2019 E-Consult Workshop

Sierra Health Foundation
November 4, 2019
<table>
<thead>
<tr>
<th>Session</th>
<th>Description</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Celebration of our achievements, review of the day’s agenda and objectives</td>
<td>10:00-10:15</td>
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</tbody>
</table>
| Keynote Speakers                    | Thoughts on the E-Consult journey and highlights from recent publications  
  • Delphine Tuot, MD, Associate Professor, Nephrology, Zuckerberg San Francisco General, Associate CMO of Specialty Care and Diagnostics  
  • Douglas Archibald, PhD, Assistant Professor and Educational Research Scientist, Department of Family Medicine, University of Ottawa  
  • Paul Giboney, MD, Associate CMO, Los Angeles County Department of Health Services | 10:15-11:15 |
| Payer Strategies for E-Consult Program Engagement | Panel on programs engaging providers and improving member satisfaction  
  • Tanya Dansky, MD, VP & CMO, Blue Shield Promise Health Plan  
  • Joel Gray, Executive Director, Anthem Blue Cross  
  • Somer Harris, Telehealth Program Manager, Partnership Health Plan  
  • Sajid Ahmed, IEHP, CEO, Wise Health Care | 11:15-12:15 |
| Lunch                               | Lunch and networking session                                                                                                                                                                                 | 12:15-12:45 |
| Lightning Round: What Challenges Remain | 10-minute lightning round presentations on:  
  • Engagement and Scale – Mark Schweyer, Director of Telehealth Programs, Health Net  
  • Operationalizing – Daren Anderson, MD, Director, Weitzman Institute, VP/CQO of Community Health Center, Inc.  
  • Payment – Mike Witte, MD, Vice President and CMO, California Primary Care Association  
  • FQHC Programs – Ella Schwartz, Director of Operations, Community Health Center Network | 12:45-1:45 |
| Tabletop Session                    | Working session on remaining challenges and strategies in each area                                                                                                                                        | 1:45-2:30 |
| State Policy Perspectives           | Perspectives on policy, PRIME program updates and next steps in reporting  
  • Paul Giboney, MD, Associate CMO, LADHS  
  • David Lown, MD, Chief Medical Officer, California Health Care Safety Net Institute  
  • Dan Southard, Deputy Director, Office of Plan Monitoring, CA Department of Managed Health Care | 2:30-3:30 |
| Vision for 2020                     | Reactor panel thoughts on day’s discussion and focus of Workgroup in 2020                                                                                                                                   | 3:30-4:00 |
| Cocktail Reception                  | Please join us for the reception at Chevy’s on the River, 1369 Garden Highway                                                                                                                               | 4:15-6:00 |
Vision for 2020

https://www.youtube.com/watch?v=i7Bt_m1cfIU
Vision for 2020 – E-Consult Workgroup Accomplishments

**eConsult Definition and Incentives**

- Monthly webinars and four annual workshops to further discussions among stakeholders
- Acceptance from DHCS (99451 CPT code and e-consult reimbursement)
- MCP support of e-consult, and engage PCPs at FQHCs
- Discussions with DHCS on specialty care timely access requirements
- Acknowledgment of e-consult in DMHC requirements

**Engagement and Collaboration**

- Opportunities for DPHs/DMPHs to share best practices in e-consult and support reporting
- Work with FQHCs, BH/MH and social services in pursuing GPP goals
- Support of e-consult reporting in PRIME, demonstrating alternative touches, closed loop communications and improved turnaround time
- Work with FQHCs to determine how to incorporate e-consult programs
E-Consult collaboration across California: Addressing Underserved Areas and Populations
Thoughts on the E-Consult Journey

Delphine Tuot, MD
Associate Professor, Nephrology, Zuckerberg San Francisco General
Associate CMO of Specialty Care and Diagnostics

Douglas Archibald, PhD
Assistant Professor and Educational Research Scientist
Department of Family Medicine, University of Ottawa

Paul Giboney, MD
Associate CMO
Los Angeles County Department of Health Services
eConsult: there and back again

Delphine S. Tuot, MDCM, MAS
Associate Professor of Medicine, UCSF
Assoc CMO Specialty Care & Diagnostics, ZSFG
Director, UCSF Center for Innovation in Access and Quality
“Every system is perfectly designed to get the results it gets.”

