Connection to Care in Changing Times:
Annual Meeting of the E-Consult Workgroup

Zoom Link - https://us02web.zoom.us/s/86304633792

Agenda

e-consult WORKGROUP

Wednesday, November 9

8:30 am-9:00 am	**Continental Breakfast** Join us for some coffee, tea, light pastries, and fruit to start your day.
9:00 am-10:00 am	**Continental Breakfast and Networking in Innovation Cafe (In-Person Only)** The California Endowment, Sacramento Join us for continental breakfast with our event sponsors, AristaMD, ConferMED, RubiconMD and WISE Healthcare.
10:00 am-10:30 am	**Welcome and Opening Remarks** · **Diana Camacho, MPH**, Senior Program Officer, California Health Care Foundation · **Hakeem Adeniyi, MD**, Medical Director, Sacramento Native American Health Center, Inc. · **Libby Sagara**, BluePath Health Live Stream: Join stream
10:30 am-11:30 am	**Forming E-Consult Coalitions** · **Jeffrey Nkansah**, Chief Executive Officer, CalViva Health Plan · **Mark Schweyer**, Director of Telehealth Programs, Health Net · **Abbie Totten**, President, California Plan, Molina Healthcare · **Les Ybarra**, President, CA Medicaid Health Plan, Anthem, Inc. Live Stream: Join stream
11:30 am-12:15 pm	**Peer-to-Peer Support for Public Health Needs** · **Timi Leslie**, President, BluePath Health · **Lisa Chew, MD**, Associate Medical Director, Harbor View Medical Center · **Daren Anderson, MD**, President, ConferMED · **Kelvin Vu, DO**, Senior Vice President of Clinical Services and Medical Officer, Open Door Community Health Centers · **Christopher Miller**, Program Specialist, AAMC Live Stream: Join stream
12:15 pm-1:00 pm	**Lunch - Provider Videos and Attendee Poll** The California Endowment, Sacramento · **Yamilett Medrano, MHA (Video)**, Program Director, Digital Health, Loma Linda University Health · **Scott Dzurella, FNP (Video)**, Family Nurse Practitioner, Chapa-De Indian Health · **Alyssa Spencer, PA (Video)**, Physician Assistant, Associate Medical Director, WellSpace Health Videos of e-consult providers and leaders sharing their patients' experiences, and providers' best practices in creating successful programs

Agenda (Continued)

e-consult WORKGROUP

1:00 pm-2:00 pm

The E-Consult Policy Path Forward

- **Robby Franceschini, JD, MPH**, Director of Policy, BluePath Health
- **Meaghan Quinn**, Program Lead, Association of American Medical Colleges
- **Allie Budenz, MPA**, Director of Population Health Management, California Primary Care Association
- **Mike Witte**, CMO, CPCA
- **Jacob Quinton, MD**, Center for Medicare and Medicaid Innovation

Live Stream: Join stream

2:00 pm-2:45 pm

Value-Based Care and E-Consult

- **Paul Giboney, MD**, Los Angeles Department of Health Care Services
- **Eric Urquiza**, Sr. Vice President, Operations & Client Experience, AristaMD
- **Suzy Goldenkranz**, VP of Business Development, Rubicon MD
- **Sean Atha**, SVP, River City Medical Group

Live Stream: Join stream

2:45 pm-3:45 pm

Demonstrating Program Impact: E-Consult Data

- **Delphine Tuot, MD**, Interim Division Chief of Nephrology, Associate CMO of Specialty Care and Diagnostics, Director of UCSF Center for Innovation in Access and QualityZSFG, Zuckerberg San Francisco General Hospital
- **Sarah Berk**, Associate Director of Monitoring, Evaluation and Research, Peterson Center on Healthcare
- **Erin Keely, MD**, Co-founder of the Champlain BASE eConsult service, University of Ottawa
- **Waheed Baqai**, Chief Operating Officer, WISE Healthcare
- **Zahra Elmekkawy**, Director, Healthcare Delivery System Innovations, Peterson Center on Healthcare

Live Stream: Join stream

3:45 pm-4:00 pm

Wrap-Up

- **Diana Camacho, MPH**, Senior Program Officer, California Health Care Foundation
- **Timi Leslie**, President, BluePath Health
- **Libby Sagara**, BluePath Health

Live Stream: Join stream

4:00 pm-5:00 pm

Networking Reception- Cafeteria 15L

Cafeteria 15L

Live Stream: Join stream

Welcome

Diana Camacho, MPH
Senior Program Officer
Improving Access
California Health Care Foundation

Thanks to Our E-Consult Workgroup 2022 Sponsors

Please join us for a reception at Cafeteria 15L immediately following the program.

Opening Remarks

Hakeem Adeniyi, MD
Medical Director
Sacramento Native American Health Center

SNAHC
Sacramento Native American Health Center

The Impact of E-Consults at Sacramento Native American Health Center

November 9, 2022

SNAHC - Purpose

- Our commitment is to continue and share the legacy of a healthy American Indian / Alaska Native community based on cultural values delivered through a traditional, innovative and accessible patient-centered health home.

SNAHC
Sacramento Native American Health Center

SNAHC - Our Care

- Beyond providing health care, our goal is to contribute to the development and empowerment of all members of the Sacramento community.

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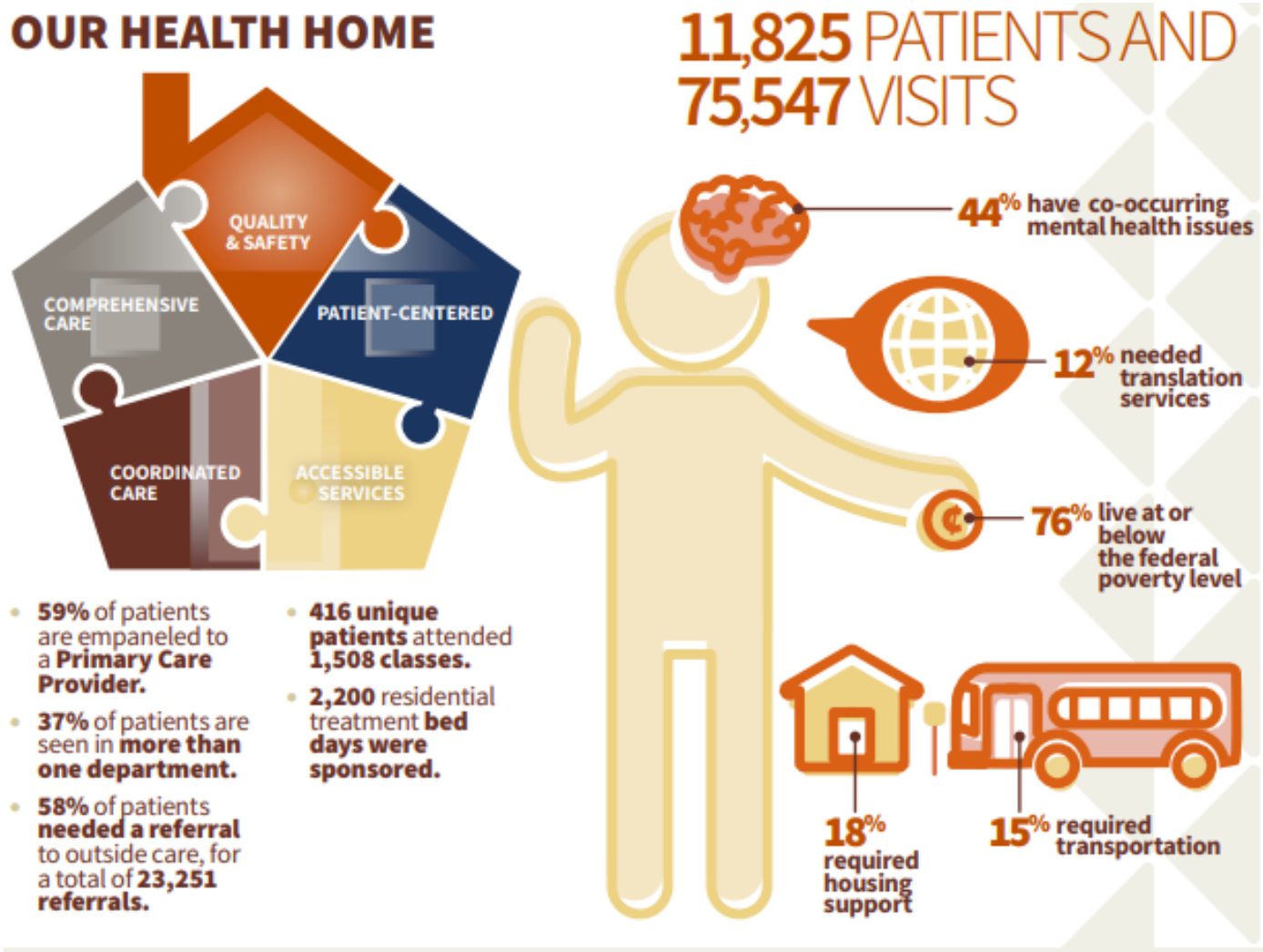
Sacramento Native American Health Center

