Daren Anderson, Victor Villagra, Emil Coman, Tamim Ahmed, Anthony Porto, Nicole Jepeal, Giuseppe Macri, Bridget Teevan

Weitzman Institute
Middletown, CT

www.weitzmaninstitute.com

HealthAffairs

CeCN

Community eConsult Network, Inc.

"Primary care is the provision of first contact, person-focused, ongoing care over time that meets the health related needs of people, **referring only those too uncommon to maintain competence**"

— Dr. Barbara Starfield

Former Director, Johns Hopkins University Primary Care Policy Center

Specialty Care for Medicaid Two Challenges:

- **Imbalance between supply and demand**
  - **Limited access/poor network adequacy**
  - **Longer wait times**
  - **High no-show rates**
  - **Health disparities**
- **Cost**
  - **Referrals to specialty care are increasing**
  - **Specialty care is a significant contributor to increasing Medicaid costs**
  - **Options for reducing cost by primary care are limited**

Community Health Center, Inc.

HealthAffairs

Setting:

- Statewide FQHC
- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Annual budget: $100m
- Staff: 1,000
- Patients/year: 100,000
- Integrated behavioral health

CHC Locations in Connecticut

THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Annals of Family Medicine 2017

Electronic Consultations to Improve the Primary Care-Specialty Care Interface for Cardiology in the Medically Underserved: A Cluster-Randomized Controlled Trial

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ABSTRACT

PURPOSE Communication between specialists and primary care clinicians is suboptimal, and access to referrals is often limited, which can lead to lower quality, inefficiency, and errors. An electronic consultation (e-consultation) is an asynchronous, non-face-to-face consultation between a primary care clinician and a specialist using a secure electronic communication platform. The purpose of this study was to conduct a randomized controlled trial of e-consultations to test its efficacy and effectiveness in reducing wait times and improving access to specialty care.

METHODS Primary care clinicians were randomized into a control (9 traditional) or an intervention (17 e-consultation) arm for referrals to cardiologists. Primary care clinicians were recruited from 12 practice sites in a community health center in Connecticut with mainly medically underserved patients. Two end points were analyzed with a Cox proportional hazards model where the hazard of either a visit or an e-consultation was linked to study arm, sex, race, and age.

RESULTS Thirty-six primary care clinicians participated in the study, referring 590 patients. In total, 69% of e-consultations were resolved without a visit to a cardiologist. After adjusting for covariates, median days to a review for an electronic consultation vs a visit for control patients were 5 and 24, respectively. A review of 6-month follow-up data found fewer cardiac-related emergency department visits for the intervention group.

CONCLUSION E-consultation referrals improved access to and timeliness of care for an underserved population, reduced overall specialty utilization, and streamlined specialty referrals without any increase in adverse cardiovascular outcomes. e-consultations are a potential solution for improving access to specialty care.

Ann Fam Med 2016;14:133-140. doi: 10.1370/afm.1869.

Conflicts of interest: authors report none.

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INTRODUCTION

The number of ambulatory care visits that result in a referral to another health care clinician has doubled during the past decade.[1] Timely access and good communication between clinicians are essential for quality, efficiency, and patient safety. In a national survey, however, only 34% of specialists reported routinely receiving information from referring primary care clinicians, and only 62% of the clinicians reported reliably receiving information back from the specialist.[2] This suboptimal exchange of information leads to an increase in medical errors, wasteful spending, and poor quality of care.[3,4]

In addition, access to subspecialty care is often limited, especially for medically underserved populations. At least 1 in 4 medical encounters at community health centers result in a referral to a specialist.[5] Obtaining appointments for these referrals is challenging because so few specialists are willing to accommodate them.[5,6] This imbalance in supply and demand leads to waiting times for appointments that can be as long as 1

CHC-UCONN Cardiology eConsult Trial

Target population

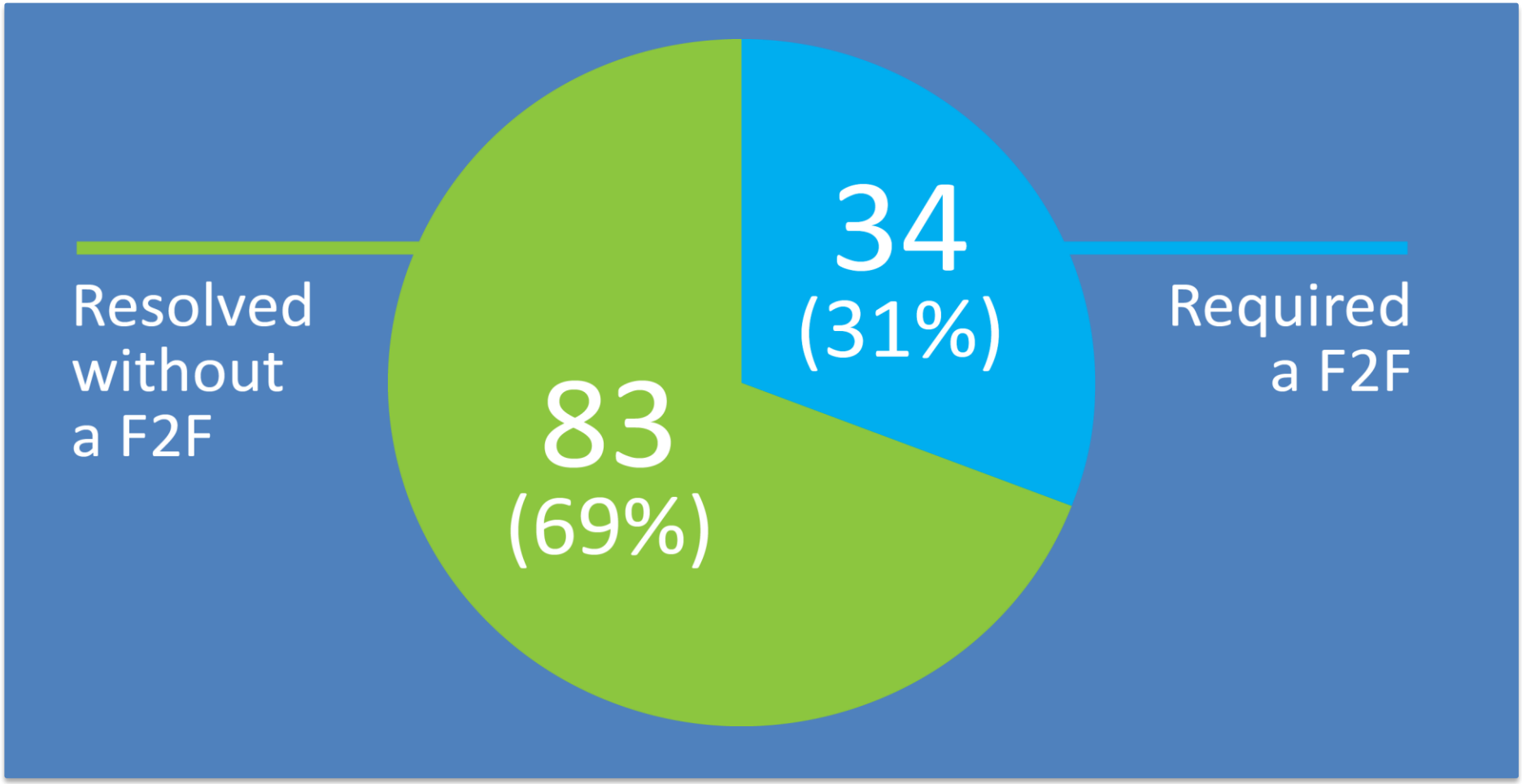
- Primary Care Providers: in a large, multisite FQHC in CT