Paul Batalden, MD to Don Berwick, MD, circa 1996
Spread of new models

The law of diffusion of innovation

How innovations spread

- Relative attributes of the innovation (effectiveness, cost-efficient, complexity)
- Compatibility with existing delivery systems
- Observability (modeling by early adopters)
- Trialability / ability to pilot
- Observability (outcomes can be easily observed)
- Implementation support & Technical assistance
- Influence of change agents (policy, payment reform)

Improved patient experience
- Reduced wait times for in-person specialty care appointments
- Faster turnaround time for specialty expertise
- Virtual management keeps patients in medical-home, reduces need for in-person care coordination, transportation & associated costs

Improved provider experience
- High PCP satisfaction; ambivalent or high specialist satisfaction
- Continued Medication Education; ongoing learning for referring providers
- Opportunity to teach for seasoned specialists; retirement plan?

Population Health
- Reduced wait times for specialty care delivery (virtual and in-person) with most recommendations delivered to patients
- Similar safety profile as referrals for in-person SC visits
- Identification of patients that should be seen in SC
- Quality of SC care similar to CKD, DM, Cardiology

Lower costs/greater efficiency of specialty care delivery
- Decreased costs to payors (Medicaid, ACO)
- Decreased cost to patients (less travel, co-pays, associated costs)
- Increased complexity in specialty care clinics

References:
Chen, NEJM 2013
McAdams, Fed Practitioner, 2014
Tuot, Healthcare, 2015
Gleason, Healthcare, 2016
Pecina, SAGE Open Med, 2016
Kwok, J Telemed and Telecare, 2017
Olayiwola, HSR, 2017
Liddy, Can Fam Phy, 2017
Barnett, Health Affairs, 2017
Anderson, AJMC, 2018
Newman, AJMC, 2019
Vimalanada, JAMIA, 2019
Adoption/spread across U.S.

- Kaiser Permanente
- Veterans Administration
- Jail health
- Colorado ACC
- San Juaquin
- CHCN
- AHS
- UCSF
- SFHN
- SCVMC
- SMMC
- UCLA
- LADHS
- Ventura
- UCSD
- CA Health Plans
- Partnership Health Plan
- CA Health & Wellness
- Inland Empire Health Plan
- LA Care
- University of Mass. Memorial Medical Center
- Mayo Clinic
- Univ of Iowa
- Univ of Wisc
- Dartmouth-Hitchcock
- Brigham and Women’s Hospital
- Mass General
- NY HHS
- Geinsinger
- Community Clinics, Inc.
- Univ North Carolina
- Duke Univ
- Univ of Virginia
- AAMC: Project Core (Wave 2 + 3)
- East Carolina Univ Physicians
- Greenville Health System
- Medical College of Wisc.
- Ohio State University
- Oregon Health and Sciences
- Penn State Health
- Univ of Colorado
- Univ of Michigan
- Univ of Utah Health
- Univ of Washington Medicine
- Vidant Health
- Wake Forest Baptist Health
- Yale Medicine
Diffusion: there and back again

- Relative attributes of the innovation (effectiveness, cost-efficient, complexity)
- Compatibility with existing delivery systems
- Observability (modeling by early adopters)
- Trialability / ability to pilot
- **Observability (outcomes can be easily observed)**
- Implementation support & Technical assistance
- Influence of change agents (policy, payment reform)
**Diffusion: there and back again**

**Observability (outcomes can be easily observed; i.e. more data!)**
- Efficacy at population level (pragmatic RCTs)
- Overall cost data from diverse organizations
- Simulated cost data from health centers
- Stakeholder stories, placing patients in the center

**Implementation support & Technical assistance**
- Enhanced communication/expectations with patients, caregivers, families, policy-makers
- Integration with patient portal
- Spread the work among PC team members
- Greater integration with EHRs for efficiency, safety, accountability
- Local remuneration for specialist time and PC coordination
- Sharing best practices at national level

**Influence of change agents (policy, payment reform)**
- Advocate for ongoing payment reform and acceptance
Electronic consultations (E-consults) and their outcomes: a systematic review

Varsha G Vimalanada, Jay D Olander, Melissa K Afable, B. Graeme Fincke, Amanda K Solch, Seppo T Rinne, Eun Ji Kim, Sarah L Cutrona, Dylan D Thomas, Judith L Strymish and Steven R Simon

Records identified through database searching (n = 1544)

Duplicates removed (n = 482)

Titles and abstracts screened (n = 1062)

Records excluded (n = 928)
- 525 not topical
- 176 about different forms of consultation
- 122 not peer-reviewed empiric studies
- 68 image-based
- 27 e-referral only
- 8 review articles
- 2 not in English

Full-text articles assessed for eligibility (n = 134)

Full-text articles excluded (n = 71)
- 58 did not report outcomes relevant to this review
- 10 about different forms of consultations
- 3 not peer-reviewed empiric studies

Studies included in qualitative synthesis (n = 63)
Patient educational material for use at point-of-care

• What is an eConsult?
• What are the next steps?
• Set expectations

Iterative process with patient advisors and advocates

• Simple language
• Less text
• Translations into Spanish and Cantonese

San Francisco Health Network eConsults

What is an eConsult?
Your doctor/provider may send an electronic message (eConsult) to a specialist asking for advice about your health concerns.