SNAHC Demographics



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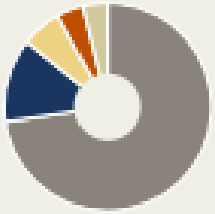
Sacramento Native American Health Center

SNAHC Demographics

PATIENT VISITS

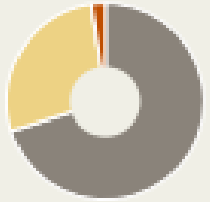
- **32,848** MEDICAL
- **19,454** DENTAL
- **8,813** OTHER
- **7,111** BEHAVIORAL HEALTH AND ALCOHOL OR OTHER DRUGS
- **5,262** MEMBER SERVICES
- **2,059** OPTOMETRY

PRIMARY INSURANCE



- **72.7%** MEDI-CAL MANAGED CARE
- **13.1%** MEDI-CAL FFS
- **6.2%** MEDI-CARE
- **4.1%** PRIVATE INSURANCE
- **3.9%** SELF-PAY

ETHNICITY



- **70.2%** NON-HISPANIC/ LATINO
- **27.6%** HISPANIC/LATINO
- **2.2%** UNKNOWN

RACE

- **32.6** WHITE
- **19.5%** BLACK
- **16.3%** AMERICAN INDIAN/ ALASKA NATIVE
- **12.6%** ASIAN/ PACIFIC ISLANDER
- **10.5%** MORE THAN ONE RACE
- **8.5%** OTHER/UNKNOWN

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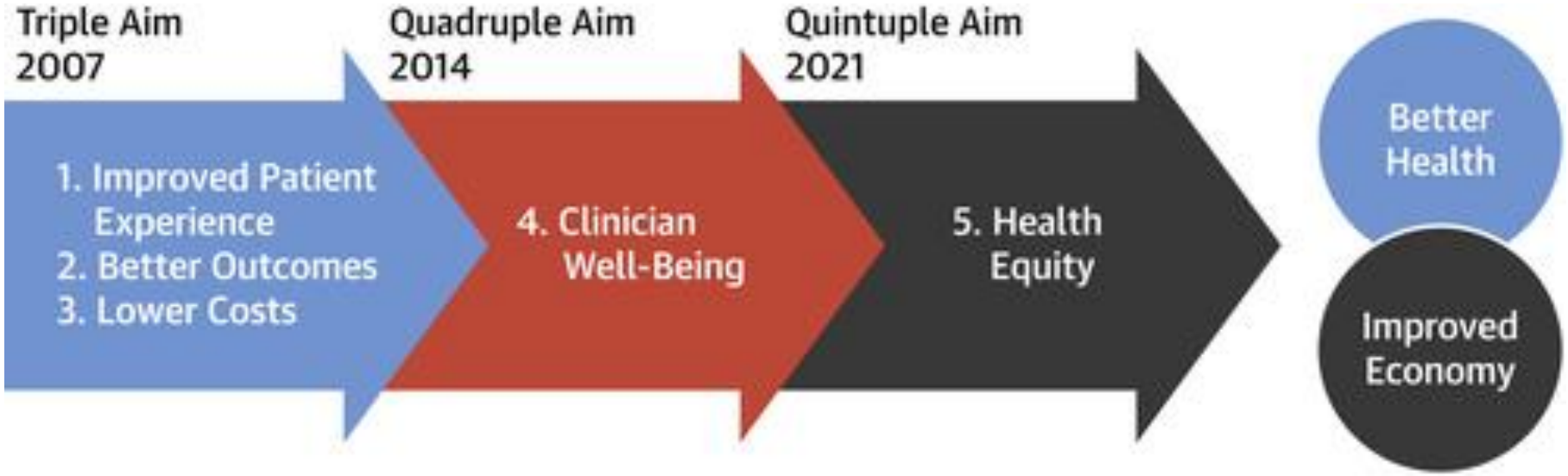
What is the impact of e-consults?

November 9, 2022

SNAHC
Sacramento Native American Health Center

Quintuple AIM



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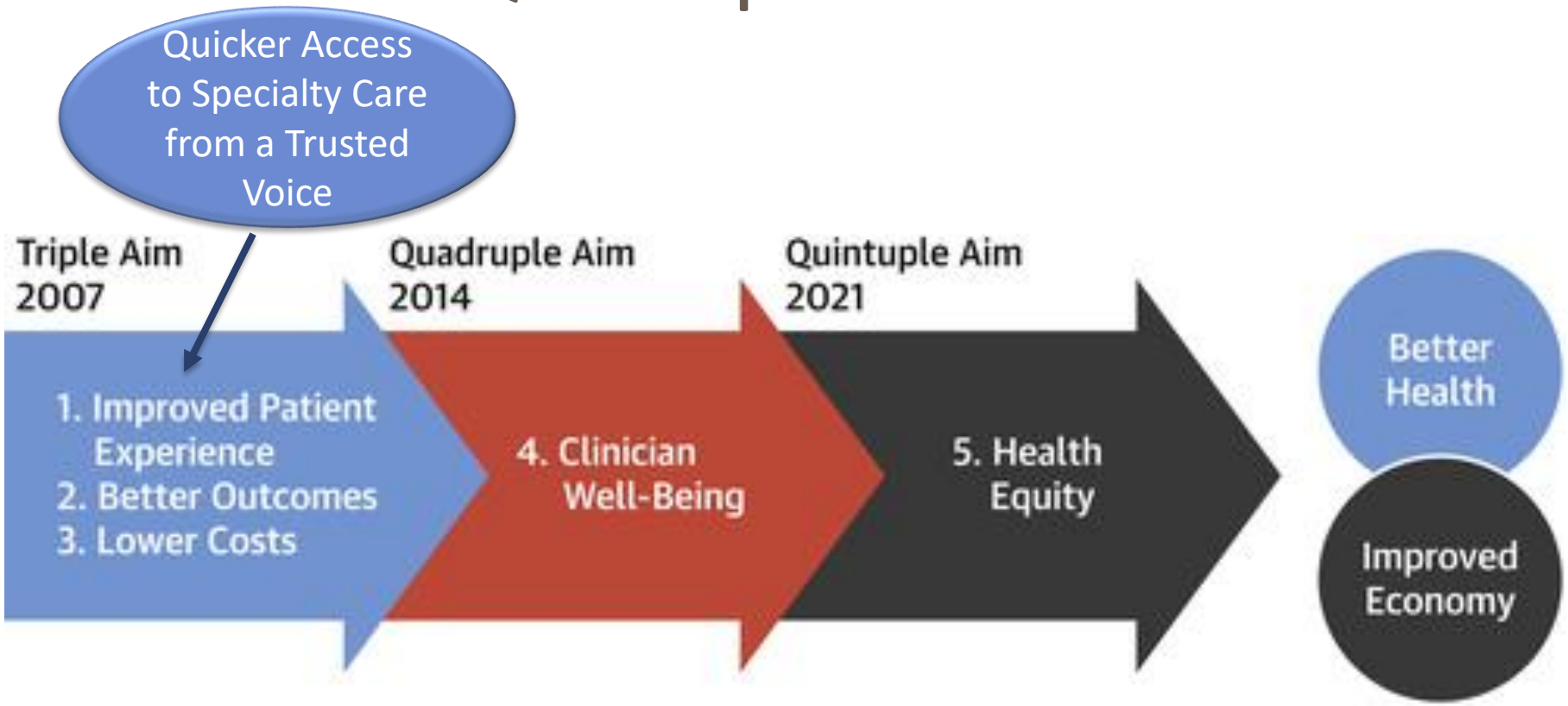

