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Tomorrow's Doctors, Tomorrow's Cures®

CORE

Coordinating Optimal Referral Experiences:

Implementing eConsults and Enhanced Referrals

Association of
American Medical Colleges

Project CORE: Coordinating Optimal Referral Experiences

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Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

Implementing eConsults and Enhancing Referrals

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Association of American Medical Colleges

Project CORE: Coordinating Optimal Referral Experiences

3 Problems at Interface of Primary care and Specialty Care

1. **Poor access to specialty care for patients**
2. **Poor communication/ coordination between PCPs and specialist colleagues**
3. **Wide variations in care**

Using Specialists Wisely…

Referral volume to specialists has more than DOUBLED in a decade (1999-2009)[1]

For common chronic conditions, more than 75% of visits to specialists are for established patients[2]

PCPs & specialists agree that many patients seen by specialists could be managed by primary care[3]

[1]Barnett 2012; [2]Hollingsworth 2011; [3]Gleason 2014

Poor Access to Specialists: Implications for an AMC

Decreased Quality of Care & Patient Satisfaction
For patients who need timely specialty input

Impairs Negotiations
For payers who include timely access as bargaining point

Crowding Out
Loss of higher revenue patients

Decreased Referrals
From community PCPs & internal leakage

Inefficiency → Waste
In shared risk/global payment models

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The Primary Care & Specialty Care Interface

Then:

PC – Specialist Communication

Now:

Fragmentation

Quality **Costs**

VIEWPOINT

Patient Referrals
A Linchpin for Increasing the Value of Care

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The success of accountable care organizations (ACOs) under global payment may depend in part on a common yet poorly understood clinical decision: the patient referral in the outpatient setting. Fundamental to collaboration among physicians and other health care professionals, patient referrals have been largely ignored in the payment reform debate.

Referral rates in the United States more than doubled from 1999 to 2009, with about 10% of outpatient visits resulting in a consultation or visit to another physician.[1] Referrals seem to be both underused and overused, with clinical information often poorly transferred between physicians and frequent confusion between primary care physicians and specialists over the specialist's role.[2] Yet little is known about referrals. By systematically measuring and evaluating referrals in their physician networks, ACOs may be able to better target efforts to improve care coordination and reduce spending.

Referrals may be driven by a number of factors. Physician knowledge gaps due to specialization create a natural demand for referrals. Time pressures on outpatient clinicians may intensify this demand, because

Much can be learned from examining patterns of physician referrals within a single organization.

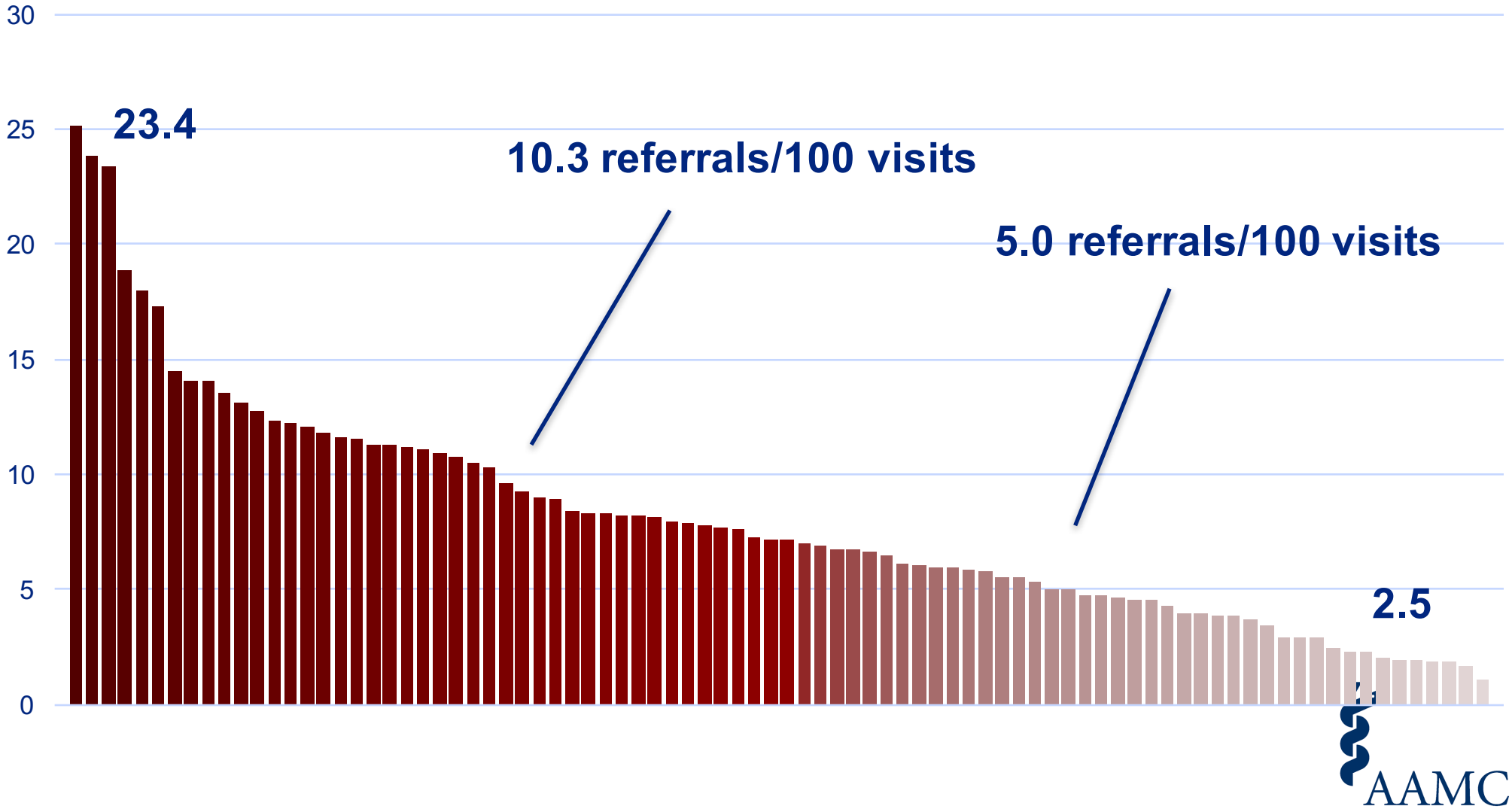
number of physicians was 3.0 times greater in the same comparison, correlating with imaging, diagnostic tests, and minor procedures used on the order of 1 to 3 times as frequently.[3] Surveys of primary care physicians suggest that for a patient with a given clinical profile, the largest variation in clinical decision making between high- and low-spending regions was in the likelihood to refer.[4]

Referrals also affect prices. Given fee differences across private payers, shifting referrals from more expensive to less expensive clinicians and health care organizations may garner price discounts. Among early ACOs in Massachusetts, initial savings measured through claims were largely achieved by referring patients to physicians and facilities that charged lower prices, consistent with early efforts by these ACOs to control referral patterns.[5]

In addition, referrals may affect quality. Fragmentation of care increases with the number of physicians a patient sees, reflecting the challenges in communication and teamwork among physicians in a complex delivery system. Medicare beneficiaries with chronic diseases such as heart failure or diabetes see a median of 8 to 10 physicians in a year, and the typical primary care physician needs to coordinate care with hundreds of other physicians for a panel of patients.[6] Poor continuity of care is associated with more preventable hospitalizations, complications of