Study Design

- Prospective, cluster-randomized controlled trial
- One-year intervention
- Key implementation characteristic: “default” standing order for submission

Annals of Family Medicine 2017

eConsults



Reduction in ED Use

	Intervention			Control
	Total N=229	Traditional Pathway N=109	eConsults Pathway N=120	N=361
Death from any Cause	0	0	0	1 (0.3)
Myocardial Infarction	0	0	0	0
Coronary Artery Bypass Surgery	0	0	0	0
Catheterization with Stenting or Angioplasty	3 (1.3)	1 (0.9)	2 (1.7)	2 (0.6)
ED Visits with Possible Cardiac Symptoms*	4 (1.7)	3 (2.8)	1 (0.8)	21 (5.8)
Hospitalization for Arrhythmia	2 (0.9)	2 (1.8)	0	5 (1.4)
Hospitalization for Atypical Chest Pain	6 (2.6)	4 (3.7)	2 (1.7)	10 (2.8)
Hospitalization for Syncope or Near Syncope	0	0	0	4 (1.1)
Hospitalization for Congestive Heart Failure	2 (0.9)	1 (0.9)	1 (0.8)	0

American Journal of Managed Care 2018

CLINICAL

A Cost-Effectiveness Analysis of Cardiology eConsults for Medicaid Patients

Daren Anderson, MD; Victor Villagra, MD; Emil N. Coman, PhD; Ianita Zlateva, MPH; Alex Hutchinson, MBA; Jose Villagra, BS; and J. Nwando Olayiwola, MD, MPH

ABSTRACT

OBJECTIVES: To evaluate the cost-effectiveness of electronic consultations (eConsults) for cardiology compared with traditional face-to-face consults.

STUDY DESIGN: Cost-effectiveness analysis for a subset of Medicaid-insured patients in a cluster-randomized trial of eConsults versus the traditional face-to-face consultation process in a statewide federally qualified health center.

METHODS: A total of 369 Medicaid patients were referred for cardiology consultations by primary care providers who were randomly assigned to use either eConsults or their usual face-to-face referral process. Primary care providers in the eConsult arm transmitted consults to cardiologists using a secure peer-to-peer communication platform in an electronic health record. Intention-to-treat analysis was used to assess the total cost of care and cost across 7 categories: inpatient, outpatient, emergency department, pharmacy, labs, cardiac procedures, and "all other." Costs are from the payer's perspective.

RESULTS: Six months after the cardiology consult, patients in the eConsult group had significantly lower mean unadjusted total costs by $655 per patient, or lower mean costs by $466 per patient when adjusted for non-normality, compared with those in the face-to-face arm. The eConsult group had a significantly lower cost by $81 per patient in the outpatient cardiac procedures category.

CONCLUSIONS: These findings suggest that eConsults are associated with total cost savings to payers due principally to reductions in the cost of cardiac outpatient procedures.

Am J Manag Care. 2018;24(1):e294–e301

Many initiatives aimed at transforming primary care have concentrated on the development of patient-centered medical homes, with emphasis on elements including the adoption of electronic health records (EHRs), multidisciplinary team-based care, and care coordination. Fewer efforts have been directed at improving the interface between primary care providers (PCPs) and specialists in the outpatient setting.[1-3] This gap is notable given the significant clinical importance and financial impact of the PCP–specialist relationship. Outpatient specialty visits represent a disproportionate source of year-over-year increases in healthcare expenditures,[4,5] with research suggesting that a typical PCP interacts with more than 200 specialists in a year.[6] Such financial considerations are increasingly important as payment reform gains momentum across the country and stimulates experimentation with novel reimbursement arrangements. Additionally, the proliferation and adoption of new technologies, including EHRs and secure health information exchanges, are creating fertile conditions for improving the interface between specialists and PCPs.