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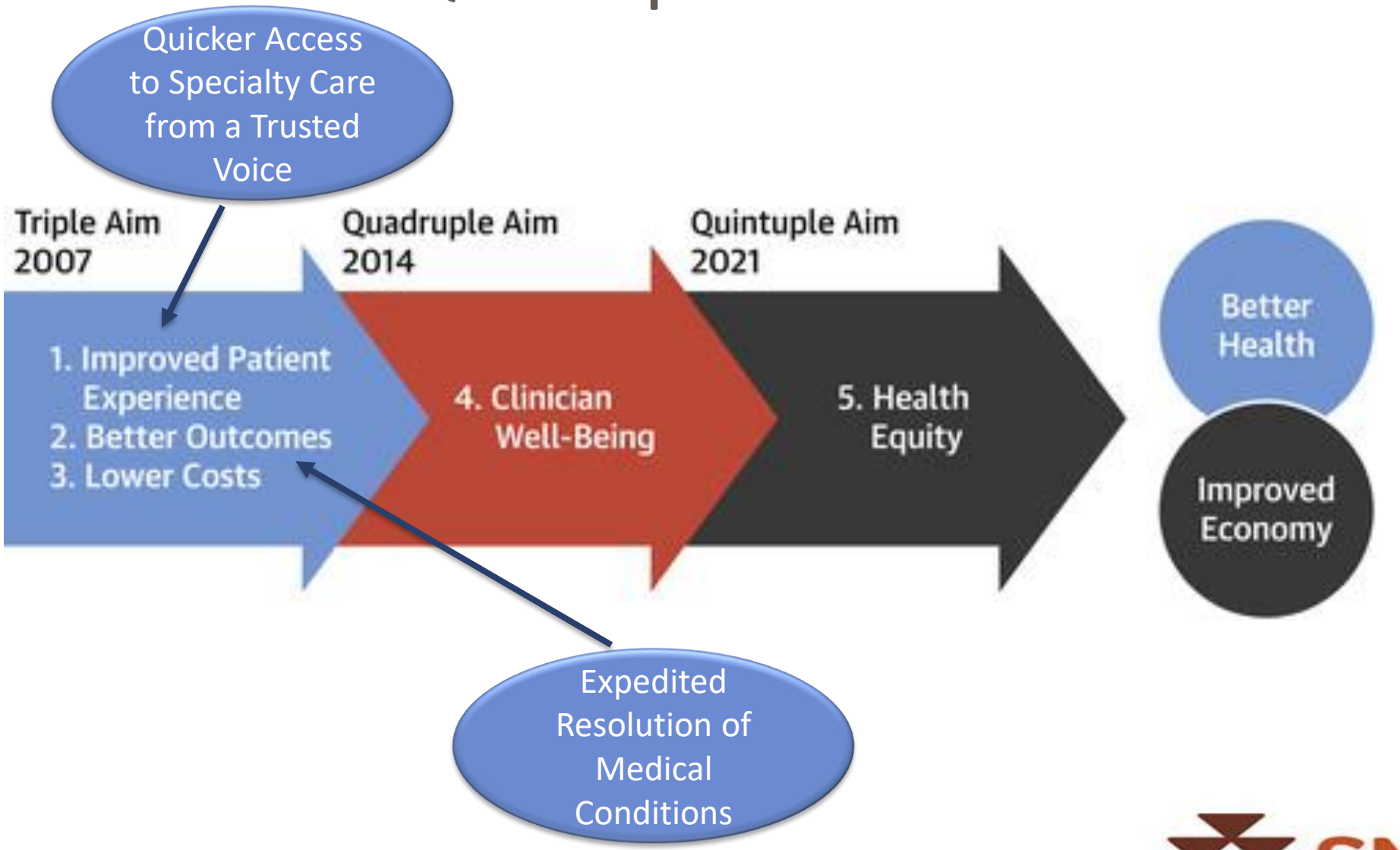

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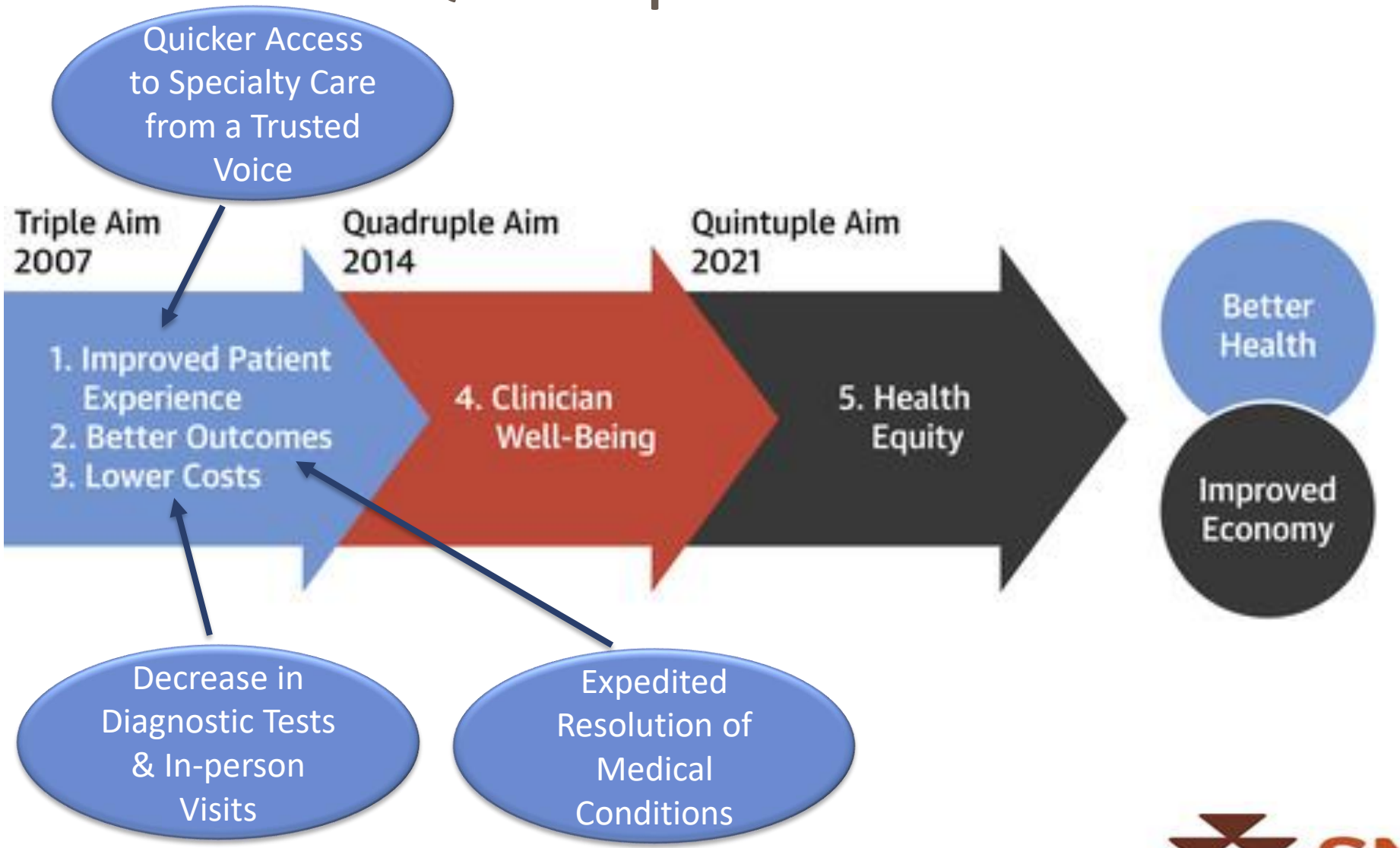

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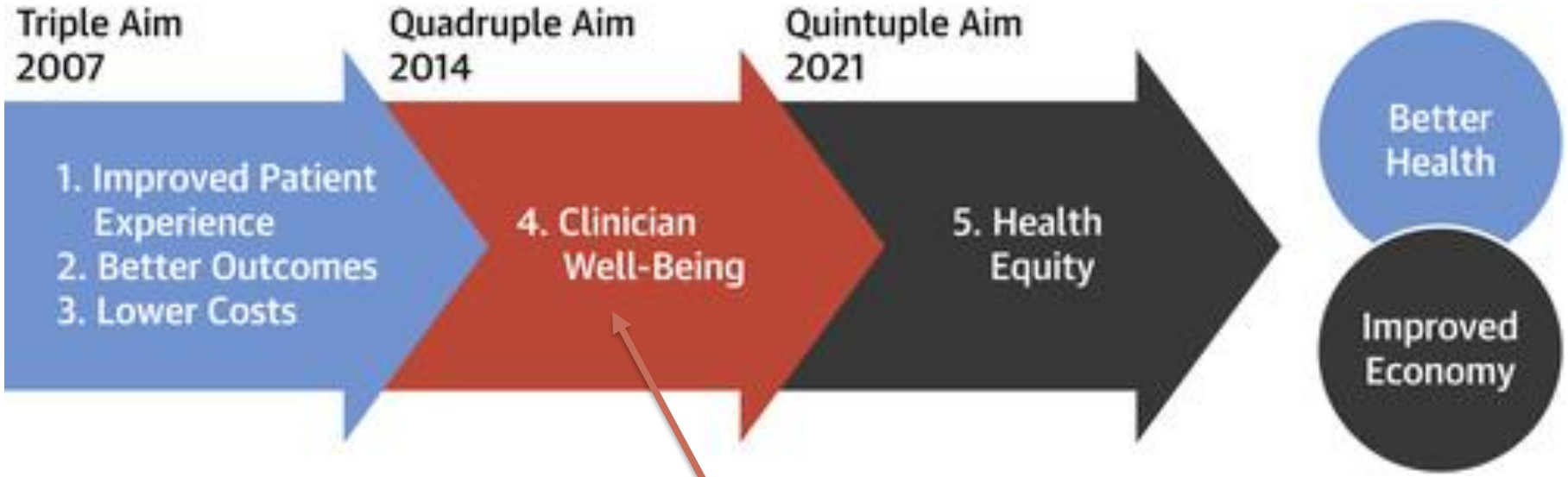

Clinicians are more easily able to meet the needs of the patient population.

