

INCREASING ACCESS TO SPECIALTY CARE THROUGH COLLABORATION: eREFERRAL AND eCONSULT

Heidi Emerson, PhD; Erin Brantley, MPH; Janelle Schrag, MPH

Providers at community health centers and essential hospitals, those who serve a high proportion of vulnerable patients, have cited access to specialty services as a significant barrier for their patients who are uninsured and publicly insured, as compared to their privately insured patients. Many refer to perceived biases towards specific insurance plans and lack of coverage for services as common challenges related to this issue.¹⁻²

While care models such as the patient center medical home may increase access to primary care and care coordination, many patients still require other services related to specialty care and diagnostics. Addressing this need requires an approach that includes other clinicians and institutions as well as communication and collaboration between primary care, specialists, hospitals, and other types of providers as described in the literature.³⁻⁴ In response, providers at health centers and essential hospitals are exploring innovative models for improving access to specialty care through electronic referral and consultation.

Provider Collaboration through the eReferral/eConsult Model

In light of challenges that they face in providing specialty care to their patients, health centers and essential hospitals have led innovation by increasing specialty care capacity through eReferral/eConsult models. The eReferral/eConsult models use electronic systems for specialty referrals and provide asynchronous communication between primary care providers and specialists. A specialist reviews each eReferral/eConsult within a specified timeframe, usually 2-3 days, and determines whether an in-person visit is indicated, further information is needed (such as additional labs), or whether the primary care physician (PCP) can continue to manage the patient's care with specialist advice. This process of communication can reduce wait times for necessary in-person appointments.

This brief highlights health centers and essential hospitals in three communities – San Francisco, Los Angeles, and Connecticut – as examples of collaborative eReferral/eConsult models. The National Partnership interviewed leadership at each of these programs, Hal Yee, Chief Medical Officer for the Los Angeles County Department of Health Services (previously with the San Francisco General Hospital), Delphine Tuot, eReferral Director at San Francisco General Hospital, and Daren Anderson, Vice President and Chief Quality Officer of Community Health Center, Inc., to explore lessons learned from their experiences.

In each of these three communities, PCPs, specialists, and hospital leadership have collaborated to improve access to specialty care. The eReferral program was developed and implemented by [San Francisco General Hospital](#) and the SFGH-based, University of California, San Francisco (UCSF) faculty in 2005.⁵ The eReferral program is mandatory for referrals into participating SFGH specialty clinics, which contributes to the program's success. The technological platform for the eReferral program was developed by SFGH's information technology staff and is embedded in the hospital's electronic medical

record (EMR).⁶ The eReferral is an iterative process that allows bi-directional communication between the primary care provider and the specialist. Dr. Hal Yee, who led the gastroenterology eReferral pilot program at SFGH, successfully transferred the eReferral model to Los Angeles. The [L.A. Care Health Plan and L.A. Department of Health Services](#) eConsult program began in 2010 and expanded in 2012.⁷ Primary care and specialty care providers connect via a third-party platform. In Connecticut, Dr. Daren Anderson and colleagues at the Weitzman Institute at [Community Health Center, Inc.](#) established an eConsult program with the University of Connecticut in 2011. This program sends eConsult requests to specialist networks for review through referral coordinators, and the specialist sends back a response. After demonstrating positive outcomes through a trial for cardiology patients,⁸ the program expanded to include additional specialty services and a health center in Maine. See descriptions below for details on these three programs.

San Francisco General Hospital eReferral

Year established: Piloted in 2005 in gastroenterology; formally implemented in 2007

Participating organizations: SFGH clinics, staffed by UCSF providers; expanded to include additional primary care providers.

Specialties covered: gastroenterology (GI), cardiology, pulmonology, endocrinology, rheumatology, neurology, orthopedics, breast cancer evaluation.

Platform: In-house system developed by SFGH, integrated into their EMR; all providers must connect to the SFGH EMR

Funding: \$2 million in grant funding from SF Health Plan for implementation, and from Kaiser Permanente Community Benefit, Blue Shield of California, Agency for Healthcare Research and Quality (AHRQ) for expansion and innovation

Results: 20-40% decrease in in-person specialist visits; up to 90% decrease in wait time for non-urgent visits.⁹⁻¹⁰

LA Care eConsult

Year established: Piloted in 2010; widespread implementation in 2012

Participating organizations: Los Angeles County Department of Health, MedPOINT Management, the Community Clinic Association of LA County and Health Care LA Independent Physicians Association. As of 2013, includes 4 hospitals and 126 local primary care sites in LA County (40 LA Department of Health Service sites and 86 health centers)

Specialties covered: more than 30 specialties

Platform: Contracted with Safety Net Connect; connects providers with different EMR platforms

Funding: \$1.5 million in funding from LA Care

Results: Up to 71% decrease in in-person specialist visits; decrease in wait time for appointments with participating specialists.¹¹

Community eConsult Network

Year established: Piloted beginning in 2011; expanded in 2015-2016 to health centers in Maine, Delaware, Washington, and Oregon.