Electronic consultations (eConsults) are non–face-to-face (F2F) consultations between a PCP and a specialist that utilize secure messaging to exchange information. Unlike electronic referral systems that link primary care practices with specialty providers for F2F appointment triage, eConsults provide a virtual consultation by the specialist after clinical information sent by the PCP is reviewed and returned with recommendations, which potentially eliminates the need for the patient to be seen in person by the specialist. Health systems that implemented eConsults have improved specialty access, reduced wait times,[7] and decreased F2F consultations between 9% and 51% depending on setting and specialty.[8-14] However, few studies have evaluated the effects of PCP access to a secure eConsult platform on total healthcare expenditures. Findings using retrospective data from an eConsult program in Canada suggest the potential for cost savings,[7,15] but these studies were not randomized and did not evaluate the impact on total cost of care. The reduction in F2F

Medicaid Claims Data Analysis of previous RCT

Randomized Trial of Cardiology eConsults

“Default” model for eConsult submission

UCONN Cardiologists

Connecticut Medical Assistance Program
Policy Transmittal 2016-25

Provider Bulletin 2016-67
October 2016

Roderick L. Bremby, Commissioner

Effective Date: July 1, 2016
Contact: Dana Robinson-Rush @ 860-424-5615

TO: **Federally Qualified Health Centers (FQHCs)**

RE: **Guidance for E-Consultation Services Performed by FQHCs**

Effective for dates of service beginning July 1, 2016 and forward Federally Qualified Health Centers (FQHCs) are eligible to receive a supplemental payment for electronic consultations (e-consults) related to medical diagnoses. FQHCs will **not** receive a supplemental payment for e-consults with behavioral health or dental specialists.

FQHCs may qualify for e-consults billed for members who are currently enrolled under HUSKY A, C and D. At this time, services provided to HUSKY B members do **not** qualify for the e-consult supplemental payment.

The Department of Social Services (the Department) has established the following conditions to qualify for the supplemental payment for e-consults to FQHCs:

Specialists Providing E-consults:

- An agreement between the FQHC and the specialists or the entities, who are representing the specialists must be in place prior to the transmission of the e-consults;
- The agreement will state whether the specialist is either employed or contracted with the FQHCs, as defined in Sec. 17b-424-338(46) of the regulations of Connecticut state agencies; and,
- The specialist must be licensed to practice medicine in Connecticut and be enrolled as a Medicaid provider, in accordance to section 1902(a)(kk)(7) of the Social Security Act, which includes enrollment as an ordering, prescribing or referring (OPR) only status.

Requirements of E-consult's Electronic System:

- Compliance with HIPAA and other applicable security and privacy requirements;
- Enables transmission through electronic communication systems to a specialist who uses the information to evaluate the cases for the type of e-consults for which it is used; and,
- Compatibility to FQHC's electronic health records (EHR) system.

Expectations for E-consult:

E-consults must be performed in a timely manner, within 5 business days after the initial or follow-up medical appointment providing that the FQHC documents the medical justification of the referral.

Coding Requirements for E-consults:

When the e-consult is performed on the same day:

- FQHCs will be required to bill code T1015 along with Current Procedural Terminology (CPT) code 99213 'Office or other outpatient visit for evaluation and management of an established patient, 2-3 components', and
- The modifier GQ **must** be used to certify that an asynchronous medical file was collected and transmitted at the distant site.

When the e-consult is performed within 5 business days (only) after the initial or follow-up corresponding medical encounter:

- If the e-consult was performed within 5 business days after the initial or follow-up corresponding medical encounter, the detail billed with CPT code 99213 with GQ modifier must have the **actual date** the e-consult was performed.

Department of Social Services Division of Health Services 55 Farmington Avenue Hartford, CT 06105
www.ctdssmap.com

CT State Plan Amendment

- Provided path for sustainability
- Additional specialties added: dermatology, endocrinology, GI, orthopedics

Journal of the American Academy of Dermatology 2017

ARTICLE IN PRESS

ORIGINAL ARTICLE

Impact of dermatology eConsults on access to care and skin cancer screening in underserved populations: A model for teledermatology services in community health centers

Fludiona Naka, BA,[a] Jun Lu, MD,[b] Anthony Porto, BA,[c] Jose Villagra, BS,[c] Zhao Helen Wu, PhD,[d] and Daren Anderson, MD[c]
Farmington and Middletown, Connecticut

Background: The clinical outcome of teledermatology with dermoscopy in large-scale primary care networks remains unclear.

Objective: We evaluate the impact of implementing a teledermatology consultation program with dermoscopy on a statewide scale, focusing on access to care and skin cancer screening for medically underserved populations.

Methods: Descriptive retrospective cohort study of 2385 dermatology referrals from primary care from June 2014 through November 2015.

Results: Before implementation of electronic consultations (eConsults), access to dermatology was limited; only 139 (11%) of 1258 referrals resulted in a confirmed appointment with a median wait time of 77 days. Post implementation, 499 of 1127 consults (44%) were sent electronically, and of those, 16% required a face-to-face visit with a median wait time of 28 days. Ten malignancies were identified via eConsults. Overall consult volume remained stable pre- and post-eConsult implementation.