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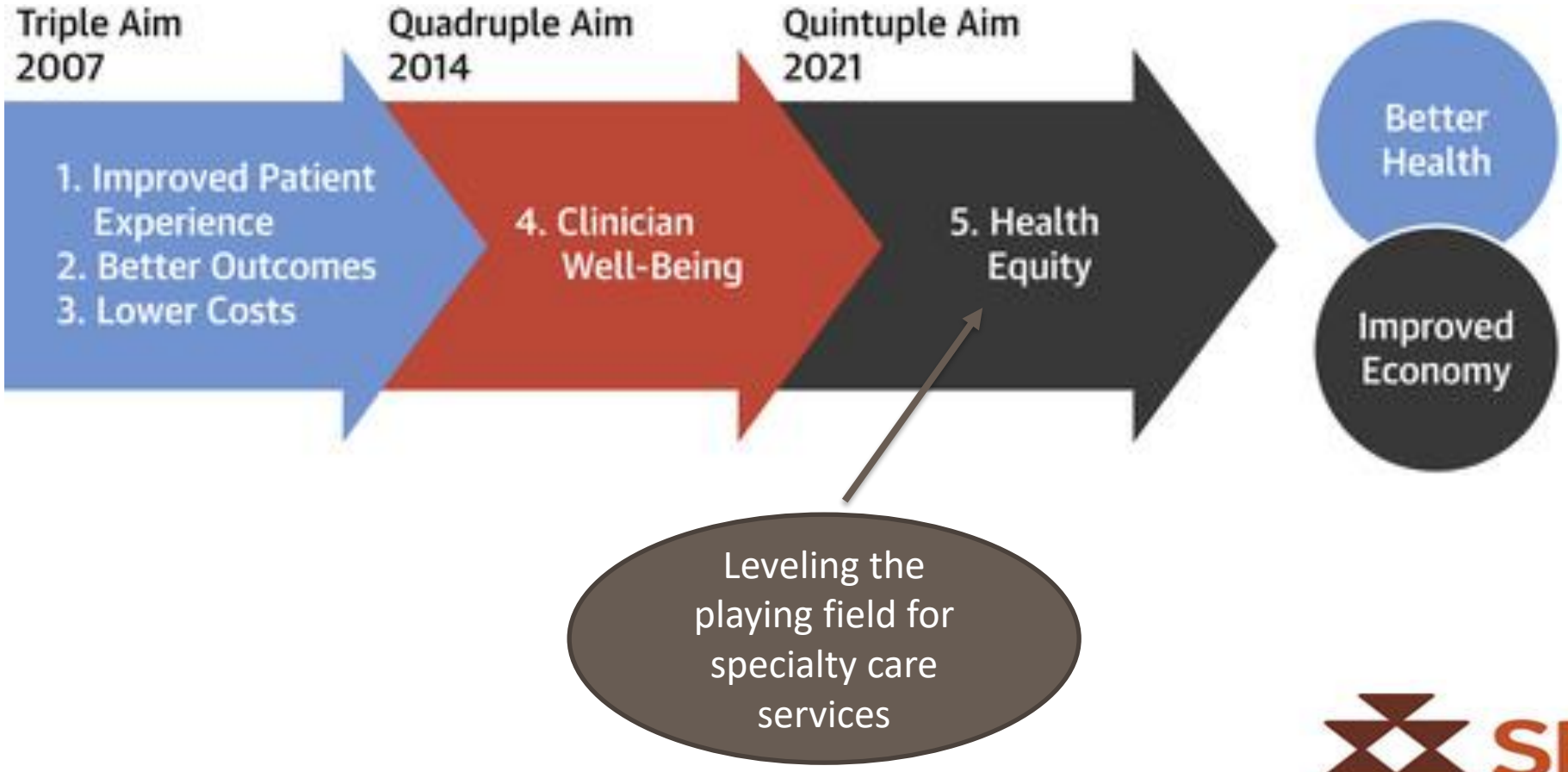

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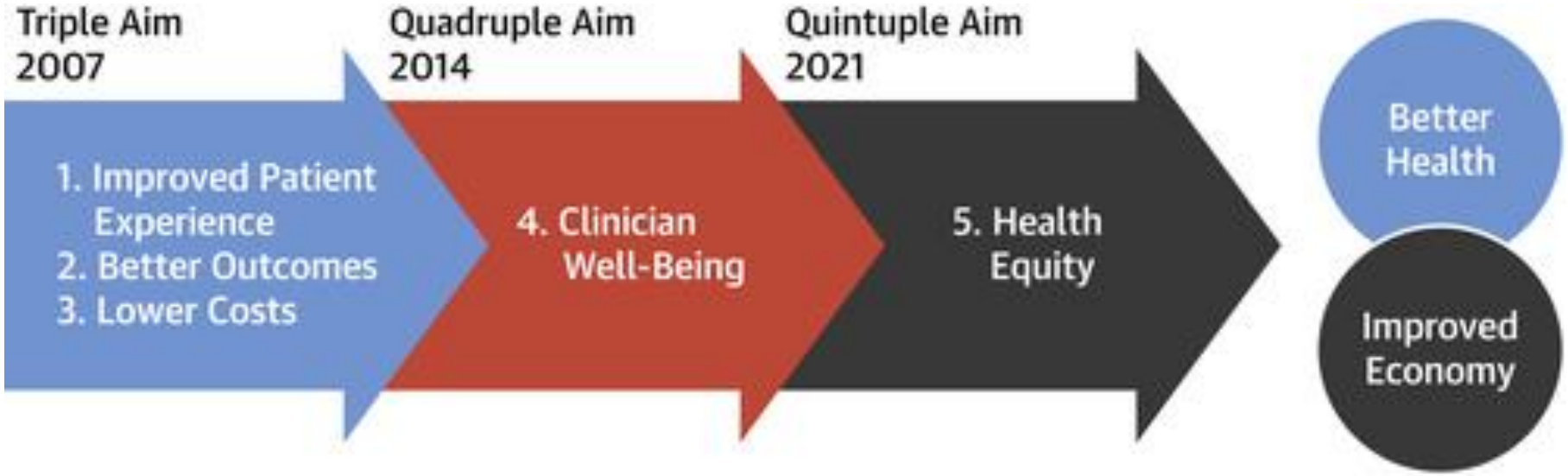

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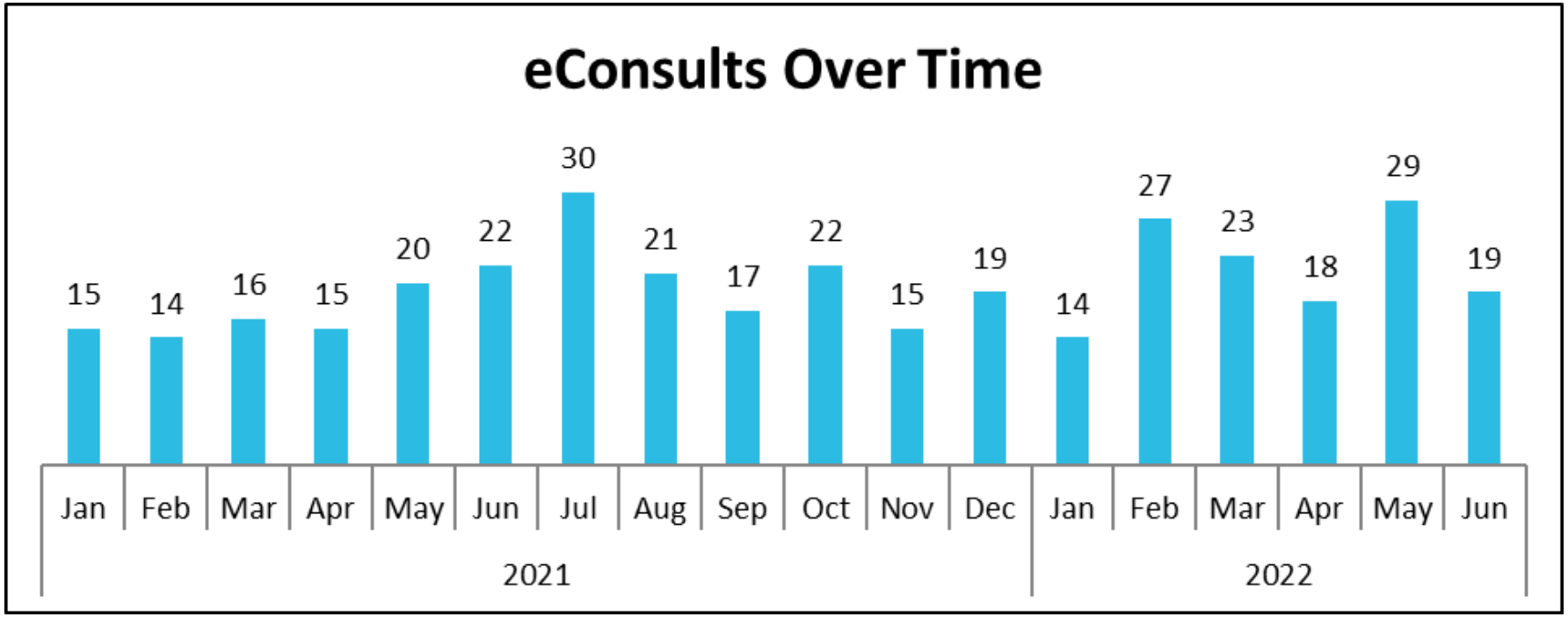
What is the impact of e-consults at SNAHC?