Referral Rates are Highly Variable Across PCPs

(Referrals/100 PC visits; each bar represents a single provider at one AMC)



Project CORE Goals

By improving care delivery at the primary care – specialty care interface, the CORE model seeks to:

- Improve **specialty access**
- Enhance **primary care comprehensiveness**
- Reduce **unwarranted variation** in referral thresholds
- Improve **communication and coordination** between primary care and specialists
- Improve **quality** and **convenience** for patients
- Control **costs of care**

Evolution of the CORE Model

AAMC receives 3 year, $7M award from CMMI

Sept 2014

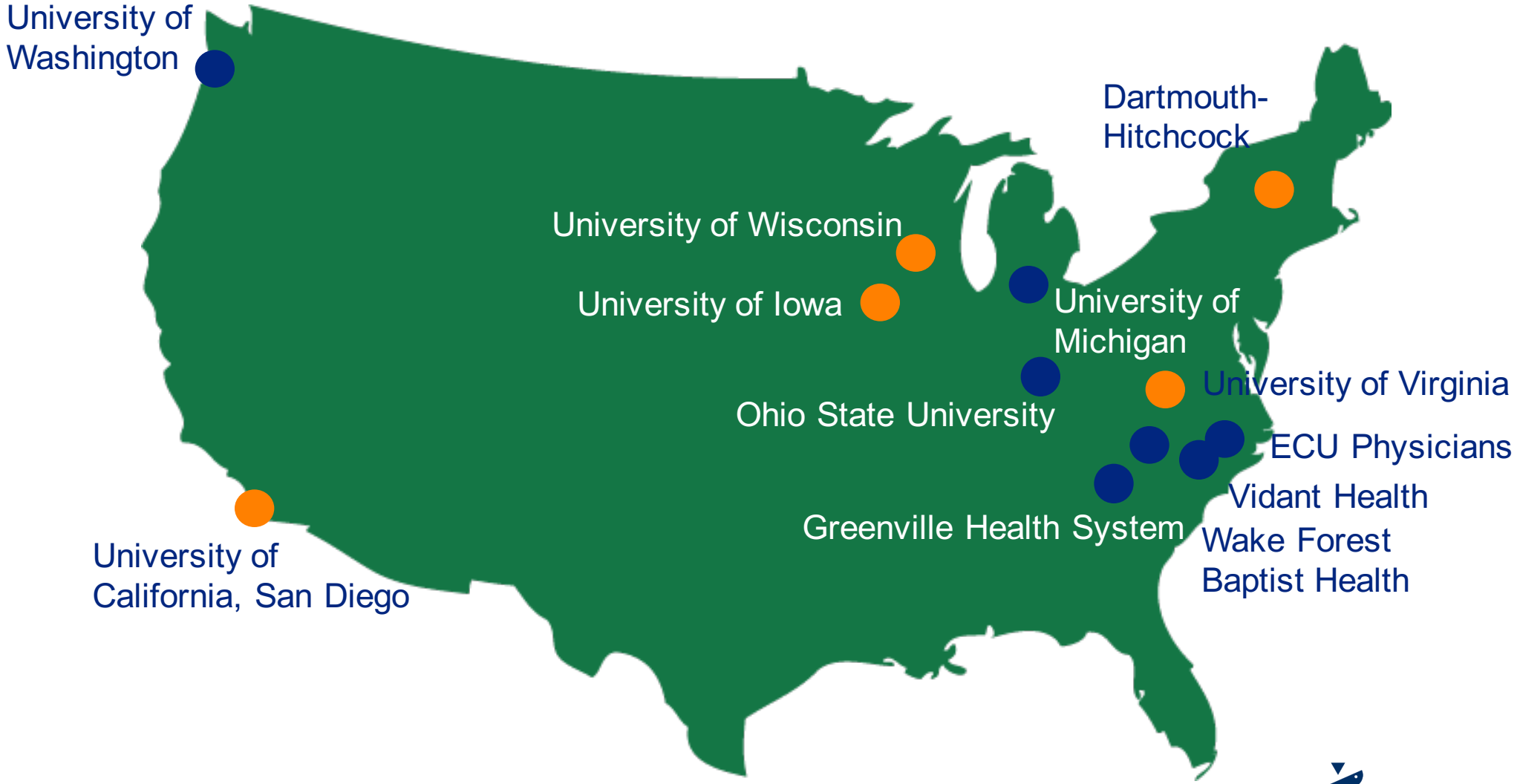
AAMC, with UCSF and 2 data partners, convene 5 AMCs to implement the CORE model (eConsults & enhanced referrals)

The CORE model implemented across 15+ medical & surgical specialties

March 2016

Program expansion to 7 additional AMCs (outside of the initial CMMI grant funding)

12 Participating AMCs



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Elements of the CORE Model

1. **Improve communication** through optimized EMR workflows
2. **Improve coordination** through care coordination agreements
3. **Improve access** through introduction of eConsults
   - Align incentives for providers
4. **Improve clinical alignment** of PCP and specialist through point-of-care decision support
5. **Seek to create a culture** of trust, partnership between PCPs and specialists

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Optimizing Care in the EMR

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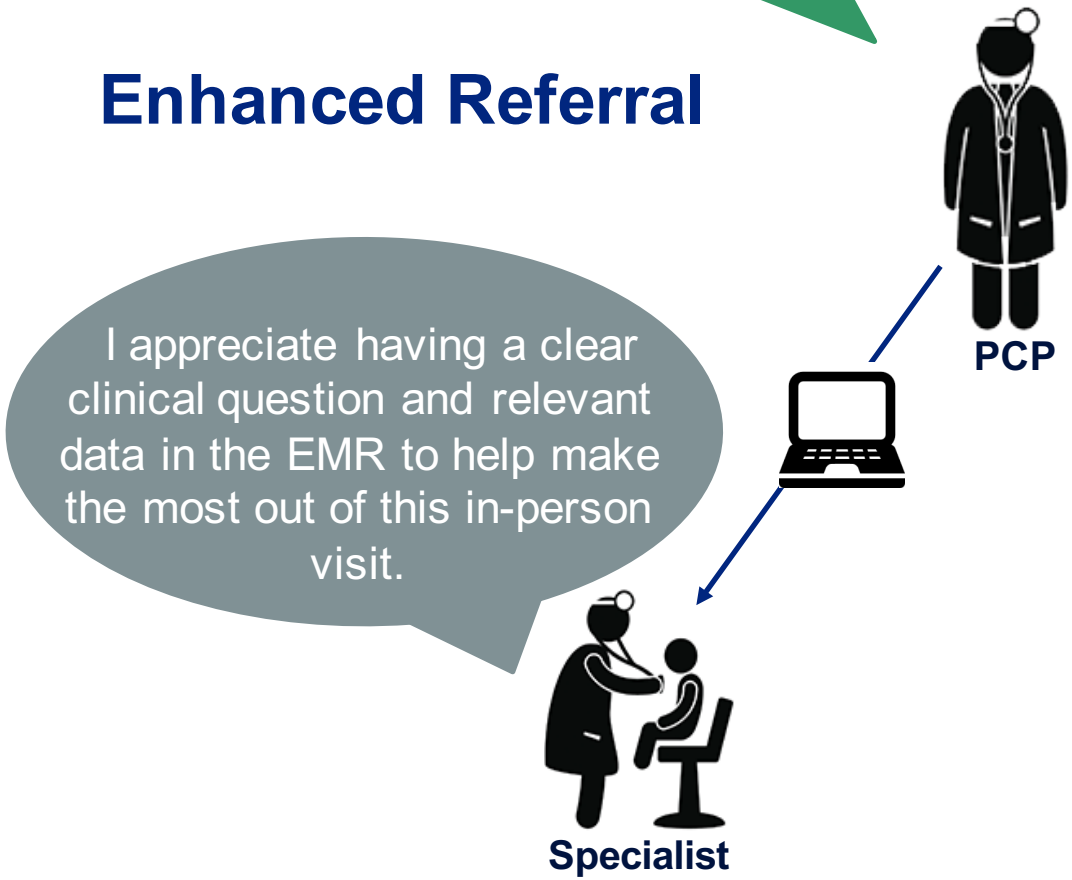
Optimizing Care in the EMR

My patient needs to see a specialist about a specific clinical issue.