What happens during an eConsult?

Step 1: Today
Your doctor/provider sends a message (eConsult) to a specialist about your health concern.

Step 2: Within 1 week
The specialist reviews the eConsult and responds to your doctor/provider with advice or recommends an appointment.

Step 3: Within 2 weeks
If no appointment: A member of your care team may contact you about specialist advice.

OR

Step 3: Within 2 weeks
If an appointment is recommended, the specialist’s office will call or send a letter with appointment details.

“* If you don’t hear anything about your eConsult within 3 weeks, call your clinic to find out! **

Please make sure that your phone number and address are up to date in our system so that we can reach you.

Funded by the Blue Shield of California Foundation
Optimizing clinic workflow

- Shared language: talking points about eConsult
- Empower all team members to discuss eConsults with after-visit-summary

**eConsult Talking Points for Primary Care Teams**

Emphasize how you are all in this together:

- To work with the specialist to find the answers to your questions.
- To make sure that your questions and concerns are represented in our communications to the specialist.

Set clear expectations for three possible outcomes of the eConsult:

1. **No specialist appointment** will be scheduled – primary care will continue managing the patient’s concerns using the specialist’s advice.
2. **Further testing** is recommended by the specialist.
3. **The specialist office will contact the patient** by phone or by mail to schedule an appointment.

Make a plan with your patient for closing the loop

- Confirm the patient’s address and phone number.
- Inform the patient that further testing and/or an in-person primary care appointment may be the recommended next step. The patient will receive a phone call from the primary care team if this is the case.
- Give the patient an approximate time frame for when you will be able to contact them with the results of the eConsult. For example:
  - Primary care team will call the patient with the specialist’s feedback if no specialist appointment has been scheduled within 2 weeks.
  - If a specialist appointment is scheduled, patient will receive a phone call or a letter from the specialist office within 2 weeks. Patients should call the primary care call center to close the loop if they don’t hear from anyone about the eConsult result in that time frame.
Thoughts on the E-Consult journey and highlights from recent publications

Presented by Doug Archibald, PhD
Director of Research and Innovation
Department of Family Medicine, University of Ottawa
Investigator, Bruyère Research Institute, Ottawa, Canada
Overview of eConsult
eConsult National Updates – October 2019

British Columbia
- Uses Doctor-to-Doctor platform
- Launched April 2017

Alberta
- Uses Alberta Netcare to offer eAdvice to all PCPs
- Launched October 2016

Manitoba
- Uses BASE™ platform
- Direct replication
- Launched Fall 2017

Ontario
- Ontario eConsult Program for all PCPs in province using four services (ChamplainBASE™ (SharePoint), Ontario eConsult Service (OTNHub), Teledermatology and Teleophthalmology (separate platforms))

Newfoundland and Labrador
- Uses BASE™ platform
- Direct replication
- Provincial focus