November 9, 2022

SNAHC
Sacramento Native American Health Center

SNAHC E-Consults



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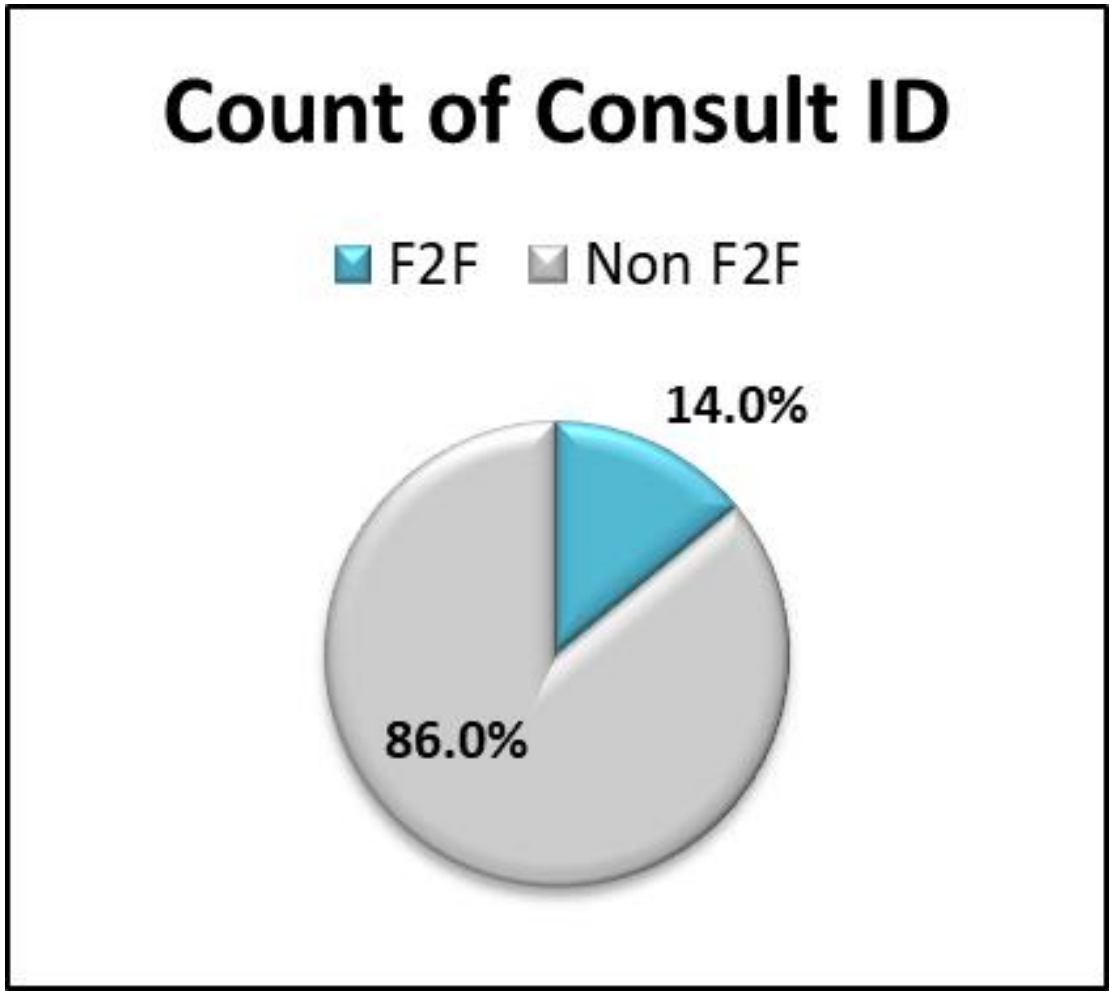
SNAHC E-Consults



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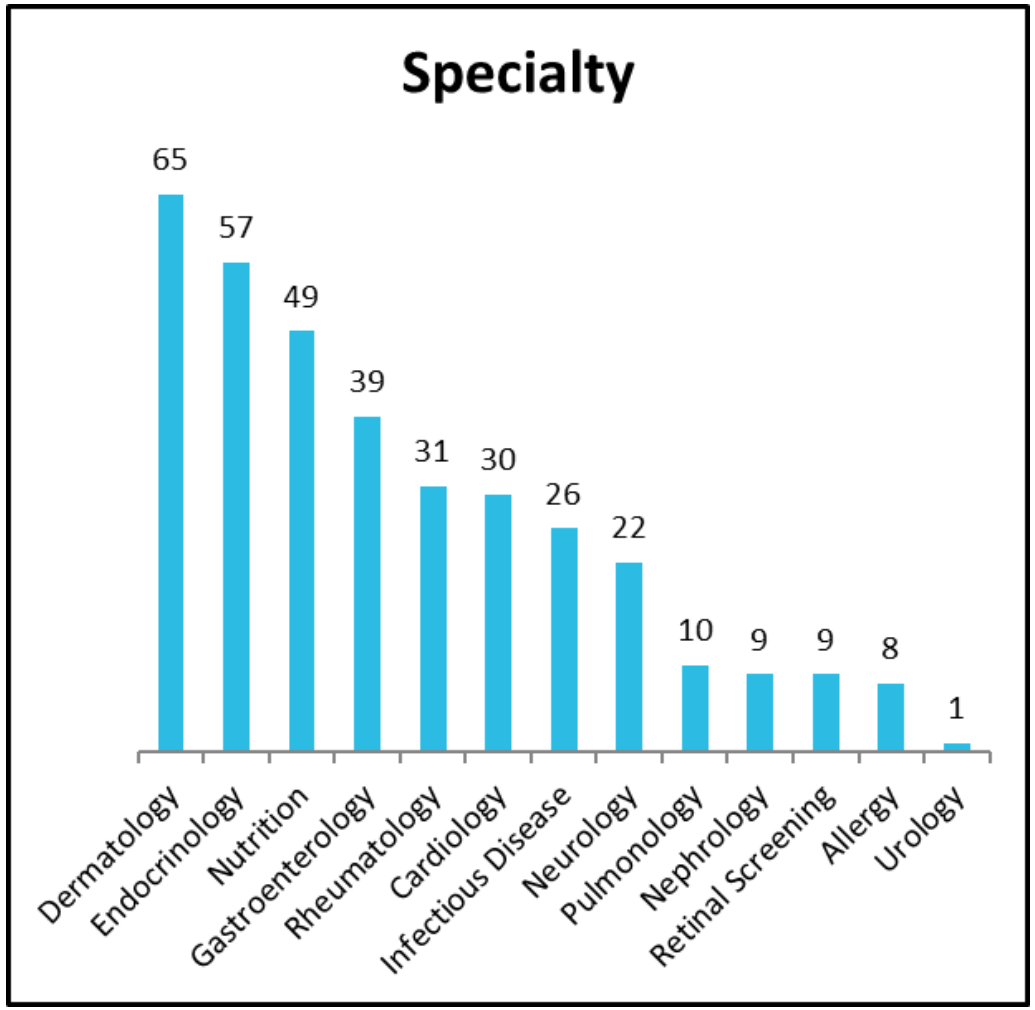
SNAHC E-Consults