Enhanced Referral



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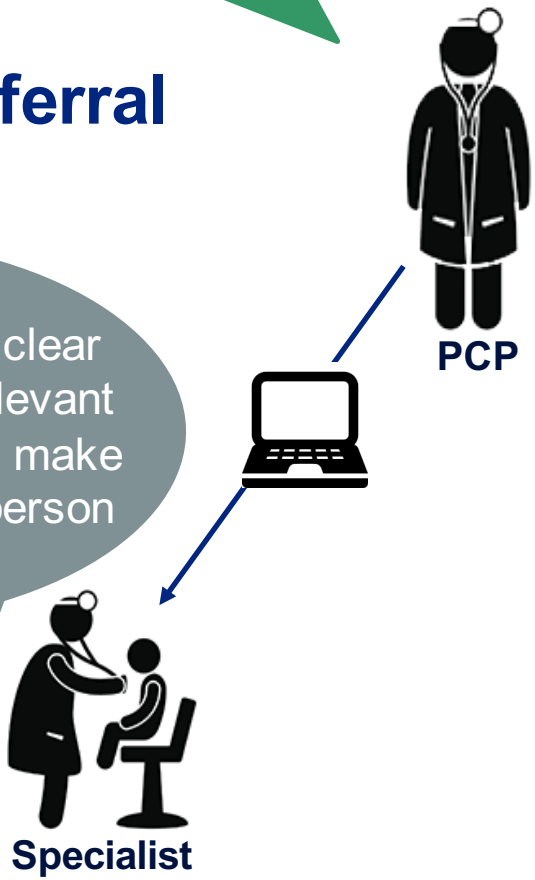
Optimizing Care in the EMR

My patient needs to see a specialist about a specific clinical issue.

I have a clear clinical question for a specialist to help me manage my patient's care plan.

Enhanced Referral

eConsult



I appreciate having a clear clinical question and relevant data in the EMR to help make the most out of this in-person visit.

I reply to the PCP with my recommendation and next steps for the patient so that the PCP can continue managing the patient's care.

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University of Iowa HealthCare Examples of **e-Consultations**

Paul James MD

Professor and Chair

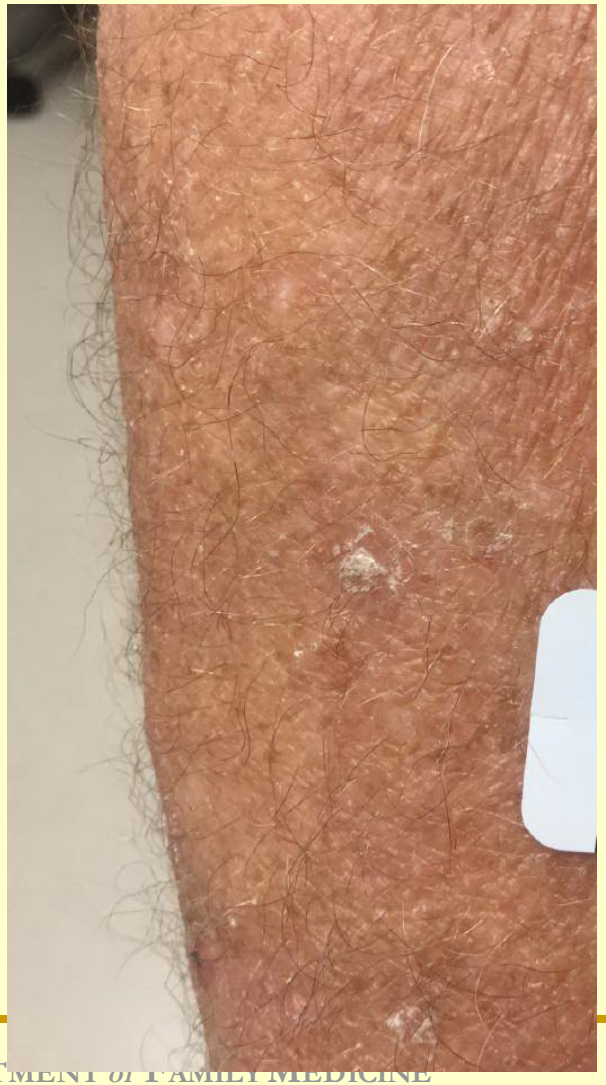
Department of Family Medicine
University of Iowa Carver College of Medicine

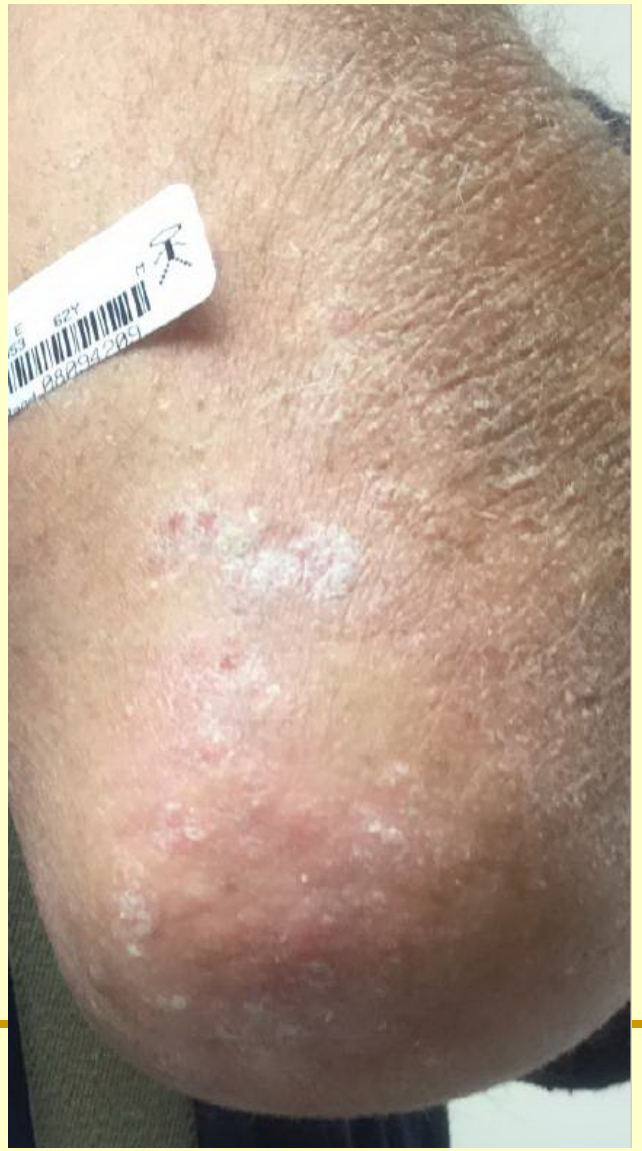
Dermatology e-Consult

Clinical Question: Psoriatic lesions versus actinic keratosis.