Participating organizations: Community Health Center, Inc., Penobscot Community Health Care (Bangor, ME), The University of Connecticut, Telemed2U, Connections Community Support Programs (Delaware), and Yakima Valley Farmworkers Clinic (Washington and Oregon)

Specialties covered: Piloted with cardiology; expanded to eight additional specialties.

Platform: Contracted with Safety Net Connect to develop a secure messaging system outside of the providers' EMR

Funding: After successful results from a randomized control trial, received a \$500,000 grant to scale up the program. Payment now provided by CT Medicaid and certain private payers.

Results: Pilot trial found that 69% of referrals did not require an in-person visit.⁸

Key Takeaways

While all three programs emerged out of the same need to increase access to specialty care, the design and implementation processes differ due to various factors. They shared many of the same challenges and lessons learned, but also had some community-specific issues to address. The importance of **leadership buy-in** was critical for the success of each program. It was important that there was a champion for the program who had credibility amongst all the stakeholders, including health centers, specialists, private primary care providers, public health clinics, health departments, hospitals, and in some cases, Medicaid and health plans.

Collaboration is a core component of each of these eReferral and eConsult programs, and multiple stakeholders were brought together to define the problem and align priorities. Providers in some cases may be in the same system, or have a history of working together, but in other communities, it may be necessary to bring together providers, some of whom may be seen as competitors, and build trust through collaboration. In LA, provider workgroups were convened to better understand the challenges and priorities for each of the stakeholders. In Connecticut, a full-time project manager was critical to developing the cross-departmental and interdisciplinary workgroups needed for implementation. Workgroups included not only providers, but also staff with a focus on technology, evaluation, and finance as well as payers or funders.

In addition, the **local context** of the program, such as geography, number of providers, and patient population, must be considered in implementation. The size of the community, organizational culture, and differences in relationships between providers in an urban vs. rural setting can influence both program design and timeline for implementation. It was noted that the continuity of having the same specialist provide the eConsults and in-person referrals can be helpful with building relationships between providers, which may be challenging if the SFGH model was expanded to rural areas. Community Health Center, Inc. has 12 sites, and each of them sent their referrals to many different specialty networks or hospitals. To address this issue, the Connecticut model was designed to make it

possible to scale up the program, by giving the reviewing specialist a more centralized role. Thus, the Connecticut program was set up such that the specialist reviewing the consult would not need to be the individual who would see the patient for a face-to-face visit, if it were required.

Furthermore, each program took a unique approach to developing a **technological platform** and **workflow process**. At SFGH, the hospital invested in a home-grown system that was integrated into their existing EMR. While most of the providers using SFGH's eReferral program have the same EMR, for those providers who are outside the system, it was necessary to develop a solution to allow those providers to access to the eReferral system. In LA and Connecticut, providers use different EMRs, and thus, it was necessary to create a communication strategy to link their systems. However, redesigning provider workflow was considered to be just as important as, or more important than, technology. Implementation of eReferral/eConsult programs required staff time for re-engineering and streamlining the referral process. In Connecticut, the program was designed to minimize the impact on the provider

The issue is the supply and demand mismatch for specialty care. There is a huge demand for specialty care and limited supply of specialist visit time.

Because of that supply-demand mismatch, there are huge wait times for specialty care clinics. And that is something everybody wanted, and still wants, to improve upon. ...That was really the driver for eReferral to start off. How do we find ways to deliver specialty care that is not based on a visit? Electronic consultation is one way of doing that.

-Delphine Tuot, MD, eReferral Director, San Francisco General Hospital

workflow. In this program, the provider did not change how they made referrals. The referrals were managed by a referral coordinator responsible for setting up the eConsult or in-person referrals.