Nova Scotia
- Planning underway

New Brunswick
- BASE™ model on EHR platform for all PCPs
- Launched Spring 2018

Quebec
- BASE™ model on Quebec platform
- Launched July 2017

Nunavut
- Access to Champlain BASE™ specialists for remote PCPs

2019-11-06
## Snapshot of Provincial eConsult Services

<table>
<thead>
<tr>
<th>Province</th>
<th># eConsults Sent</th>
<th># Primary Care Providers</th>
<th># Specialists</th>
<th># Specialty Services Available</th>
<th>Notes</th>
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<tbody>
<tr>
<td>British Columbia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>~60/case per month currently</td>
</tr>
<tr>
<td>Data</td>
<td>&gt;1000</td>
<td>621</td>
<td>102</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Data Reporting Period</td>
<td>April 2017 – October 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data</td>
<td>14,672</td>
<td>1448</td>
<td>249</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Primary care providers do not need to register to use the service. We only capture number of providers who submitted a request.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Data Reporting Period</td>
<td>January 2014 - March 2018</td>
<td></td>
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<tr>
<td>Manitoba</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Data</td>
<td>797</td>
<td>182</td>
<td>45</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Data Reporting Period</td>
<td>13 Dec 17 - 30 Sep 19</td>
<td>25 Sep 15 - 30 Sep 19</td>
<td>19 Nov 17 - 22 Oct 19</td>
<td></td>
<td></td>
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<tr>
<td>Ontario</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ontario is reporting active users only, meaning the provider has submitted 3 or more eConsults in the last 6 months and includes three services under the Ontario eConsult Program: Champlain BASE™, Ontario eConsult Service and Teledermatology</td>
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<tr>
<td>Data</td>
<td>52,346</td>
<td>2042</td>
<td>694</td>
<td>228</td>
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<tr>
<td>Data Reporting Period</td>
<td>1 Oct 18 - 30 Sep 19</td>
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<td></td>
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<tr>
<td>Québec</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Data</td>
<td>2463</td>
<td>197</td>
<td>54</td>
<td>26</td>
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<tr>
<td>Data Reporting Period</td>
<td>4 Jul 17 - 16 Oct 19</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>New Brunswick</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Data</td>
<td>314</td>
<td>84</td>
<td>23</td>
<td>8</td>
<td>Access was given to all Primary Care physicians within the EHR. All physicians in the province have the ability to access the EHR but must make a request and complete some privacy training. NP’s currently do not have access but should within the calendar year.</td>
</tr>
<tr>
<td>Data Reporting Period</td>
<td>8 May 18 - 10 Oct 19</td>
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<td></td>
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<tr>
<td>Newfoundland &amp; Labrador</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt; 75,000 eConsults nationally</td>
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<tr>
<td>Data</td>
<td>4069</td>
<td>84</td>
<td>23</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Data Reporting Period</td>
<td>as of 27 Sep 19</td>
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On the Horizon

National eConsult expansion
• Talks underway with Saskatchewan
• Planning for new discussions with the territories and PEI

eConsult/eReferral Integration
• Alberta has an integrated eConsult/eReferral system (NetCare)
• Ontario has a pilot underway
• Newfoundland and Labrador is in the planning stages
• A national working group has been established to look into three major areas of interest:
  – Developing national strategies
  – Developing strategies for providers
  – Influencing eConsult/eReferral integration
Harnessing Practice Based eHealth Technologies and Assessments to Improve Feedback and Promote Reflection

THE EDWARD J. STEMMLER, MD
MEDICAL EDUCATION RESEARCH FUND
Project Team

Principal Investigator:
Douglas Archibald, uOttawa, BRI

Project Manager:
Rachel Grant, uOttawa, BRI

Research Assistant:
Sheena Guglani, BRI

Co-Investigators:
Craig Campbell, RCPSC
Roland Grad, McGill University
Mira Irons, ABMS
Erin Keely, uOttawa
Clare Liddy, uOttawa, BRI
David Price, ABMS
Justin Sewell, UCSF
Scott Shipman, AAMC
Jeffery Sisler, CFPC
Delphine Tuot, UCSF
Timothy Wood, uOttawa
Purpose

Develop and pilot two eConsult reflective learning tools for PCPs and specialists that:

1. Document and reflect on their learning from eConsults

2. Provide specialists with feedback on their consultative responses
Study Objectives

1. Develop two tools to assess reflective learning in eConsult services
2. Ensure the tools allow clinicians to document their learning
3. Pilot the tools
4. Identify elements and processes to inform how learning from eConsults may be incorporated into MOC programs
Methods

1. Subject Matter Experts Meeting
2. Delphi Method
3. Testing
4. Pilot
1. Subject Matter Experts Meeting

• 6 subject matter experts
• Explored existing reflective practice tools
• Decided to modify two validated tools:
  – IAM Push
  – IAM Search
2. Delphi Method

Consensus technique; uses iterative surveys to reach consensus

Consensus:
- 70% on a single item, or
- ≥80% on adjacent items
Delphi Participants

Specialists (7)
PCPs (11)

Nurse Practitioner
Physician

Specialists (9)
PCPs (9)
3. Testing

- Users apply the RLT to at least 3 of their own eConsult/eReferral cases

- Conducted in-person or via telephone

### Primary Care Providers

<table>
<thead>
<tr>
<th>Country</th>
<th>NP</th>
<th>MD</th>
<th>TOTAL</th>
</tr>
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<tbody>
<tr>
<td>American</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Canadian</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0</td>
<td>3</td>
<td>3</td>
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</table>

### Specialists

<table>
<thead>
<tr>
<th>Country</th>
<th>NP</th>
<th>MD</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>American</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Canadian</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
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</table>
PCP Pilot Participants

SFHN eReferral (4)
- RLTs submitted: 31
- Advanced Care Providers
- Physician

Champlain BASE (6)
- RLTs submitted: 29
Impact on Knowledge/Understanding

- I learned something new
- I am reassured
- I am motivated to learn more
- This response will not impact my knowledge and understanding
- I am reminded of something I already knew
- I intend to use this information in my teaching
Examples of Learning Points:

“I was unwilling to consider the treatment recommendation when I read it in Up to Date as it seemed to aggressive. This consult confirmed that it was the next best treatment option.”