This is a 62 y.o. male with long-standing history of mild psoriasis since childhood. He has significant solar damage over the forearms (L>R). Over the last 2 years he has noted new lesions on the forearms which he interprets as psoriasis but I am concerned about actinic keratosis.

Left Arm Photos





Consultant's Response

Keratotic papules on the left arm are concerning for actinic keratosis (arm that hangs out driver side window) but it is impossible to distinguish with absolute certainty in this case. The lesions on the right arm and elbows appear to be more consistent with psoriasis and benign keratoses. No lesions appear to be concerning for non-melanoma skin cancer at this time.

E- Consult Recommendations

1. At some point in the Fall (September - November), consider topical Efudex (fluorouracil 5% cream) treatment to the dorsal forearms and dorsal hands: apply twice daily for 2-3 weeks, then stop. Patient will experience redness, scaling, and discomfort- that is normal. Counsel patient to stop at any point if he develops significant irritation.
2. Recommend regular use of broad-spectrum sunscreens SPF>30.
3. Recommend liberal use of emollients- such as white petrolatum ointment (Vaseline), Aquaphilic, Vaniply ointment, Vanicream, CeraVe moisturizing cream, or Cetaphil moisturizing cream- applied at least twice daily and immediately after bathing or swimming.
4. Recommend triamcinolone 0.1% cream applied to the elbows twice daily for 2 weeks, then twice daily 2-3 days per week as needed. Do not apply to the face, armpits, or groin.

Dermatology Staff Physician(staff)

Rheumatology e-Consult

My question is about diagnosis of early RA vs. other serious rheumatological disease.

This is a 36 y.o. female South Korean with classic history of bilateral PCP, MCP stiffness, swelling and pain. No warmth and exam is unrevealing. 2 year history of progression. FH is remarkable for mother and MGM with Rheumatoid Arthritis. X-rays and labs are unrevealing. Should I continue NSAIDs or referral now to consider DMARD?

Rheumatologist's Assessment

I personally reviewed this patients recent hand films and agree with the findings as recorded (normal films, no erosions). I also reviewed lab results and her recent clinic note documenting several years symptoms, progressive AM stiffness and pain affecting hands, but no objective swelling on exam. Positive family history of RA. Creatinine normal today, but otherwise no basic labs since 2013, at which time there was anemia. **ANA is pending.** Both RF and CCP are negative.

Assessment:

- RA is unlikely given absence of objective swelling after 2 years of symptoms, normal ESR, CRP and negative RF and CCP
- A lupus arthritis could cause this degree of hand pain & stiffness without objective swelling.

Rheumatology Recommendations

Agree with checking ANA (pending)

- recommend that you also check a CBC with differential to rule out cytopenia or unexplained anemia and Urinalysis with micro.

[in general, if you have enough suspicion for lupus to order ANA, you should also check CBC with diff, creatinine, & urinalysis if they have not been done recently].

If all of the above are normal, I think you are fine to continue NSAID and regular follow-up without formal rheumatology consult (until or unless there are additional problems to raise concern for autoimmune disease. Occupational therapy consult may be helpful for hand pain ("evaluate and treat").

If the ANA is positive:

Please add-on the following labs: SSA, SSB, Smith, RNP, & dsDNA.

Will then convert this to formal consult for arthritis.

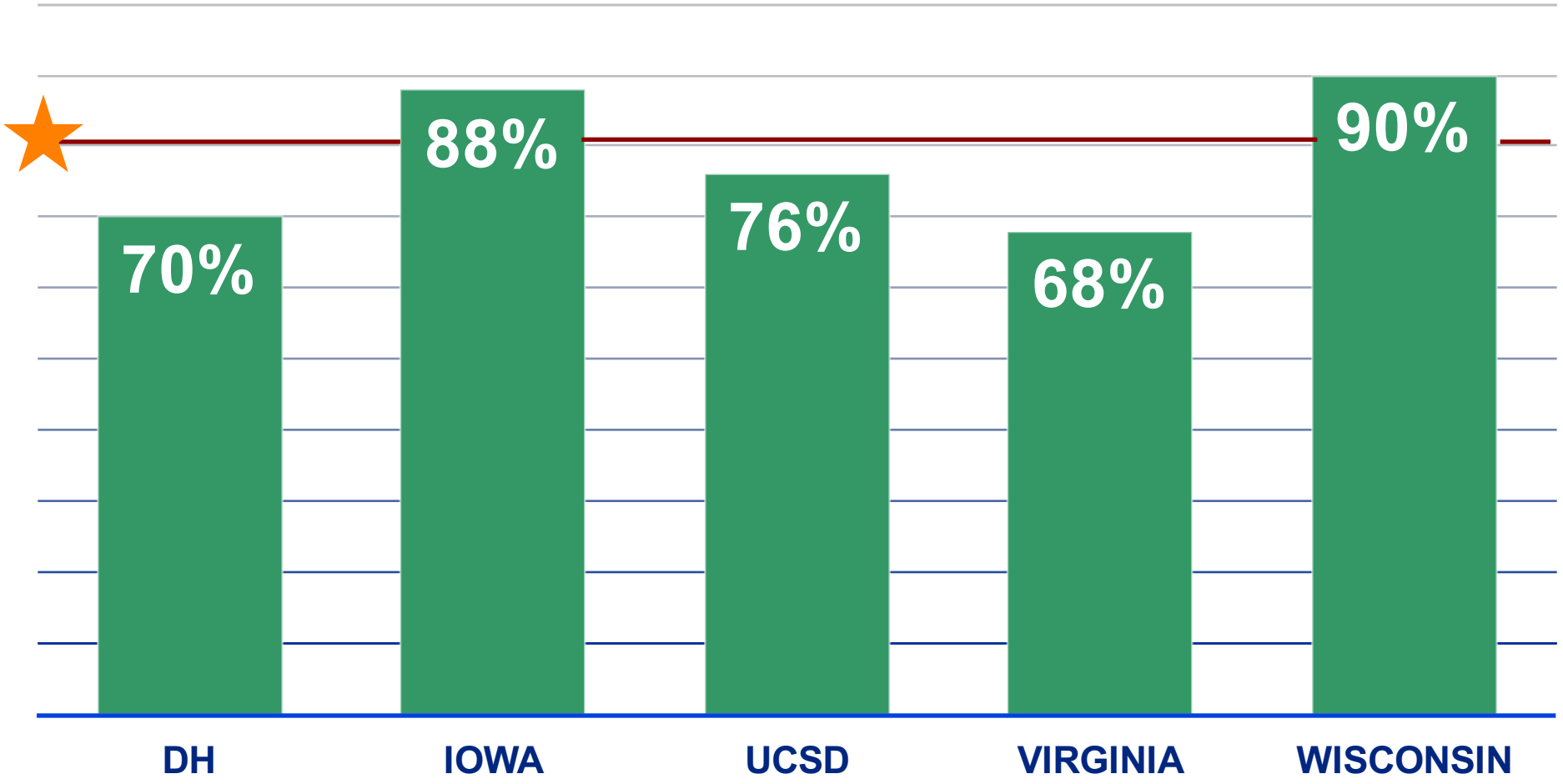
Please let me know if you have any questions.