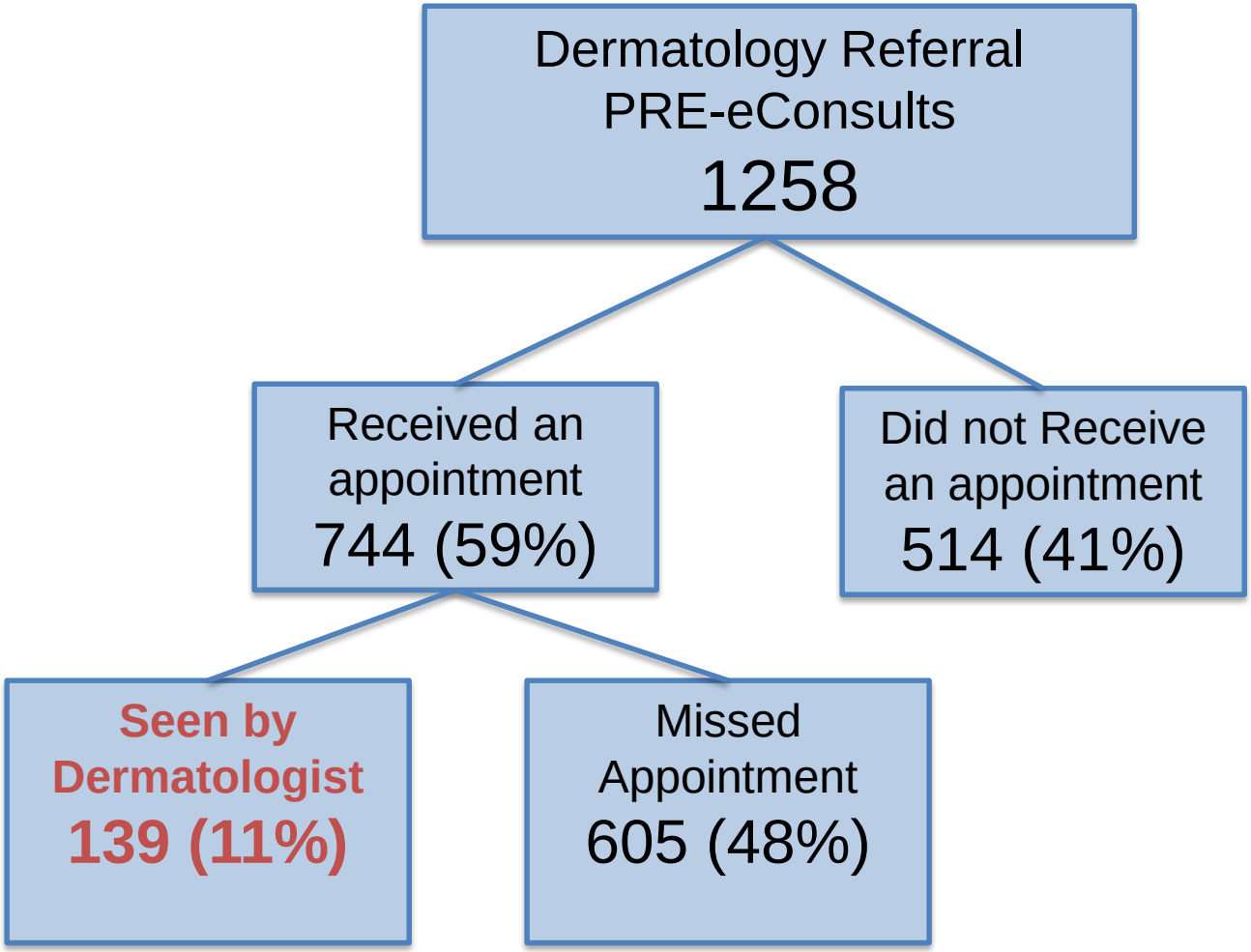
Limitations: We evaluated eConsults in medically underserved populations seeking care at community health centers. Results might not be generalizable to other populations or in other settings.

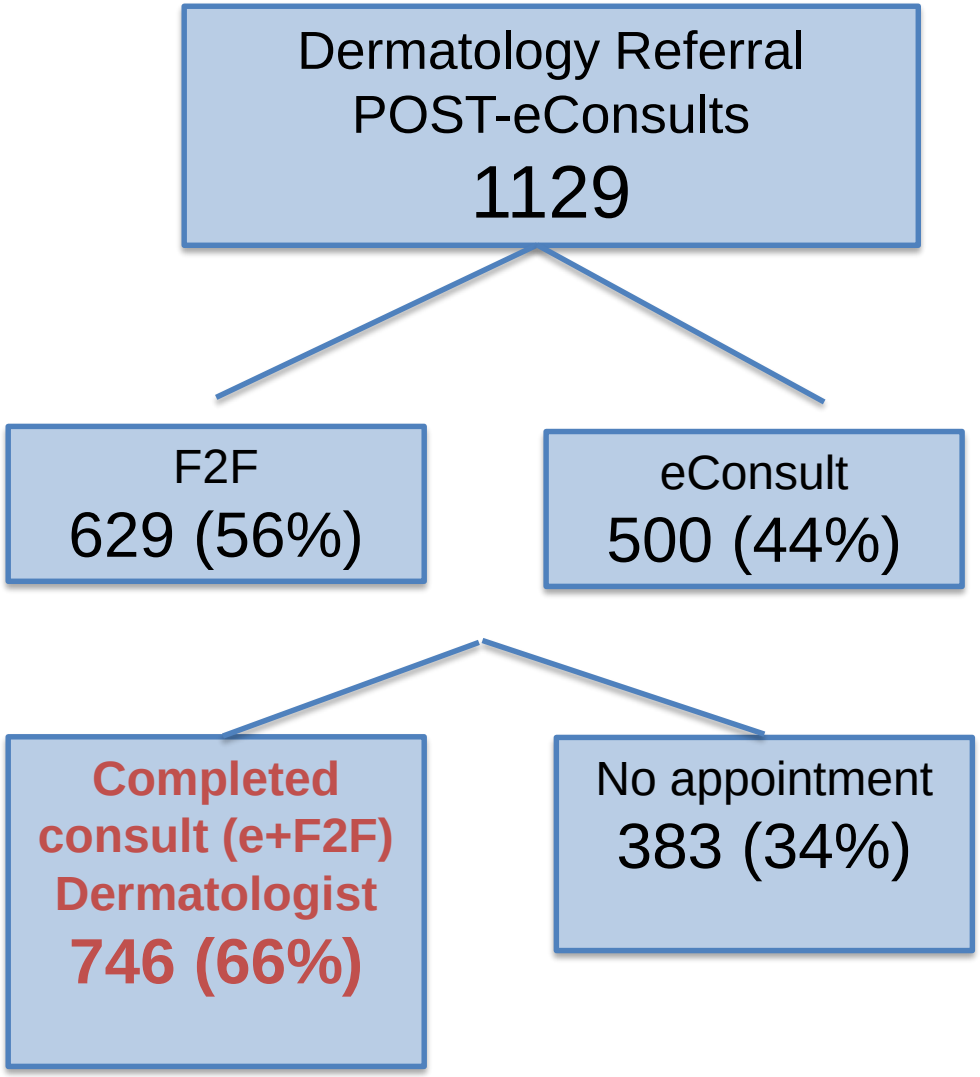
Conclusion: eConsults increase access to dermatologic care and reduce wait times for patients receiving medical care at community health centers. Implementing dermoscopy into teledermatology could increase access to skin cancer screening and treatment for medically disadvantaged populations. (J Am Acad Dermatol https://doi.org/10.1016/j.jaad.2017.09.017.)