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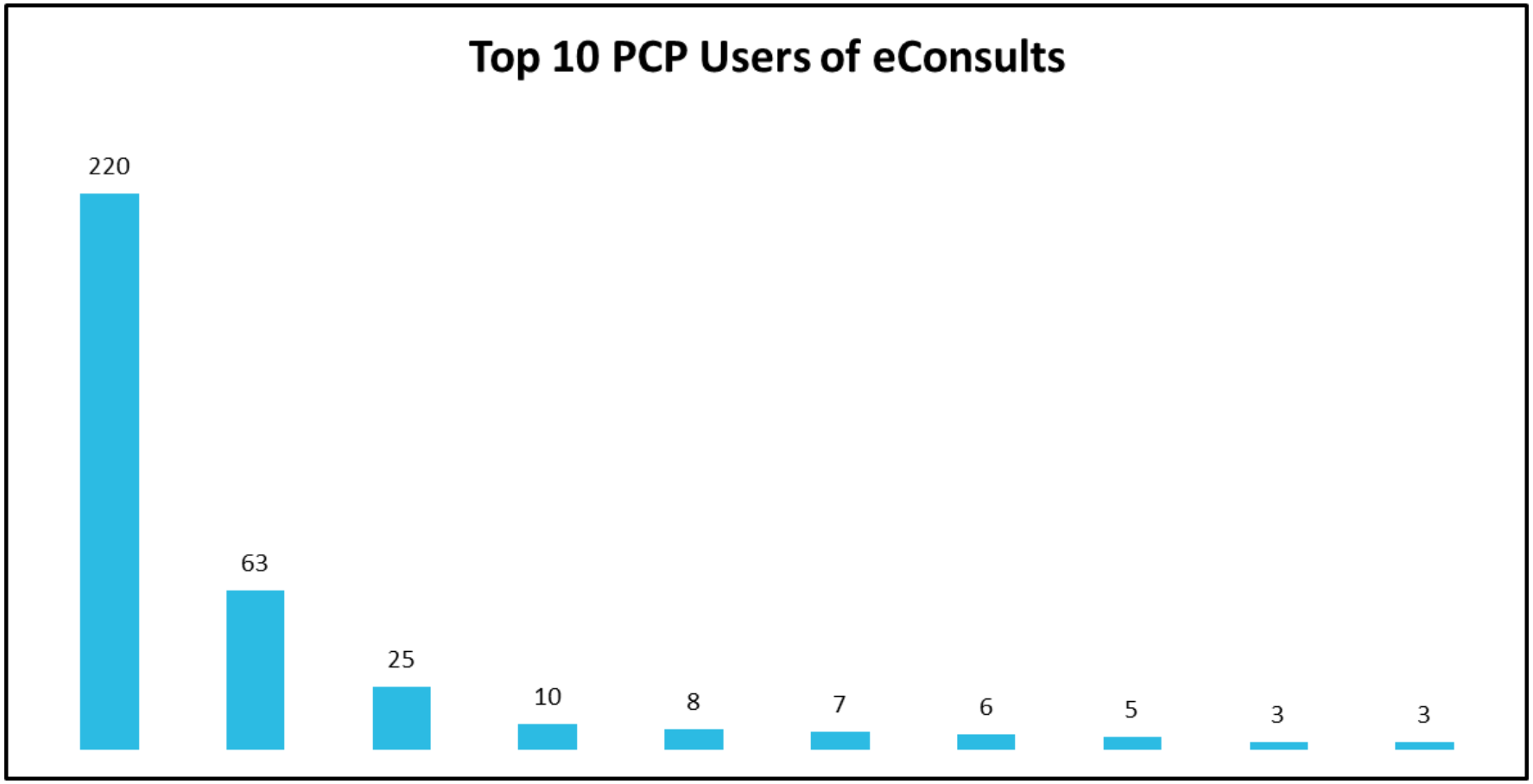
SNAHC E-Consults



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SNAHC E-Consult – Next Steps

- Work with IPAs to improve e-consult access
- Review Opt-In vs. Opt-Out Model
- Develop Typical Workup Strategies

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Thank You!

Hakeem O. Adeniyi, Jr., MD (he/him)
Hakeem.Adeniyi@snahc.org

E-Consult Workgroup Progress

e-consult WORKGROUP

2022 Accomplishments

- Growth of payer-supported programs facilitating provider engagement
- Expansion of e-consult programs to support the uninsured
- Facilitation of Continuing Medical Education to engage providers
- Payer and provider reporting to demonstrate impact on access to care
- Focus on public health, behavioral and mental health impacts

E-Consult Workgroup Annual Meeting

Continued Work in 2023

- Support models and strategies for engaging primary care providers and their teams
- Address the need for treating provider reimbursement
- Incorporate e-consult in alternative payment methodology (APM)
- Encouraging consistent coverage across plan business lines
- Share e-consult program data to address health disparities

Forming E-Consult Coalitions

Jeffrey Nkansah, MPA
Chief Executive Officer
CalViva Health Plan

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

Abbie Totten
President, California Plan
Molina Healthcare

Les Ybarra
President, CA Medicaid Health Plan
Anthem, Inc

Peer-to-Peer Support for Public Health Needs

e-consult WORKGROUP

Timi Leslie
Founder and President
BluePath Health

Daren Anderson, MD
President
ConferMED

Lisa Chew, MD, MPH
Associate Medical Director
Harbor View Medical Center

Christopher Miller
Program Specialist
Association of American Medical Colleges

Kelvin Vu, DO, FAAFP
SVP Clinical Services & Medical Officer
Open Door Community Health Centers

Connected Care for COVID-19

BluePath Health E-Consult Workgroup Annual Meeting: *Peer-to-Peer Support for Public Health Needs*

November 9, 2022

CDC Cooperative Agreement to Build Vaccine Confidence

CORE®

AAMC Improving Clinical and Public Health Outcomes through National Partnerships to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats" (FAIN: NU50CK000586): This initiative, beginning in February 2021, is part of the AAMC's efforts to improve health care access, collaborate with communities, and advance health equity.

Target Population

- Health care personnel (clinical and non-clinical)
  - Vaccine confidence and acceptance
- Communities disproportionately impacted by COVID-19
  - Empower and equip AMC health care personnel

Focus on Several Strategies

- Disseminate and amplify critical content and best practices
  - Media messaging through broadcast and social media platforms
  - Digital hub and clearinghouse resources for health care personnel
- Trustworthiness and Community Collaborations
  - Long-term trustworthiness
  - Partnership with AAMC Center for Health Justice

CDC Supplemental Grant: Connected Care for COVID-19

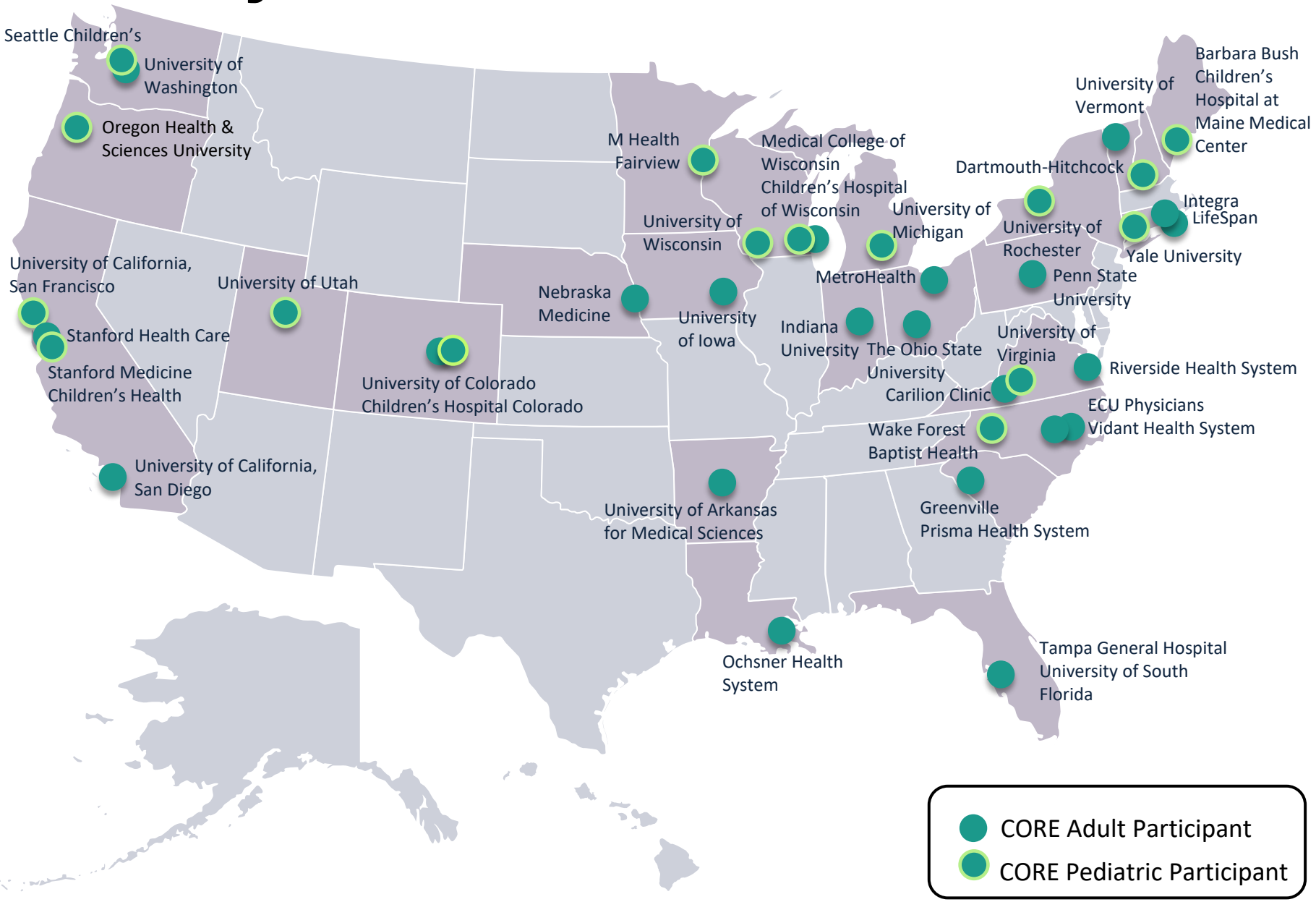
CORE®

- Funding period: 10/1/2021 – 9/30/2022
- Three key areas of focus:
  - Reducing the digital divide through AMC-community partnerships
  - Strengthen COVID-19 vaccine confidence through increased knowledge and competence among PCPs through peer-mentored care networks
  - Design and promote COVID-19 vaccination-specific eConsult tools and expand access to COVID-19 eConsults