Disclaimer

The service provided through the e-Consult service is different from the diagnostic services typically provided by a health care provider. The e-Consult is based on the information available to me and is furnished without the benefit of a comprehensive evaluation or physical examination. Therefore, I may not be aware of information that might affect my opinion of the patient's diagnosis and treatment. By deciding to engage this service, you acknowledge and agree that: (1) you are aware of these limitations and agree to assume the risk of these limitations; and (2) no warranty or guarantee has been made concerning any particular opinion, result, or cure of a condition addressed via the e-Consult service.

Program Impact

Primary Care Faculty Usage of eConsults



**Cumulative use through July 2016*

Source: AMC Monthly Reports (July 2016)

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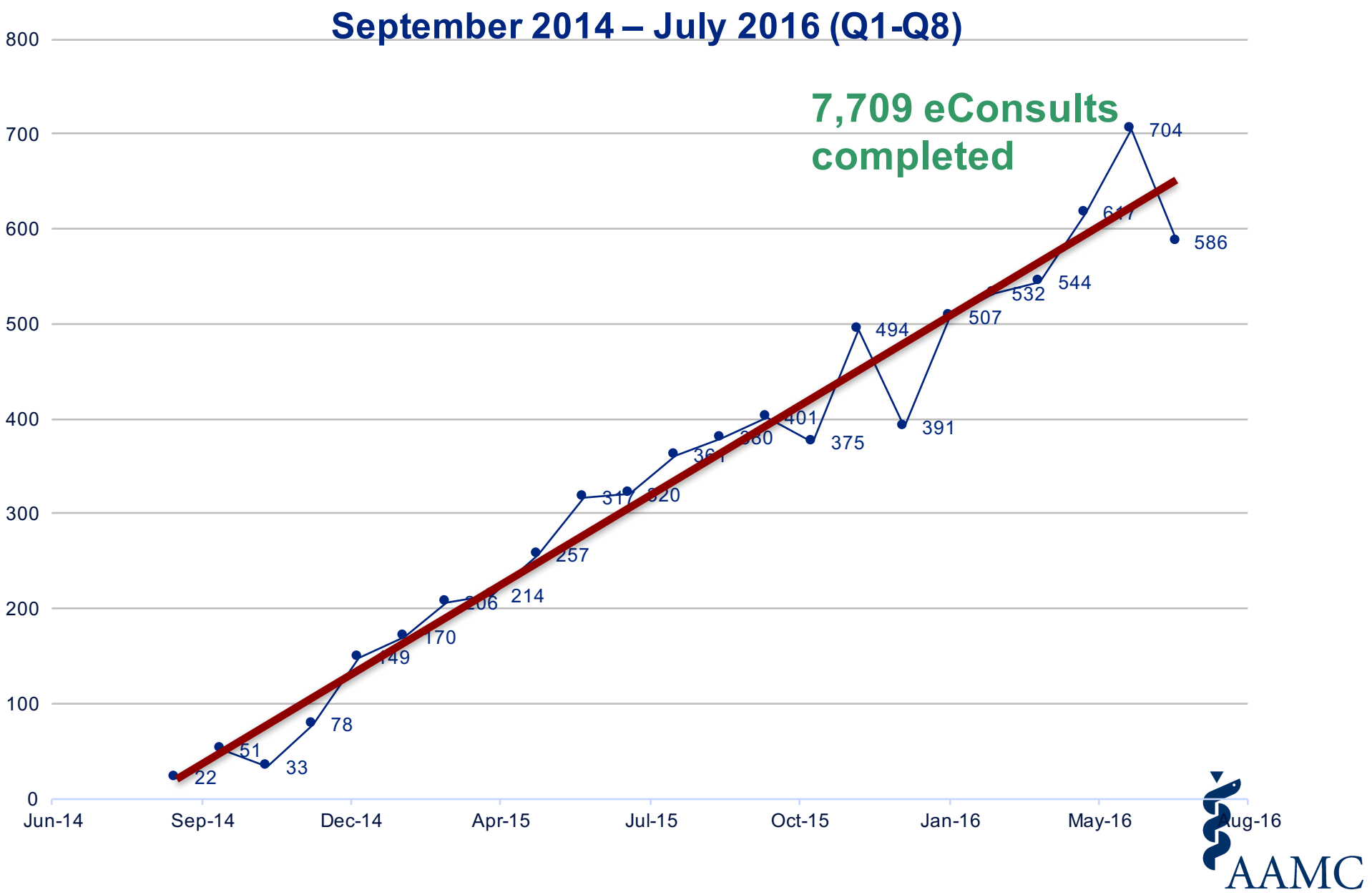
CMMI Collaborative: eConsult Volume



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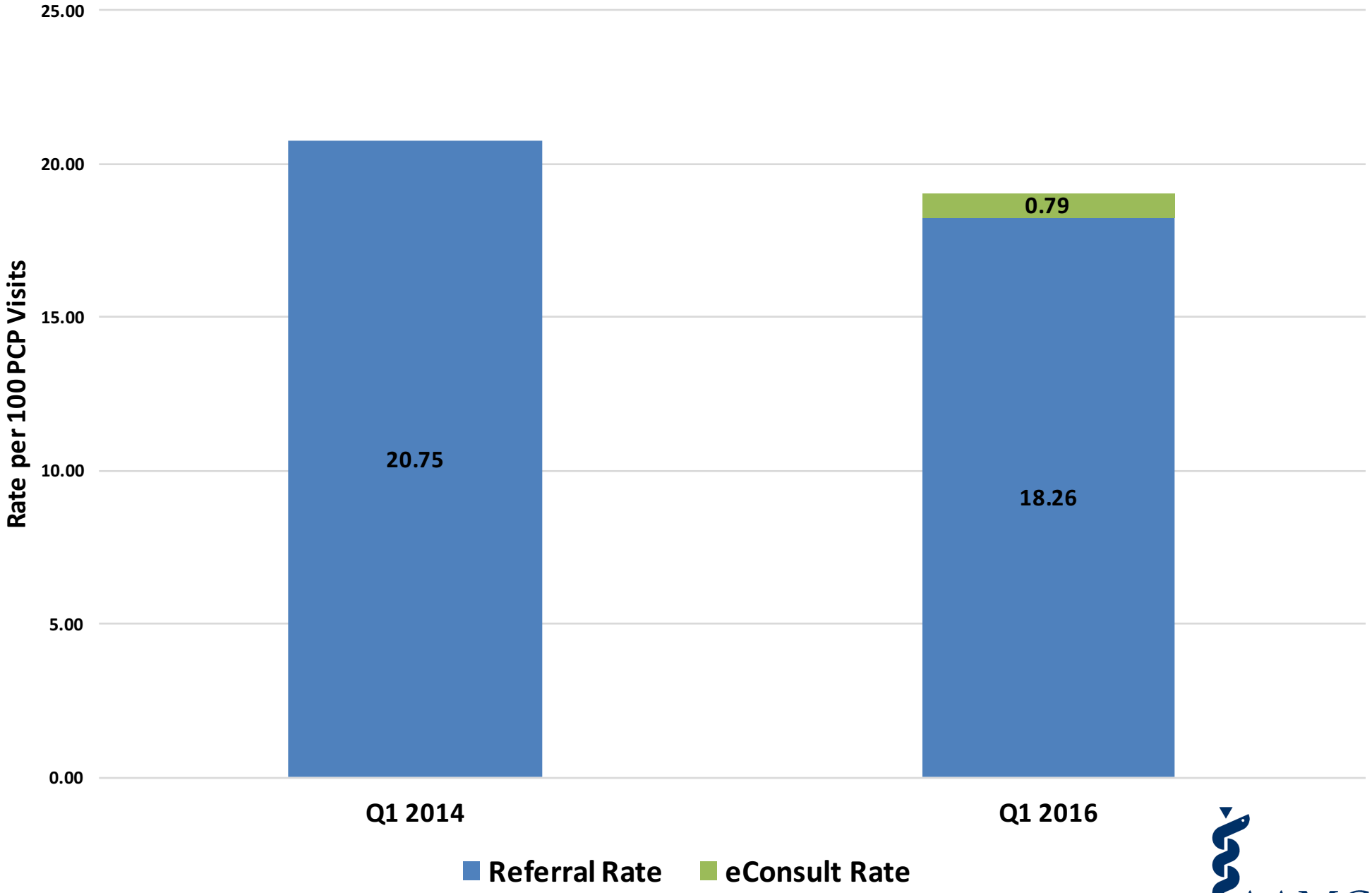
Referral and eConsult Rate for Live Program Specialties at 1 AMC