(Canadian MD)

“Gastric resection can have an impact on iron stores that may contribute to his anemia.”

(American MD)
Application to Practice

- Manage this patient differently
- Use this information to justify a choice
- Use this information to inform my discussion with the patient or...
- Use this information to be more certain about the management of...
- Use this information to better understand a particular issue...

<table>
<thead>
<tr>
<th>Use this information to...</th>
<th>USA</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage this patient differently</td>
<td>Q10</td>
<td>Q15</td>
</tr>
<tr>
<td>Use this information to justify a choice</td>
<td>Q15</td>
<td>Q20</td>
</tr>
<tr>
<td>Use this information to inform my discussion with the patient or...</td>
<td>Q15</td>
<td>Q20</td>
</tr>
<tr>
<td>Use this information to be more certain about the management of...</td>
<td>Q10</td>
<td>Q15</td>
</tr>
<tr>
<td>Use this information to better understand a particular issue...</td>
<td>Q5</td>
<td>Q10</td>
</tr>
</tbody>
</table>
Specialist Pilot Participants

SFHN eReferral (7)
RLTs submitted: 62
- Advanced Care Providers
- Physician

Champlain BASE (7)
RLTs submitted: 58
Specialist RLT: Results Overview

• American MDs more likely to seek additional information from the PCP (78.9%) compared to Canadian (8.6%)

• Overall, 26.1% of RLTs submitted indicated they had learned something from the eConsult
  – Canadian MDs: 29.3%
  – American MDs: 10.5%
  – American ACPs: 47.4%
Examples of Learning Points

“Assessment of undifferentiated CKD [chronic kidney disease] in the young person”

(Canadian MD)

“Use of pure sliding scale insulin is still in use even though we’re trying to get away from this practice inpatient and outpatient. PCP also expressed other misconceptions about insulin regimens which are common, and we can work on provider education around this”

(American ACP)
Application to Practice

- Share with other healthcare professionals
- Use in teaching of trainees
- Learned something new to use in patient care
- Share with other patients

USA
Canada
Interviews

• 12 semi-structured interviews conducted with RLT pilot participants
  – 3 PCPs
  – 9 specialists

• The research team has developed an initial coding framework.
Coding Framework

Feedback

- Patient outcomes
- Timing
- Anonymity
- Adequate information

Teaching & Learning

- Scaffolding
- Practice patterns
- Critical reflection
- Specialist as knowledge translator

Trust

- Advanced care providers
- In-person relationships
Reflections on the eConsult Journey

Paul Giboney, MD
Associate CMO
Los Angeles County Department of Health Services
Principles

**Responsiveness**
- quick answers to requests for assistance

**Equity**
- Care irrespective of payor

**Collaboration**
- the power of dialogue

**Customer Service**
- A system that patients will choose

**Effective Practice**
- Practical “real world” improvement
Payer Strategies for E-Consult Program Engagement

Timi Leslie
BluePath Health

Tanya Dansky, MD
CMO, Blue Shield of California Promise Health Plan

Joel Gray
Executive Director
Anthem Blue Cross

Somer Harris
Telehealth Program Manager
Partnership Health Plan

Sajid Ahmed, IEHP
CEO, WISE Health Care
E-Consult Support for Primary Care

Key Components

Initial Launch Overview

Recipients and Satisfaction Criteria

Percent of Membership Served

Future Plans
Lunch
Lightning Round:
What Challenges Remain?

Mark Schweyer, BSN, MBA
Director of Telehealth Programs, Health Net

Daren Anderson, MD
Director, Weitzman Institute, VP/CQO of Community Health Center, Inc.