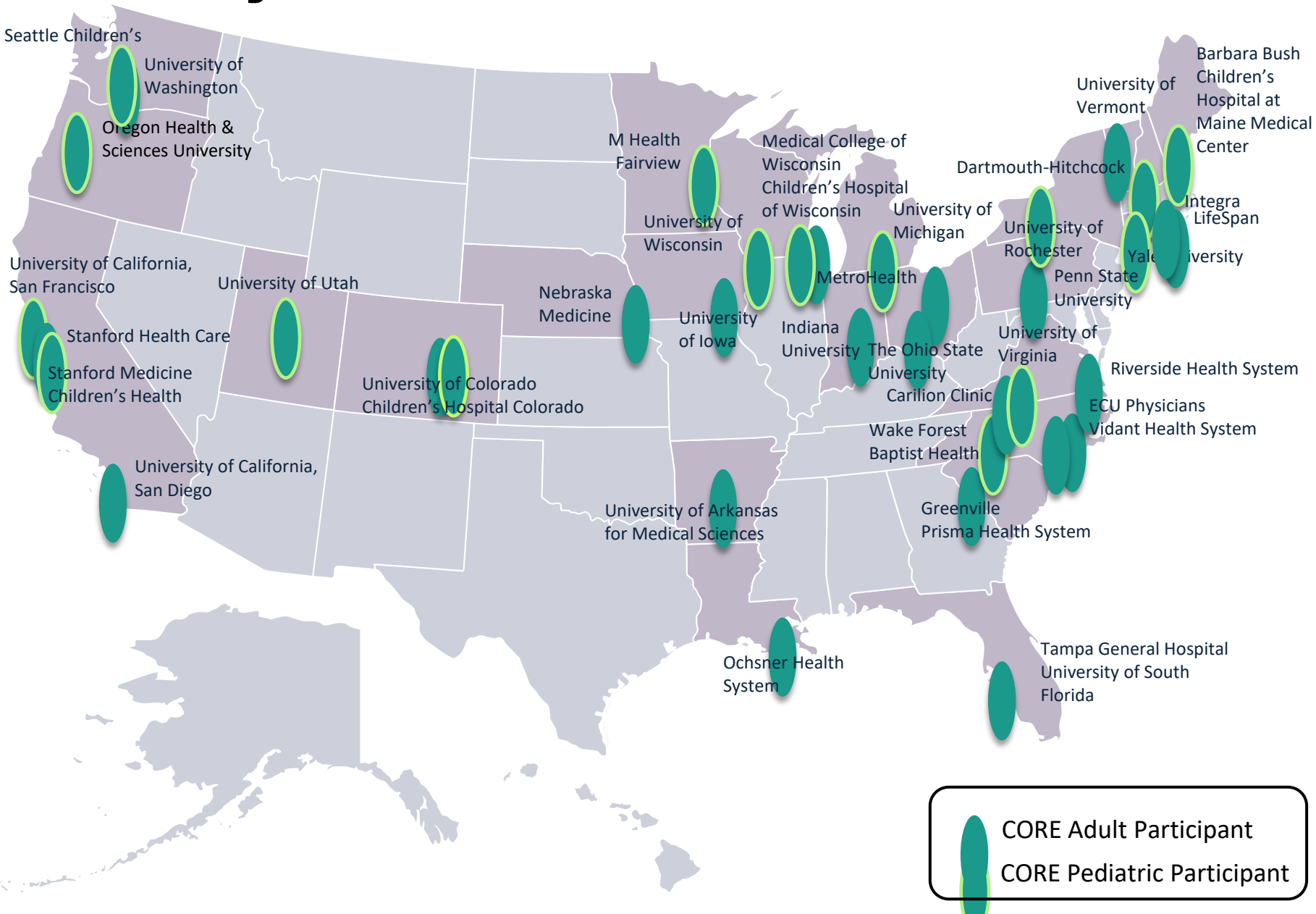
This work supports "Addressing the Digital Divide to Improve Vaccine Access & Information," a supplemental award (#6NU50CK000506-02-01) funded under a cooperative agreement from the Centers for Disease Control and Prevention.

AAMC

Project CORE Network



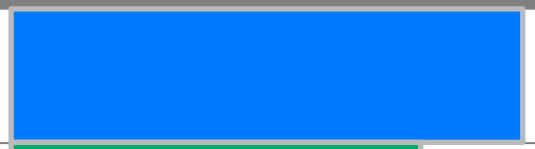
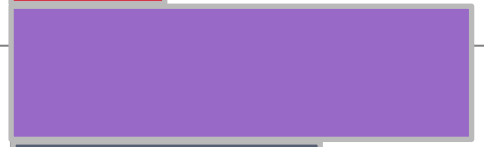
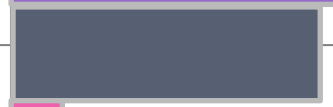
Project CORE Network