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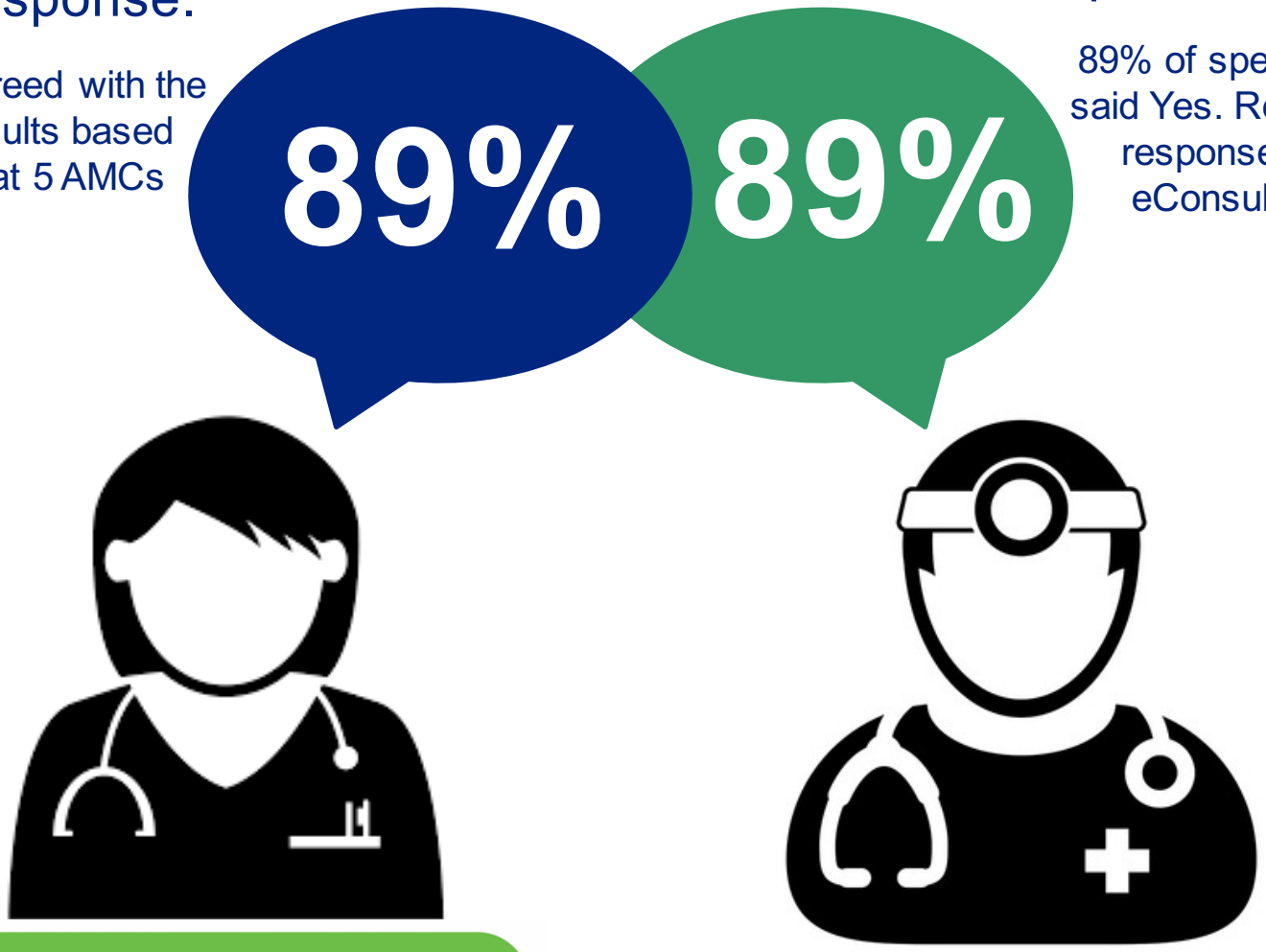
Provider Satisfaction Survey

PCP Survey: I am highly satisfied with this eConsult response.

89% of PCPs agreed with the statement. Results based on 316 PCPs at 5 AMCs

Specialist Survey: Was this eConsult question appropriate?

89% of specialist eConsultants said Yes. Results based on 693 responses from specialist eConsultants at 5 AMCs



Primary Care Physician Survey

In the absence of an eConsult option, what would you have done?