Mike Witte, MD
Vice President and CMO, California Primary Care Association

Ella Schwartz
Director of Operations, Community Health Center Network
Annual eConsult Workshop

Remaining Challenges

Mark Schweyer, BSN, MBA
Director of Telehealth Programs
11/4/2019
Wholesale Awareness and Adoption

Messaging

• Broad communication within healthcare delivery system
• Clear value proposition
• “Top down” engagement
• Organization expectation and commitment
• Medical leadership
• Including patient/member as key stakeholder
• Stamina is key
Distinct Partnerships and Roles

Essential component of success

Shared vision, goals and performance metrics required

• Primary care clinicians and specialists
• Clinicians and medical groups/leadership
• Collaboratives, consortiums and coalitions
• Electronic consultation vendors
• Non-profit organizations and advocacy groups
• Health plans
Equity

• Investment required by primary care sites to implement and effective operationalize and administer programs

• Primary care practitioners are required to change practice patterns

• Ongoing interest and consideration by health plans on how to effectively support implementation and adoption,

• Expense necessary to continue building infrastructure and capacity across fee-for-service and shared risk contractual environments

• Long-term considerations as we move further towards value-based care
Questions and Discussion

Mark Schweyer, BSN, MBA
Director of Telehealth Programs
Health Net
mschweyer@cahealthwellness.com
Operationalizing eConsults

Daren Anderson, MD
Director

weitzman institute
eConsults

- Improve access to specialty care
- Reduce burden and expense for patients
- Expand primary care scope
- Save money
- Are paid for by a growing number of payers

Why is everyone not doing them?
eConsults can create more work for the PCP

1. More work submitting the consult
2. More work acting on the consultant’s recommendation
POINT #1: WE HAVE TO MOVE BEYOND ACCESS AS THE DRIVER TO COST SAVINGS, EFFICIENCY, AND PATIENT EXPERIENCE
Monthly Costs of Claims per Patient: eConsult vs. Face-to-Face (FTF)

Thousand $US (unadjusted) per patient

Months in the study (-6 pre to +6 post referral)
POINT #2: ECONSULTS WILL NOT BE SPREAD NATIONWIDE BY MAKING THEM MANDATORY
In non mandatory model the PCP has to:

• 1) Remember that eConsults are available (may depend on payer and specialty)

• 2) Decide that they want an eConsults (lots of variability)

• 3) Take extra steps to order the consult
Tips for non-mandatory models

1) Don’t rely on memory: Utilize a standing order “default” for eConsult submission
Tips for non-mandatory models

2) Limit reasons for not ordering an eConsult (exclusion criteria)
Tips for non-mandatory models

3) Make the process easy:
   a. Keep the PCP in their own EHR
   b. Capitalize on existing referral workflow
Tips for non-mandatory models

3) Make the process easy:
   a. Keep the PCP in their own EHR
   b. Capitalize on existing referral workflow
   c. Utilize referral coordination staff to submit the eConsult
Tips for non-mandatory models

4. Active management of the process:
   a. Audit and feedback
   b. Payment/incentives
eConsult...and...

PAYMENT REFORM?
VALUE-BASED…
Improved Value…to Whom?

• To the Healthcare System?
  – “31% of all healthcare has no real value.”
  – Which 31% is this?
  – How much time, energy, and resource could be re-allocated to high-value care?
  – What is “high-value” care? How to define it?
  – What does it mean to “take care of the right person, the right way, in the right place, at the right time?”
California’s Proposed APM

- CalAIM—Advancing and Innovating MediCal
- Monthly PM/PM for all assigned patients
- Managed Care payment and State payment will likely be PM/PM for both.
- SDOH: Transportation is one of the top 3 needs.
PROPOSED APM:

• Participating centers’ assigned Medi-Cal “patients” are now seen as “members”.
• They are cared for by the Center’s care teams by various members of the team, rather than by “billable providers”.
• These “alternative encounters” become recognized and valued points of service.
• Over 100 alternative encounters have been coded for use.
Types of Alternative Encounters

• eConsults*
• Case Management*
• Group Visits*
• RN visits*
• Home Visits*
• Health Education with MA*
• Panel Mgt. outreach*
• Etc.*

*Telehealth is an option under PAYMENT REFORM
Electronic Consults and Federally Qualified Health Centers

Ella Schwartz, Director of Operations

November 2019
About CHCN Financing

- Risk bearing organization, delegated for **full professional risk** for primary and specialty care, radiology, laboratory and durable medical equipment
- Electronic consult makes up less than 1% of total specialty care spending
CHCN’s Electronic Consult Program