For **sustainability**, it is important to consider the incentives and return on investment for payers in order to understand what data should be collected in order to help support their priorities. These programs are designed to reduce the number of unnecessary procedures, ensure that patients are getting appropriate care, decrease travel time, and better utilize provider time. Specialists at SFGH are salaried, but recognizing the benefits of the program, SFGH has allocated a percent of specialist time to the provision of

eReferrals. In addition, two health plans were reported to be calculating compensation based on relative value units to both the specialist and the PCP for their time providing an eReferral. Recently, the Centers for Medicare & Medicaid Services approved reimbursement for eConsults by Connecticut Medicaid, which may help support the eConsult program at Community Health Center, Inc.¹³

It has the opportunity to encourage primary care providers and specialists to think about, ‘What is the right care, where is the right location, when is the right time to provide the care, and who is the right person to do it.’

-Hal Yee, MD, PhD, Chief Medical Officer, LA County Department of Health Services

The eReferral/eConsult programs have seen positive results and provide new opportunities for improving care. The formalization of the “curbside consult” has the opportunity to develop and build relationships between providers. Although concern over liability has been reported as a challenge by some providers, this was not cited as a barrier to implementation for these three programs. Creating a streamlined process and managing workflow for PCPs and specialists with greater communication can improve care

coordination, and allows for team based care. By coordinating specialty referrals through one portal, data can be collected to better understand population health, and can help direct services or training to where they are needed. While eReferral/eConsult models may not solve all the issues associated with specialty care access, they have opened the dialogue between providers around how different models for collaboration can improve quality of care for their patients.

Implementation Considerations

eReferral and eConsult models can be effective in improving access to specialty care especially in underserved areas where there are provider shortages, or lack of capacity for specialists to treat uninsured or underinsured patients. Furthermore, these models provide greater collaboration and improved communications between primary care providers and specialists leading to better care coordination. As noted in previous reports,¹² there are various issues that impact the implementation, spread, and sustainability of eReferral/eConsult models.

Don’t get hung up on IT [*information technology*]. eConsults is less about technology and more about establishing new ways of communicating across systems. The technology that exists today is more than sufficient to accomplish the job.

-Daren Anderson, MD, VP/Chief Quality Officer, Community Health Center, Inc., Director, Weitzman Institute

Reimbursement: In consideration of the financial pressures faced by providers in community health centers and essential hospitals that serve a disproportionate number of uninsured and publicly insured patients, it is important that innovative models are sustainable. Incentives and reimbursement from payers, such as health plans or Medicaid, may increase the capacity for specialists and primary care providers to use these models or facilitate similar innovations in other settings. A payment structure that does not rely on face-to-face encounters or fee-for-service, and accounts for the time specialists spend to review consults and the additional time of the PCP, would support the integration of eReferral/eConsult models into patient care.

Development of Metrics: While the various programs have been evaluating their impact on measures such as wait time, number of in-person referrals, and no-show rates, there is a need for more documentation and clarity around the impact of eReferral/eConsult programs on health outcomes. In a randomized controlled trial, a review of 6-month follow-up data for patients in the CHC, Inc. eConsult program found fewer cardiac-related emergency department visits for the intervention group.⁸ More research and evaluation is needed to better understand the components of the various eReferral/eConsult programs and identify the functionalities that lead to high quality care, to help guide the development of other programs, and would help establish implementation standards in other settings.

Investments in Information Technology and Training: Investments for developing and supporting the information technology required for eReferral/eConsult can help support these models. Not only is there a need for systems to incorporate the functionality required to adopt this model in the EMR, but also to support the training of providers and staff to manage and use the program. SFGH developed its own system for eReferral, and LA Care and CHC, Inc. have contracted for this service. The SFGH program includes a program manager and a lead specialist for training other specialists to use the eReferral system, as well as an information technology specialist. A designated referral coordinator manages the eConsults at CHC, Inc.

Policies and Regulations: Other related issues that may impact eReferral/eConsult models are existing and future telehealth policies and regulation. In states around the country, more than 200 pieces of legislation were introduced in the 2015 legislative session. Congress is also considering federal telehealth policy recommendations for inclusion in Medicare. Policies that impact telehealth address coverage, reimbursement, licensure, safety and security, provider training, and investments in broadband networks.¹³

Using technology has been part of a growing trend to increase access to and improve quality of health care, and new policies may help support this trend. While it is important to consider contextual factors in the implementation of an eReferral/eConsult model, collaboration between health centers and essential hospitals provides an opportunity to utilize such innovative new models to increase access to specialty care for their patients.

NOTES

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