Key words: access; dermoscopy; diagnosis; eConsults; skin cancer; store-and-forward; teledermatology; underserved populations.

Dermatologic conditions affect approximately one third of people in the United States.[1,2] Despite efforts to expand insurance coverage, access to specialty care for uninsured and Medicaid patients remains limited.[3,4] Access to dermatologic care is particularly challenging due to the shortage of dermatologists, limited acceptance of state-funded insurance plans, and geographic barriers.[5] Asynchronous (store-and-forward) teledermatology has emerged as a promising solution to

- Pre-Post analysis of eConsults for dermatology
- Analysis of potential malignancies


Dermatology Referral
PRE-eConsults
1258
Received an appointment
744 (59%)
Did not Receive an appointment
514 (41%)
Seen by Dermatologist
139 (11%)
Missed Appointment
605 (48%)


Dermatology Referral
POST-eConsults
1129
F2F
629 (56%)
eConsult
500 (44%)
Completed consult (e+F2F) Dermatologist
746 (66%)
No appointment
383 (34%)

Reduction in F2F Referrals				
	Total Referrals	Total referrals sent as eConsults	eConsults with no F2F needed	Total %F2F Avoided
Cardiology	949	299	273	29%
Dermatology	1882	799	633	34%
Endocrinology	750	319	285	38%
Gastroenterology	2013	279	142	7%
Orthopedics	2062	498	341	17%

Expansion to additional specialties reduced demand for F2F visit.
Question: What was the cost impact of this reduction in F2F referral

Key elements of the Health Affairs study:

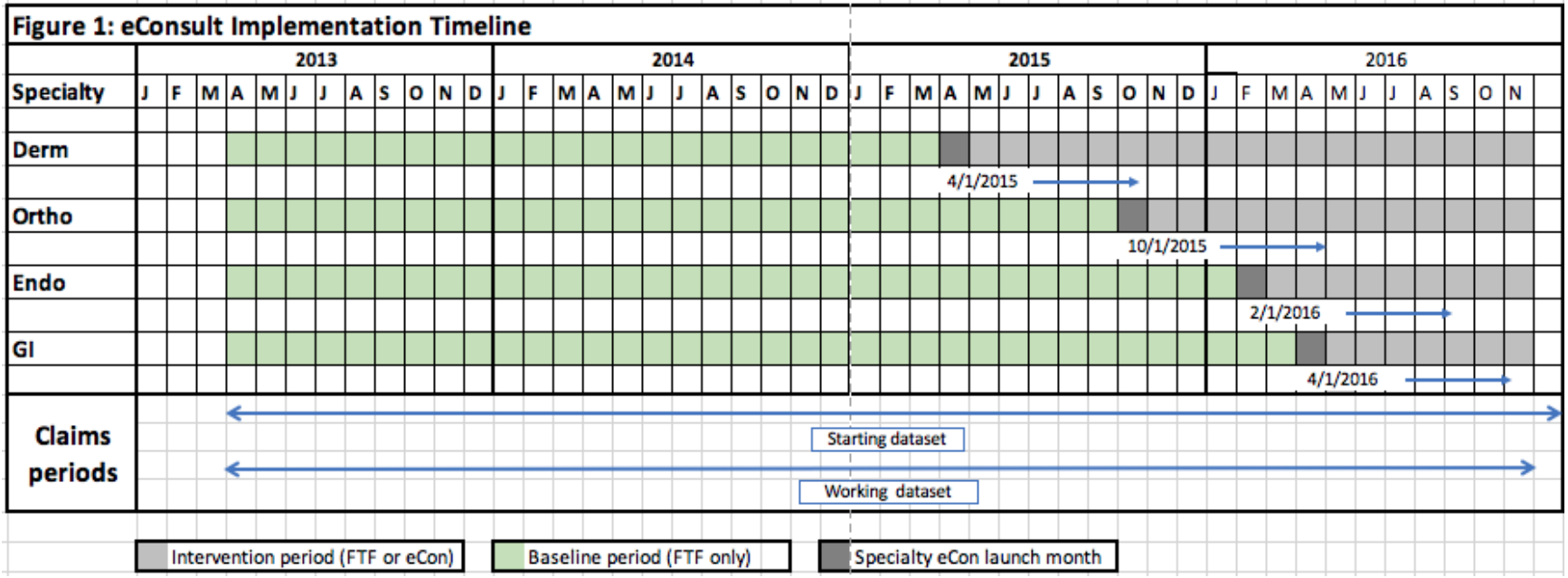
- Pragmatic trial of eConsults in a large, statewide community health center
- Simple workflow/limited impact on PCP workload
- eConsults for Endocrinology, Orthopedics, Gastroenterology, Dermatology
- Comparison between patients with consults sent electronically vs. face to face

PCP

Intervention: An eConsult sent electronically to a specialist including appropriate PHI with a formal response back from specialist