Provider satisfaction

Quick turn around time

Provider retention

Provider capacity

Local layer of specialists

Payor Agnostic

Quicker patient care

All sub-specialties

Quick turn around time

Funded by California Health Care Foundation
Engagement Strategy

• Champions (clinical & IT)
• Electronic health record integration
• Mandatory consult prior to referral
• User engagement initiatives
• Provider incentives program
• Continuing medical education
• Utilization reports
• “Hacking” the system
• Referral staff read-only access
Challenges

- Primary care provider time
- FQHC reimbursement
- Understanding return on investment
- Consult to referral workflow & specialist buy-in
- Specialist consultant credentialing
Breakout Tabletop Discussions: Vision for 2020

• Engagement and Scale
• Operationalizing E-Consult
• Payment Reform
• FQHC Programs
State Policy Perspectives

Robby Franceschini
BluePath Health

Paul Giboney, MD
Associate CMO
Los Angeles County Department of Health Services

David Lown, MD
CMO, California Health Care Safety Net Institute

Dan Southard
Deputy Director, Office of Plan Monitoring
California Department of Managed Health Care
16 state Medicaid fee schedules now include e-consult codes*

Most states do not publish e-consult as a listed benefit in provider manuals or other publications, but many do include reimbursement codes in fee schedules

*Includes CPT 99446-9, 99451-2
New Medi-Cal policy and legislation likely to expand access to telehealth, including e-consult

- **New Medi-Cal provider manual:** New policy published in August; e-consult now included as a covered service, specialist time captured (99451); other changes include home as originating site, expanded reimbursement for live video

- **Telehealth parity:** A.B. 744 (signed 2019) requires commercial health plans to reimburse services using telehealth modalities in the same way as comparable in-person visits, among other changes

- **DHCS alternative access approvals:** A.B. 1642 (signed 2019) requires Medi-Cal plans to provide DHCS justification for the approval of alternative access standards, including for telehealth

- **Telehealth in emergencies:** A.B. 1494 (signed 2019) waives any face-to-face or physical presence requirements for FQHCs, RHCs to be reimbursed for telehealth services provided during states of emergency
2020 holds promise for legislative and administrative progress on telehealth

California

- **Interoperability standards**: S.B. 441 (introduced 2019) would require Cal. HHS to issue regulations requiring interoperability for all EHR vendors operating in the state

- **School-based telehealth guidelines**: Follow-up to A.B. 2315 (passed 2018) requires DHCS and CDE to develop guidelines on using telehealth for school-based behavioral health services

- **CalAIM**: DHCS initiative to reform Medi-Cal through waiver renewal and managed care procurement

Federal

- **Interoperability standards**: Forthcoming CMS and ONC guidance on interoperability standards and TEFCA

- **Funding for technical assistance**: STAR Act would provide funding for e-consult and other telehealth technical assistance; sponsored by Rep. Harder

- **Removal of Medicare restrictions**: CONNECT for Health Act would remove or allow for CMS waiver of many Medicare restrictions on telehealth
PRIME & QIP Comparison
Comparison: PRIME Overview

• P4P program under CA Medicaid 1115 Waiver
• **Duration**: 5 years (July 2015 – June 2020). NO RENEWAL.
• **Participants**: 55 Public Hospitals & Health Systems (17 DPHs, 38 DMPHs)
• **Measures**: Project selection requirements with set Project specific measure sets
  • Includes “Innovative Metrics” (e.g. “Specialty Care Touches”)
• **Populations**: Encountered (DPH & DMPH) + MCMC Assigned (DPH)
• **Payment**: DHCS to DPH/DMPH (~4 mos post reporting)
Comparison: QIP (current) Overview

- **P4P Medi-Cal Managed Care Directed Payment program**
- **Duration**: Started (retroactively) June 2017. Initial approval of 3 Program Years (til 6/2020). No time limits for renewals.
- **Participants**: 17 DPHs
- **Measures**: Menu (currently 29). DPH must report on ≥20 in any given Program Year (can change metrics year to year).
  - “Established” Measures (e.g., HEDIS, QPP, PQA)
- **Population**: Mainly Medi-Cal. Requirement for 1 MCMC life/denominator
- **Payment**: DHCS directs MCPs to pay DPHs based on achievement of metric targets (~15 mos post reporting)
PRIME to QIP
Evolution
Shift in program timing due to DHCS shifting entire MediCal program Rate Years from Fiscal Year to Calendar Year
QIP PY 3.5
QIP PY 3.5 Overview

• CMS Approval Pending: Pre-Print submitted June 2019
• Program Period: January 1, 2020 through December 31, 2020
• Participants: Both DPHs & DMPHs
• FUNCTIONALLY PY3.5 represents an “extension” of current PRIME & QIP programs