**Results based on 316 responses from PCPs at 5 sites*

Impact of eConsults

*~**8,000** eConsults completed by PCPs thru August 2016*

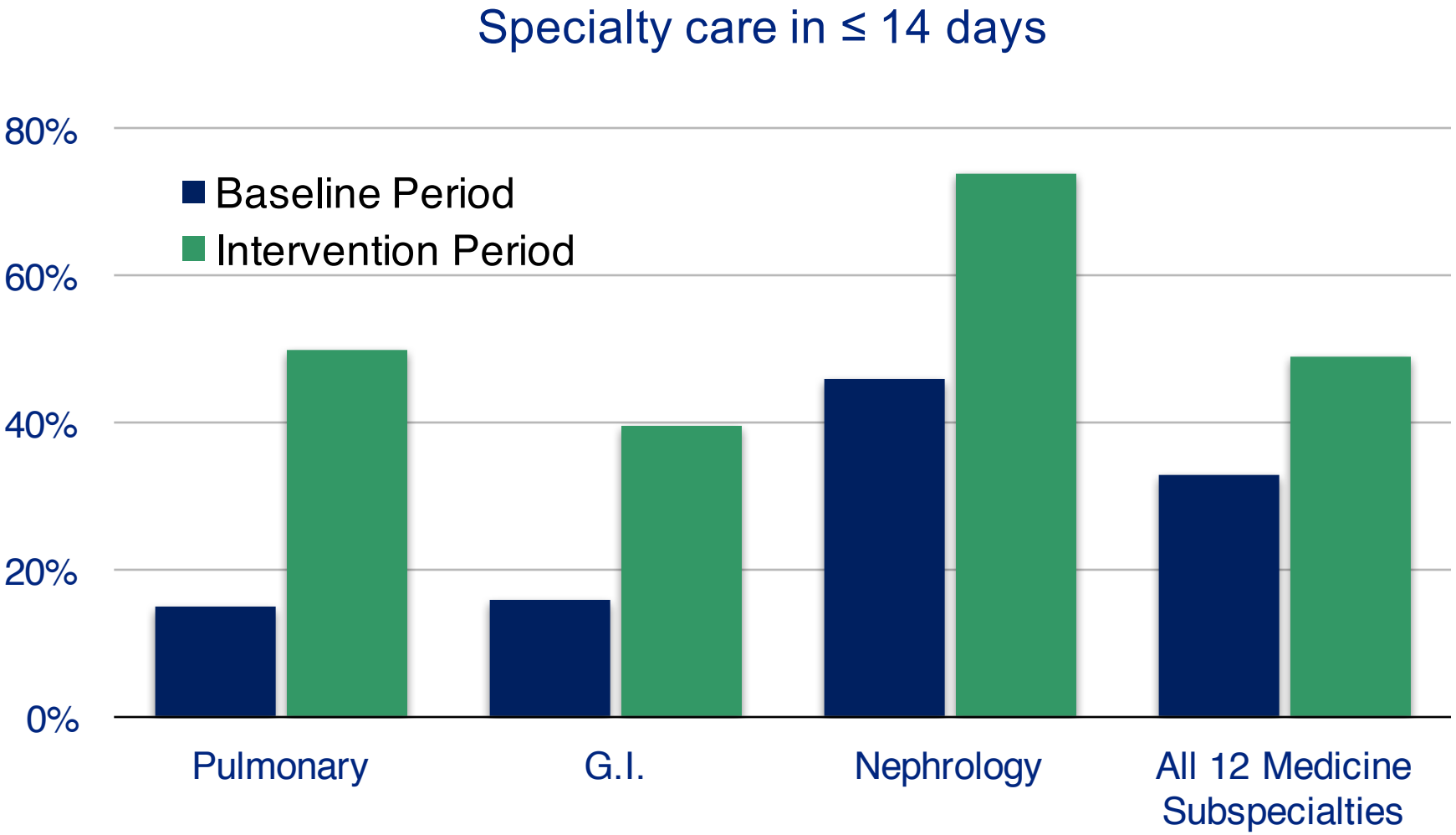
46%
would have sent a referral

40%
would have curbsided the specialist

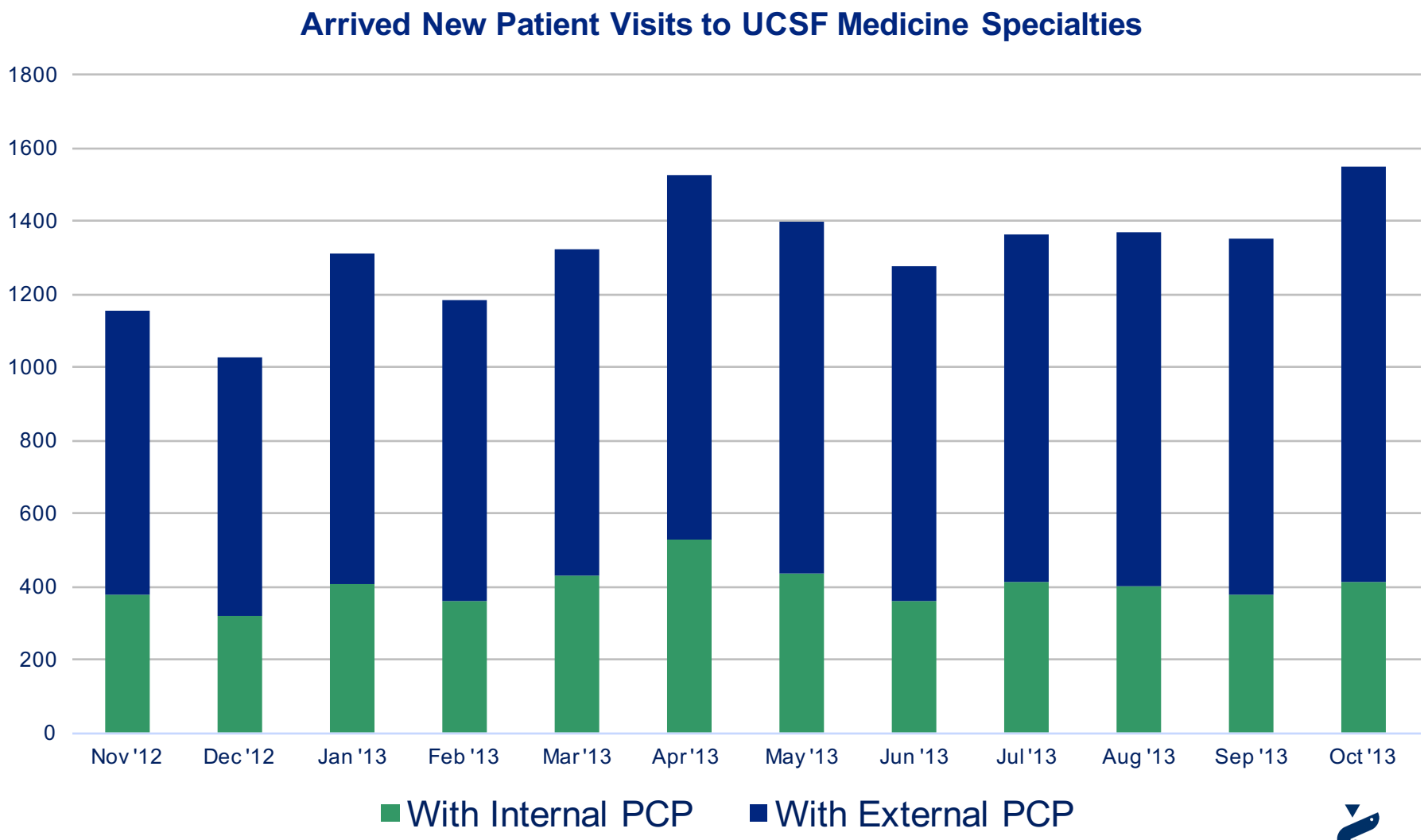
~3,600
avoided referrals

~3,200
avoided curbsides

UCSF Results: Access



UCSF Results: Increased External Referrals



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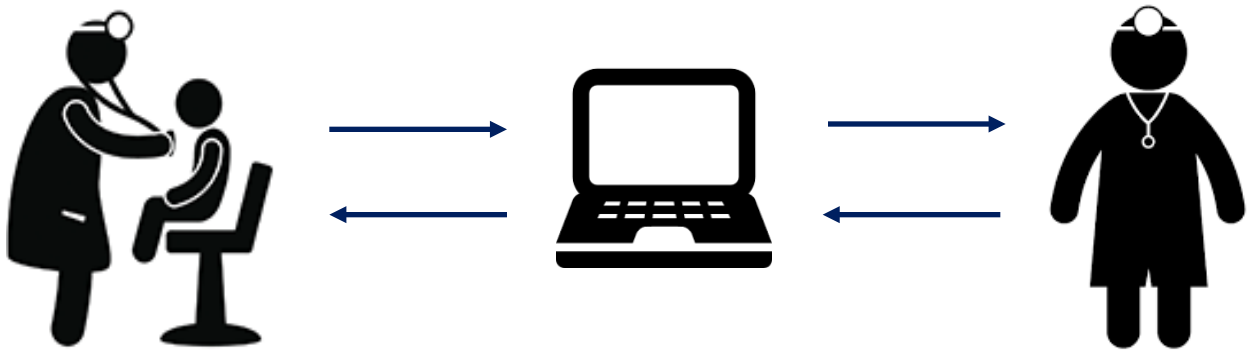
What We're Hearing…

"This model is right for our patients, our organization, and healthcare in general."
– Academic Health System CEO & President



"I have found it a very helpful way to get answers to my questions & learn at the same time, while getting my patients' needs addressed."
– AMC Primary Care Physician

"eConsults reduce the length of waiting for in-person consultations…it is the future of medicine…"
– AMC Specialist

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eConsults

Cathleen E. Morrow MD
Chair and Associate Professor
Department of Community and Family Medicine
Geisel School of Medicine at Dartmouth
Dartmouth Hitchcock Medical Center

Dartmouth-Hitchcock

Dartmouth
GEISEL SCHOOL OF MEDICINE

Joy in Practice!