Specialist

Study Timeline



Variables	Face-to-face		eConsults		Differences (Δ)	
Categorical	N	%	N	%	N	%
Females[a]	4,462	(61.4%)	366	(63.8%)		
Race/Ethnicity[a]						
Hispanic	2,857	(41.42%)	212	(39.92%)		
White	2,615	(37.92%)	207	(38.98%)		
Black	824	(11.95%)	61	(11.49%)		
Asian	198	(2.87%)	20	(3.77%)		
Native American	25	(0.36%)	3	(0.56%)		
Multi-racial	378	(5.48%)	28	(5.27%)		
Continuous	Average	95% CI	Average	95% CI	Average	95% CI
Age[a]	41.78**	(41.37; 42.20)	40.21	(38.74; 41.68)	1.58	(0.05; 3.10)
Total Costs	$221	($11; $232)	$200	($166; 234)	-$22	(-$58; $14)
Dermatology	$33	($27; $40)	$26	($16; $37)	-$7	(-$19; $5)
Endocrinology	$180	($147; $213)	$151	($75; $228)	-$29	(-$112; $55)
Gastroenterology	$57	($49; $65)	$28	(-$4; $61)	-$28	(-$62; $5)
Orthopedics	$151	($140; $163)	$103	($55; 150)	-$49	(-$98; $0)

Findings:

- Compared 574 eConsults to 7,273 face-to-face consults
- No baseline differences in specialty-specific costs
- Significant differences in PMPM costs over six months
- Lack of continuous enrollment in Medicaid was a challenge (5,923 excluded)

Differences between face to face and eConsult specialty-related costs

Differences	Average (PMPM)	95%CI
Total Costs	-$84****	(-$101; -$67)
Dermatology	-$14	(-$27; $0)
Endocrinology	-$63**	(-$102; -$25)
Gastroenterology	-$59***	(-$75; -$42)
Orthopedics	-$85****	(-$105; -$65)

Summary

- Improve specialty access for safety net practices
- eConsults are safe, andReduce ER utilization
- Reduce cost of specialty care in five common specialties
- Enhance primary care capacity

CeCN
Community eConsult Network, Inc.

2018 E-Consult Workshop Objectives
November 7, Sierra Health Foundation, Sacramento

Optimization of Existing Programs

- What is needed to improve the provider experience?
- What is needed to improve patient understanding?
- What are best practices in referral process improvement?

Sustainability in Health Systems

- What incentive programs exist and how are they supported?
- How are systems optimizing incentive program reporting (GPP, PRIME)?
- How are cost savings being captured in health systems?

Workgroup Focus in 2019

- What regulatory changes are proposed for 2019?
- How do we support implementation of CPT code changes?
- Is legislation needed to ensure e-consult is reimbursable and sustainable?

DHCS Telehealth Provider Manual 2019 and E-Consult

DMHC and the E-Consult Workgroup met with DHCS on October 12 to discuss the draft telehealth manual and make recommendations to align Medi-Cal's processes with national project efforts. With this discussion and feedback gathered on November 7, we formally submitted comments to DHCS on November 15. We appreciate DHCS's efforts to respond to our comments.

What's New?

- **CPT code 99451** will be used to capture e-consults performed by specialists.
  - This code reflects 5 or more minutes of time spent by the consulting (not treating) provider.
- Patients' **written or verbal consent** (not informed consent) must be obtained for e-consult.
  - This can be encompassed in a general consent agreement obtained by the provider organization and does not have to be captured with each encounter.
- **E-consult providers must be licensed in California and enrolled Medi-Cal providers**, yet need not reside in California if they are affiliated with a billing organization located in California.

DHCS Telehealth Provider Manual 2019 and E-Consult

What was expected?

- **Documentation** of the e-consult must be captured in the patient's medical record.
- E-consults may be applied to time and distance requirements if the provider organization submits an **alternative access request** to the Medi-Cal Quality and Monitoring Division.
- Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Centers (IHCs) cannot bill for e-consult as originating sites.
- **Only one site** (distant site) can bill for the e-consult.
- Telehealth services including e-consult must be made available to **all beneficiaries.**

DHCS Telehealth Provider Manual 2019 and E-Consult

What needs to be clarified?

- ***The reimbursement amount for CPT code 99451.*** This has not yet been determined and will be made available on the physician fee schedule once finalized.
- **E-consult providers must be licensed in California and enrolled Medi-Cal providers.** What if they are part of a remote vendor panel and affiliated with a billing organization located in California? Clarification is requested.
- ***When these codes will be billable.*** This is anticipated in spring 2019, and will be prospective from the effective date in the All Plan Letter to be published.

The E-Consult Workgroup appreciates DHCS's acknowledgment of our group's comments, many of which were reflected in the process of capturing e-consult in 2019 and ongoing. Additional information can be found on the DHCS web site under Telehealth:

https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx

DMHC and E-Consult Workgroup Collaboration with MCOs

DMHC has met with California Managed Care Organizations throughout 2018 to discuss how plans can capture their e-consult program successes in improving access and network adequacy and presenting these accomplishments to the department.

Access	***Network***	***Quality***	***Effectiveness***
• E-consult results in improved timely access rates of compliance for the patients who receive FTF visits	• E-consult does not result in a narrower network – it expands the list of specialists available for specialty access	• E-consult for routine and non-urgent cases improves the quality of care delivered - FTF visits that occur are those of high value	• Rates of satisfaction and resolution without the need for a FTF visit are tracked at the specialty level

*State of California Business and Professions Code Section 2290.5, 1.

California Managed Care Plans are Sharing Successes from E-Consult Programs

In addressing the potential for including e-consult in annual network reporting, MCOs are presenting sample filings to demonstrate the impact of their e-consult programs on timely access to specialty care and network adequacy.