• Measures
  • DPH/DMPH: Exact same PRIME DY15 reported measures PLUS
  • DPH: Choice of ≥20 of any of the QIP PY3 measures

• Denominator population
  • All same as reported under DY15 and PY3 respectfully.
  • QIP ONLY Requirement: 1 MCMC life/denominator

• Payment: DHCS Directed Payment through MCPs to DPHs & DMPHs
QIP PY 4+
QIP PY4+ Overview

- **PY4 Timing**: January 2021 – December 2021
- **PY4+ Participants**: DPHs & DMPHs
- **Population**: Mainly Medi-Cal. 1 MCMC life/denominator required
- **Measures**: spectrum of care provided to MCMC population
- **Minimum CMS Criteria**: Medicaid applicable benchmarks, “established” metrics
- **Menu Set**: Downsized # metrics to an appropriately sized set
  - Way too many now: PRIME + QIP = 76-99/DPH (3-45/DMPH)
- **Measure Sources**
  - Some PRIME, some current QIP measures
  - DHCS Managed Care Accountability Set (especially MCP MPL)
  - Other CMS Core Set or Medicare measures
  - HEDIS & UDS
QIP PY4+ & eConsult/Telehealth

- “eConsult measures”: Maybe, maybe not
- **Telehealth**: Increasing (gradual) incorporation of virtual care into metrics
  - Almost exclusively patient to provider, not provider to provider
- QIP Metric examples:
  - Diabetes: Eye Exam (HEDIS CDC-E)
    - 92227 Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral
    - **Patient Provider Interaction** is a denominator qualifying event
      - E-mail sent to patient or from carer
      - Encounter by SMS text messaging
      - Telemedicine consultation with patient
Continuation in 2020: GPP

• Global Payment Program for the Remaining Uninsured
• 2015 CA Medicaid 1115 Waiver (allows flexible use of Medicaid DSH $)
• **Duration**: June 2015-July 2020. **Renewal planned for 2020**.
• **Participants**: County Public Health Systems (current)
• **Goal**: Provide right care in the most appropriate setting to patients with limited access to primary and preventive care services.
• **Payment**: Point value system incentivizes provision of preventive and primary care services and disincentives inpatient & ED services
  • Synchronous & asynchronous telehealth including **eConsult**
eConsult is a foundational building block of any high performing health system that is delivering high quality, person centered, efficient and equitable value based (i.e., not FFS) care
Q&A

QUESTIONS?

David Lown, MD
dlown@caph.org
Reactions to the Day

Delphine Tuot, MD
Associate Professor, Nephrology, Zuckerberg San Francisco General
Associate CMO of Specialty Care and Diagnostics

Paul Giboney, MD
Associate CMO
Los Angeles County Department of Health Services

Jana Katz-Bell
Assistant Dean for Interprofessional Programs
Betty Irene Moore School of Nursing and UC Davis School of Medicine

Hal Yee, MD
Chief Deputy Director, Clinical Affairs and CMO
Los Angeles County Department of Health Services
Next Steps:
California Telehealth Policy Coalition Meeting November 5

CALIFORNIA TELEHEALTH POLICY COALITION

In 2011 when AB 415, the Telehealth Advancement Act, was wending its way through the legislative process, an ad hoc group of statewide organizations supporting the bill formed. Including such groups as the California Primary Care Association, the California Hospital Association and the California Rural Health Association, these groups met in meetings convened by CHHP in order to be apprised of any developments around AB 415 and share information with each other.

With the successful passage of AB 415, the group continued to meet and eventually formed into the California Telehealth Policy Coalition. From a handful of organizations, the membership has grown to include over thirty-five entities that include consumer groups, medical systems, payers, providers, technology representatives and others. CHHP continues to act as the convener of the Coalition and hosts monthly conference calls with continued support from the California Health Care Foundation in this work.

In recent months, the Coalition has decided to move beyond a mere information sharing group to become a more active collective participant in telehealth policy. The Coalition has been developing a slate of telehealth policy goals and issues that it will be working on in the coming months in the hopes of updating California telehealth policy.

https://www.telehealthpolicy.us/about/projects/california-telehealth-policy-coalition
Next Steps

Thank you for responding to our <5 minute survey.

Questions or comments? Electronic_Consult@bluepathhealth.com

http://econsulttoolkit.com/
Thank you.

Please be our guests at a reception to celebrate the accomplishments of the E-Consult Workgroup

Chevy’s on The River – 1369 Garden Highway