- Timely answers to nagging questions that would keep you awake at night
- Reduction of the worry-quotient
- Patient convenience, appreciation
- More likely to ask: not interrupting colleagues, knowledge that specialist is accruing RVU's, more focused education
- Increased specialty awareness of PC provider needs

The Medical Center View

- Increase access to specialty services: particularly important for the over-burdened ones
- Increase appropriate live consults
- Cost of care, value
- Increase connectivity between in and outpatient spaces.


UW Health
University of Wisconsin
Hospital and Clinics


THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER


UCSF
University of California
San Francisco


University of Michigan
Health System


UNIVERSITY OF IOWA
HEALTH CARE


UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER


GHS
GREENVILLE
HEALTH SYSTEM


Wake Forest University Baptist
MEDICAL CENTER


UNIVERSITY of VIRGINIA
HEALTH SYSTEM


VIDANT
Medical Center


East Carolina
UNIVERSITY


Dartmouth-Hitchcock
MEDICAL CENTER


UC San Diego
MEDICAL CENTER


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GREENVILLE HEALTH SYSTEM

CORE Coordinating Optimal Referral Experiences: Implementing eConsults and Enhanced Referrals

Project CORE at GHS: Why, How and Challenges

September 27th, 2016

Sean Bryan, MD, FAAFP

Associate Professor and Chair, Dept. of Family Medicine

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Business Needs

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Coordinating Optimal Referral Experiences:

Implementing eConsults and Enhanced Referrals

- Become a high performing multi-specialty group
- Follow more evidence based medicine protocols
- Reduce unnecessary utilization of care
- Improve standardization where appropriate
- Improve patient-centered communication between primary care and specialists while reducing fragmentation of care between providers
- Position GHS to succeed in the transition to value based alternative payment models
- Better population health management by improving patient access to specialty care, as well as reduce the cost of care for patients

Business Objectives

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Coordinating Optimal Referral Experiences:

Implementing eConsults and Enhanced Referrals

- Reducing total cost of care for primary care patients
- Improving quality of care through enhanced timeliness of specialist input and improved continuity of care within the primary care setting
- Increasing patient satisfaction by improving access to specialists for specialty care

Getting the Support Necessary

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- Obtained commitment from GSH leadership - COO, CIO, CMIO, and Chairs by showing the benefits and success obtained by other AMCs, and the alignment with:
  - PCMH
  - Medical neighborhoods
  - The IHI Triple Aim
  - GHS' strategic vision:

    "To transform health care for the benefit of the people and communities we serve"

- Chairs, Vice Chairs and Primary Care lead physicians in Family Medicine and Internal Medicine actively marketing the initiative to:
  - Colleagues
  - Administration

Challenges

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- Other Health System Strategic Priority
  - Change in the current governance structure from governmental to private not for profit
- Epic implementation / IT resources availability
  - 5 hospitals went live on Epic in February 2016
  - 2 hospitals and many practices go-live on Epic on October 1, 2016
- Primary Care Lead Physician challenges
  - Large territory to cover
  - Many new hires
  - Protected time
    - Family Medicine Vice Chair for Clinical Affairs had too many competing priorities to handle this role alone
    - Chair of Internal Medicine has agreed to support up to 0.25 FTE for newly identified Primary Care Lead Physician

Current Status

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Coordinating Optimal Referral Experiences:

Implementing eConsults and Enhanced Referrals

- PCP lead and operation team identified and are actively participating in the project
- Epic team member expected to join the team in November, after the last Epic go live
- Team of specialists and PCPs are reviewing and tweaking the Cardiology and Endocrinology eConsult and Enhanced Referral templates supplied by UCSF
- Investigating what will be the 3rd and 4th specialties to go-live so review of templates can begin, considering Neurology and Pulmonology
- Planned go-live for the first two specialties: February 2017

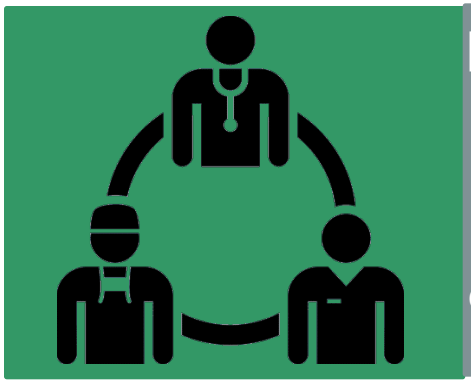
Scaling & Sustaining the CORE Model

Identify next cohort of AMCs

To create an "innovation implementation" collaborative

AAMC work with CMS

On reimbursement and a sustainable payment model

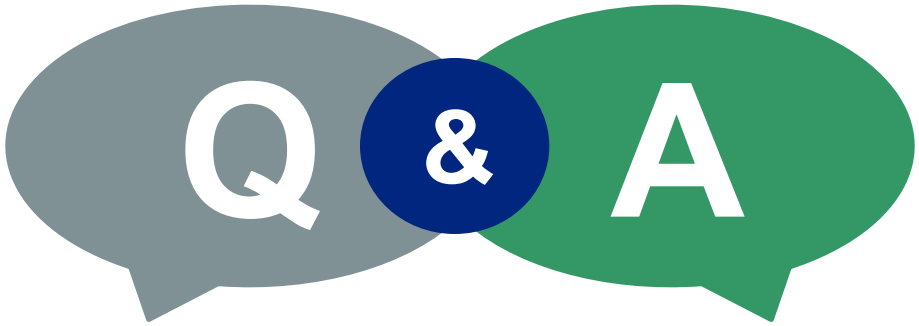


Broaden model to inpatient care

To facilitate transition of care to community-based care team

Expansion at current AMCs

To include children's hospitals and external, community PCPs



THANK YOU!

To learn more or to request additional information, visit www.aamc.org/projectcore or email projectcore@aamc.org.

Scott Shipman, MD, MPH

sshipman@aamc.org

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Implementing CORE : a few lessons

Assembling the team

"Selling" the model to key stakeholders

EMR build

Identifying specialist eConsultants

Customizing templates

Training providers

Shifting the culture

Data and quality assurance

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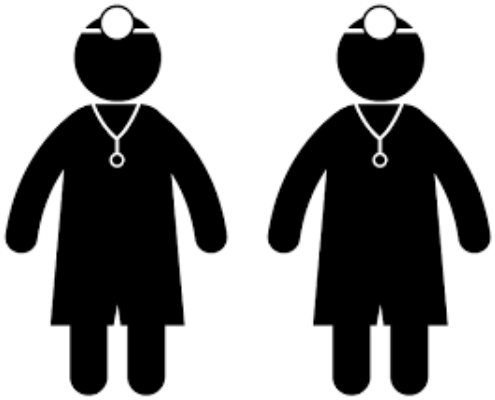
Innovation in Action

As of 2016, across the participating AMCs, over 1.2 million primary care patients can benefit from Project CORE through **timely clinical input**, **greater convenience**, **improved access**, and **lower costs**.

12 AMCs



2,000 Primary Care Providers

1.2 Million Primary Care Patients

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