Criteria included (but not limited to) MCO E-Consult Program Detail

- Description of the Telehealth Services
- List of Contracting Providers
- Calculation of Provider-to-Enrollee Ratios
- Standards of Accessibility
- Referral Process
- Internal Quality of Care Review System
- Language Assistance
- Provider Contracts
- Administrative Service Agreements
- Contracts with Government Agencies/MOU with Government Agencies
- Subscriber Contracts
- EOCs and Disclosure Documents
- Grievance Policy and Procedure

E-Consult and the DMHC Annual Network Reporting Form

DMHC has revised the draft Annual Network Report to reflect workgroup input and have released the draft to MCOs for additional input on format and usability.

DMHC Updates:

- Revising network reporting form to reflect payers' telehealth efforts
- Determining how template can be implemented in 2018-2019
- Addressing questions regarding fields/format of form

Next Steps

- Share questions needing clarification from DHCS
- Determine what information and support are needed to roll out the CPT code for e-consult across new and existing e-consult programs
- Engage managed care organizations that report to DHCS to share their e-consult program accomplishments for the purposes of improving network adequacy and timely access
- Continue sharing plan supported programs with DMHC
- Consider industry opportunities to present – and request workgroup assistance
- Share needs for tools and resources at econsulttoolkit.com

Appendix

For the past 3 years, BluePath Health has worked in collaboration with CCHP to promote e-consult adoption, policy advancement and financial sustainability

eConsult Definition and Incentives

DHCS and DMHC

- Facilitate CCHP eConsult Workshops to further reimbursement discussions among DHCS, MCPs and DPHs
- Discuss rates for eConsult CPT codes based on time spent

MCPs

- Work with MCP stakeholders within pilot regions to discuss potential reimbursement of specialist eConsults
- Consider eConsult to address increased specialty care timely access requirements following Covered California expansion

Engagement and Collaboration

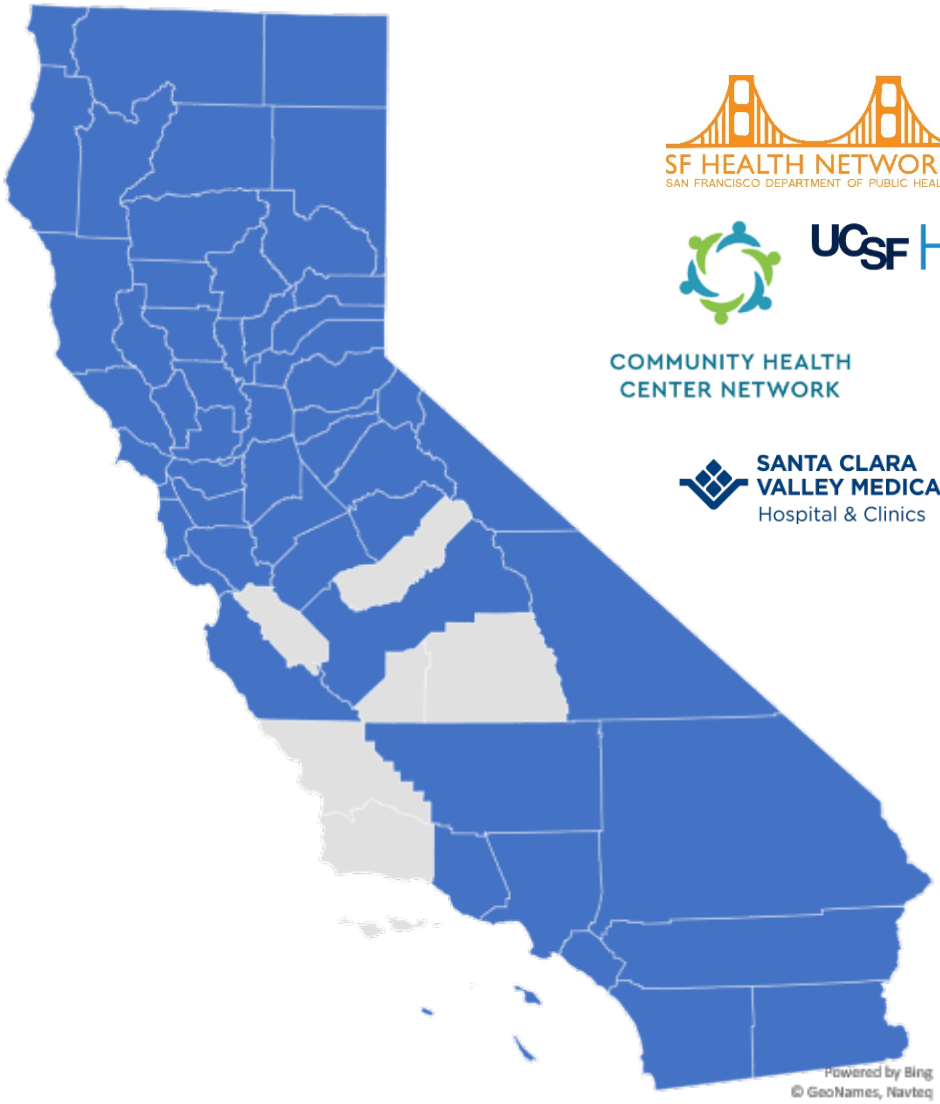
DPHs

- Share best practices in implementing eConsult, aligning measures with Waiver program and BSCF pilot requirements
- Facilitate FQHCs, BH/MH and social services in pilot regions in pursuing GPP programs, utilizing eConsult as appropriate to meet program goals

CHCs/FQHCs

- Seek opportunities to engage FQHCs in waiver programs which value alternative (specialty care) touches and avoidable utilization of high-cost health care services
- Develop an incentive plan to engage FQHCs

CA Organizations with Operational and Planning E-Consult Programs



SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

ALAMEDA HEALTH SYSTEM

PARTNERSHIP HEALTHPLAN of CALIFORNIA

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

california health & wellness

COMMUNITY HEALTH CENTER NETWORK

UCSF Health

COMMUNITY HEALTH PARTNERSHIP

UCDAVIS HEALTH SYSTEM

CHAPA-DE INDIAN HEALTH

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SHD
Seneca Healthcare District

Health Services
LOS ANGELES COUNTY

L.A. Care HEALTH PLAN

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NORTH COUNTY HEALTH SERVICES
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VENTURA COUNTY MEDICAL CENTER

ECRMC
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An Agency Of The City Of El Centro

the Coalition
of Orange County Community Health Centers

UC San Diego Health

California MCOs involved in e-consult planning to-date

Local Initiatives (LCHP)

County Organized Health Systems (COHS)

**The e-consult program in the plan's coverage area is supported by a hospital or clinic network*

2018 E-Consult Workshop Objectives
November 7, Sierra Health Foundation, Sacramento

Optimization of Existing Programs

- What is needed to improve the provider experience?
- What is needed to improve patient understanding?
- What are best practices in referral process improvement?

Sustainability in Health Systems

- What incentive programs exist and how are they supported?
- How are systems optimizing incentive program reporting (GPP, PRIME)?
- How are cost savings being captured in health systems?

Workgroup Focus in 2019

- What regulatory changes are proposed for 2019?
- How do we support implementation of CPT code changes?
- Is legislation needed to ensure e-consult is reimbursable and sustainable?

The E-Consult Workgroup and DMHC formed a subgroup to address key questions in sharing e-consult program data

DMHC Needs

- How e-consult results in improved access and network adequacy;
- Long term impact on quality of care and outcomes;
- Process of credentialing out of state specialists;
- Evidence that focus remains on getting face-to-face visits with specialists when needed; and
- Evidence of patient experience and level of satisfaction.

Plan Needs

- How e-consult should be captured in telehealth templates;
- How credit would be given in annual network review;
- How to present e-consult as a means of alternative access in meeting network adequacy requirements; and
- Reassurance that e-consult will not result in penalties (e.g. narrow networks).

DMHC Subgroup definition and Key Tenets of E-Consult

*E-consult or "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.**

Access	***Network***	***Quality***	***Effectiveness***
• E-consult results in improved timely access rates of compliance for the patients who receive FTF visits	• E-consult does not result in a narrower network – it expands the list of specialists available for specialty access	• E-consult for routine and non-urgent cases improves the quality of care delivered - FTF visits that occur are those of high value	• Rates of satisfaction and resolution without the need for a FTF visit are tracked at the specialty level

*State of California Business and Professions Code Section 2290.5, 1.

Workgroup collaboration with MCOs and DMHC resulted in draft tools to report program accomplishments

Work products include:

- Draft Annual Network Reporting form for MCOs to share e-consult and telehealth
- Sample filings by volunteer plans to present e-consult program successes

See attached draft format of Annual Network Reporting Form to reflect telehealth (including e-consult)

DMHC team members revised the draft Annual Network Report to reflect workgroup input and have released the draft to MCOs for additional input on format and usability.

Work in progress:

- Revising network reporting form to reflect payers' telehealth efforts
- Determining how template can be implemented in 2018-2019
- Addressing questions regarding fields/format of form

Workgroup members IEHP and LA Care Health Plan agreed to submit sample e-consult filings to DMHC for feedback

In addressing the potential for including e-consult in annual network reporting, MCOs are presenting sample filings to demonstrate the impact of their e-consult programs on timely access to specialty care and network adequacy. DMHC and BluePath Health are working with plans on the best format for the sample filing, in alignment with an amendment to the plan's application.

Criteria included (but not limited to) MCO E-Consult Program Detail

- Description of the Telehealth Services
- List of Contracting Providers
- Calculation of Provider-to-Enrollee Ratios
- Standards of Accessibility
- Referral Process
- Internal Quality of Care Review System
- Language Assistance
- Provider Contracts
- Administrative Service Agreements
- Contracts with Government Agencies/MOU with Government Agencies
- Subscriber Contracts
- EOCs and Disclosure Documents
- Grievance Policy and Procedure

Next Steps

- Determine pathway for managed care organizations that report to DHCS to share their e-consult program accomplishments for the purposes of improving network adequacy and timely access
- Determine what information and support are needed to incorporate CPT codes for e-consult aligned with recommendations in CMS 2019 Physician Fee Schedule
- Answer additional questions from DHCS
- Engage DHCS and DMHC in E-Consult Workgroup discussions on November 7

E-Consult Toolkit

http://econsulttoolkit.com/

Comments or contributions? Please send to electronic_consult@bluepathhealth.com

E-Consult *Toolkit* *Right care, right setting, right time*

Background · News · Policy · Case Studies · Publications · Contact · **Tools**

"E-consult provides better care and makes our providers happier. We've had great adoption throughout our system."

-Michael Mulligan, MD, Chapa De Indian Health

E-Consult News & Events

- **Next CCHP E-Consult Workgroup Webinar Scheduled for October 3rd** The first CCHP E-Consult Workgroup Webinar for Q4 2018 will be held at 12 p.m. PDT on Wednesday, October 3rd. Contact us to learn about joining the Workgroup and attending the webinar.
- **E-Consult Workgroup Submits Comments on CMS 2019 Physician Fee Schedule (PFS)** Final comments on CMS's proposed reimbursement for provider-to-provider communications were gathered from E-Consult Workgroup members and submitted to CMS on September 10th. CMS is expected to finalize the 2019 PFS rules in November.
- **Community Health Center Network (CHCN) Adopts E-Consult to Repair Speciality Referral Process** In 2015, only 16% of CHCN's Medi-Cal patients were receiving specialty care. An analysis of its specialty referral process uncovered complexities that, in addition to lack of access and patient no-shows, contributed to this lack of speciality care. **More**

Expanding Safety Net Access to Specialty Care With E-Consult:

Best Practices, Tools and Templates for Payers, Providers, Policymakers and Patient Advocates

Readiness · **Planning** · **Implementing and Scaling** · **Evaluation**

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