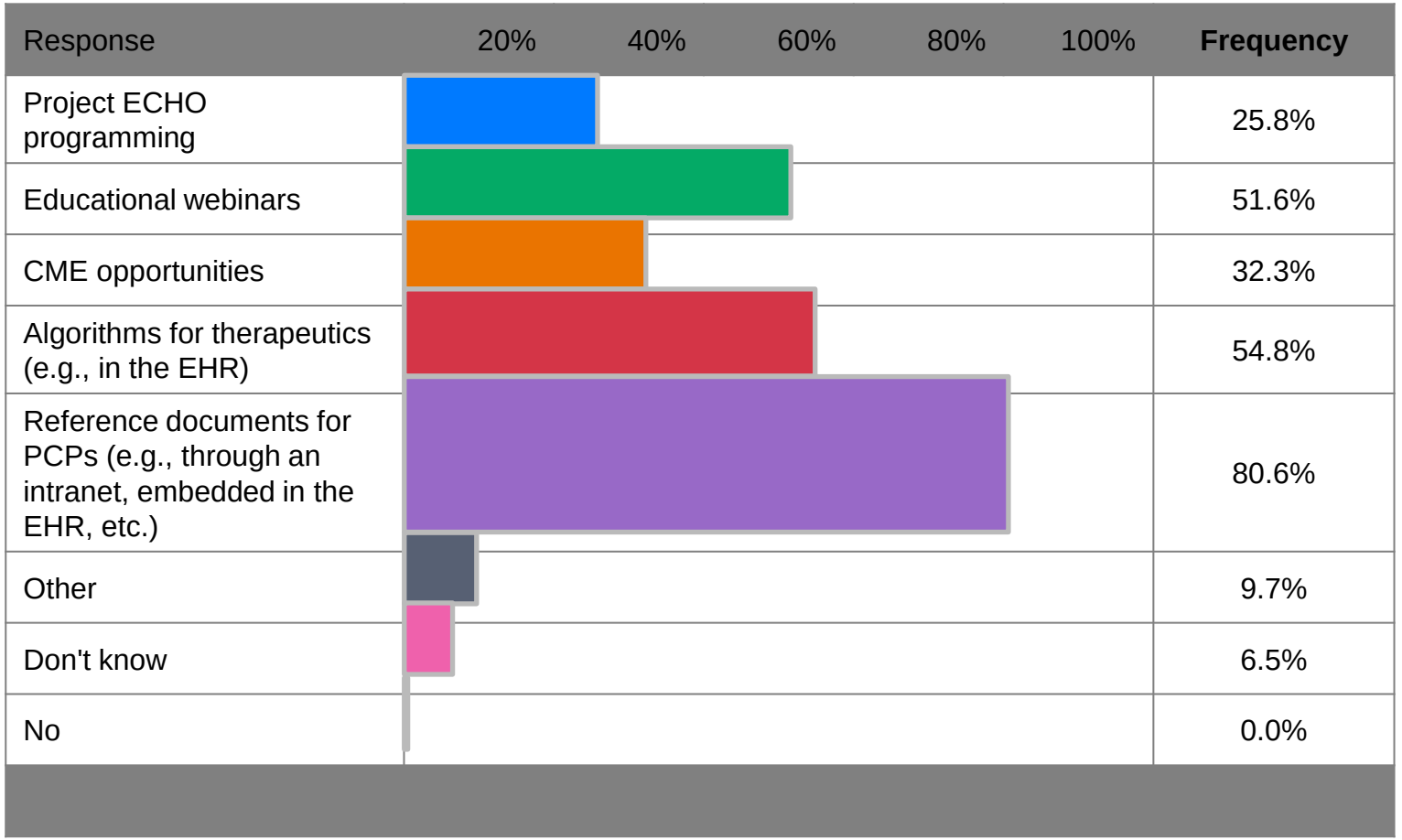
Insights from the CORE Network

- Electronic survey sent to 39 CORE participants (adult and pediatric programs) in May 2022
- 16/31 respondents were seeing use of eConsults related to COVID-19
  - Infectious Disease, Allergy/Immunology, Pulmonology, Cardiology, Neurology, Multispecialty COVID Clinic
- More helpful with vaccines and long COVID (vs. acute COVID)
- Separate infrastructures in place to support/educate PCPs in COVID management
- Potential opportunities around Long COVID (access challenges, patients may benefit from earlier interventions)

What specific topics or questions around COVID-19 are being asked by PCPs via eConsults?

Response	20% 40% 60% 80% 100%	Frequency	Count
General COVID-19 vaccine questions and vaccine contraindications		62.5%	10
COVID-19 vaccines: Addressing patient questions/concerns		50.0%	8
COVID-19 vaccines: Latest recommendations on eligibility, timing, and boosters		43.8%	7
COVID-19 therapeutics (monoclonal antibodies, antiviral therapy, evusheld)		18.8%	3
Post-acute COVID-19 management (symptoms lasting >4 weeks)		56.3%	9
Acute/initial COVID-19 treatment and management		37.5%	6
Other		6.3%	1
N/A		0.0%	0
		Valid Responses	**16**

At your institution, are there other provider education efforts principally aimed at PRIMARY CARE clinicians related to COVID-19 management and prevention (including vaccination)?



Response	Frequency
Project ECHO programming	25.8%
Educational webinars	51.6%
CME opportunities	32.3%
Algorithms for therapeutics (e.g., in the EHR)	54.8%
Reference documents for PCPs (e.g., through an intranet, embedded in the EHR, etc.)	80.6%
Other	9.7%
Don't know	6.5%
No	0.0%

Further Resources

- Connected Care for COVID-19: AAMC-led efforts on improving COVID-19 management and prevention and innovations and tools from member institutions and other organizations
- eConsult COVID-19 Library: Sample COVID-19- related eConsults from academic medical centers, children's hospitals, health systems, and independent practices (ConferMED)
- Advancing Health Equity Through Telehealth Learning Series: AAMC-led learning webinar series highlighting role of academic medicine in promoting and advancing health equity through telehealth, eConsults, and Project ECHO
- Project ECHO: Long COVID and Fatiguing Illness Recovery Program: CDC-funded collaboration between Family Health Centers of San Diego, the ECHO Institute, University of Washington, and University of Colorado; open to participants nationally through 2022

ORE®

AAMC

ConferMED™

Connecting Primary Care to the Future

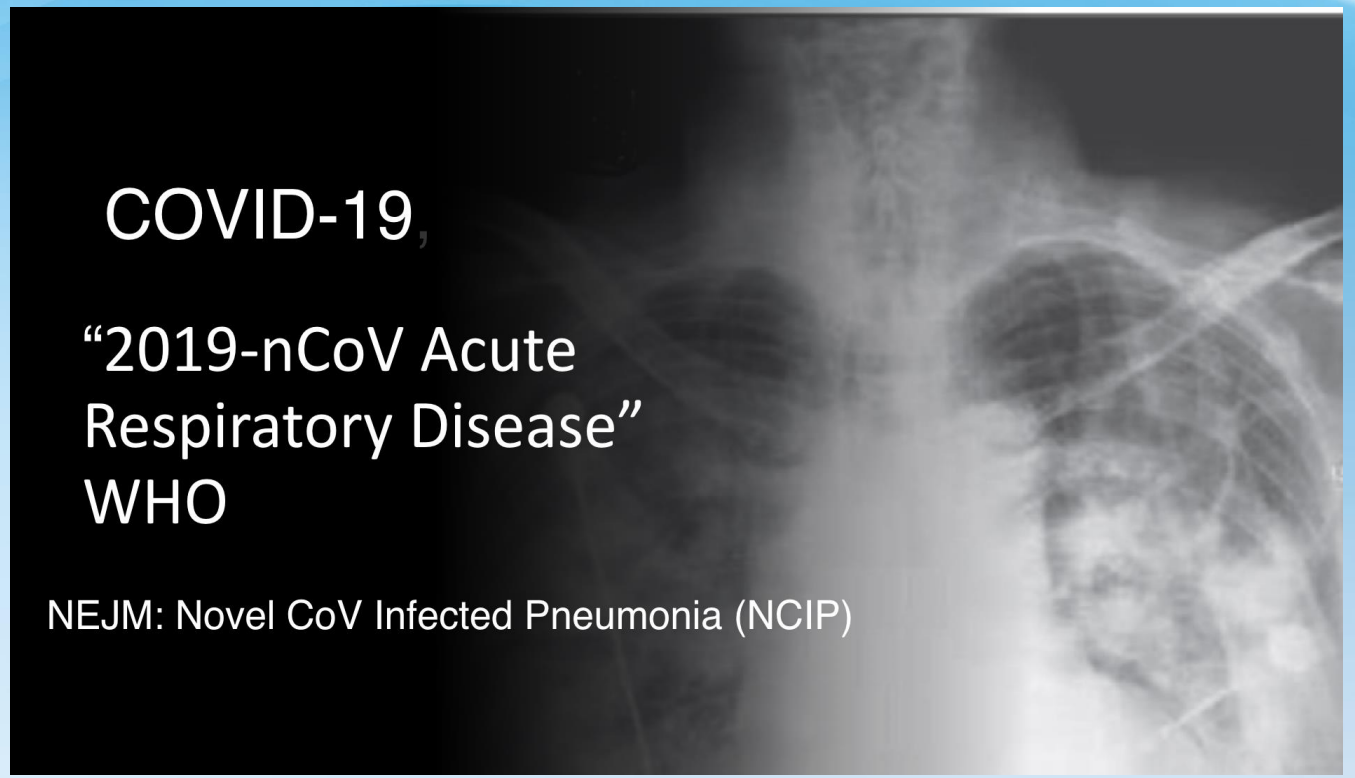
How Can Primary Care Prepare for the Next Public Health Crisis?

www.ConferMED.com

Weitzman ECHO on Coronavirus

Daren Anderson, MD
Kara Lewis, PharmD
Stephen J. Scholand, MD
Daniel Wilensky, MD

March 4, 2020


COVID-19,
"2019-nCoV Acute Respiratory Disease"
WHO
NEJM: Novel CoV Infected Pneumonia (NCIP)

Objectives for today's session:

- Briefly review the novel coronavirus (2019-nCoV, SARS-CoV-2) emergence and epidemiology
- Seek to understand viral pathogenicity and disease
- Develop and maintain awareness of clinical clues and laboratory indicators for this disease
- Recognize the impact of this new disease
- Remain vigilant for community cases
- Be prepared!

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ConferMED Connecting Primary Care to the Future

eConsult Request **Current Status:** Closed

Patient Information

Name:	Gender:	Address:	Date Of Birth:	Phone:
Mobile Phone:	Email:		Language:	Birthplace:
Account No. (MRN):	Insurance No.:			

Referred From	Refer To
Network: Site: Provider: Address: Phone/Fax:	Specialty: Pulmonology Specialist Reviewer:

Referral Information

eConsult ID:

Status: Closed (03/25/2022 01:35 PM)

Dialog Status: Follow Up Dialog Closed (03/31/2022 03:04 AM)

FUD Closed Date: 03/31/2022 03:04 AM

Auth Number:

Decision Date: 03/25/2022

Appointment:

Priority: ○ Expedite ○ Routine

Diagnosis: 2019-NCOV ACUTE RESPIRATORY DISEASE **ICD Code:** U07.1

Procedure: interprofessional telephone/Internet assessment (99451) **Qty:**

Additional Notes:

Message to Referrer: If you have any questions or feedback on this consult, please email support@confermed.com.

eConsult Dialog **If you would like to rate this consult, please click https://chc1.quickbase.com/db/bmxqgqj5w?a=nwr&_fid_6=13623072&ifv=1**

The recommendations provided in this eConsult are based on data provided by the referring provider. The Specialist did not personally interview or examine the patient.

03/25/2022 10:28 AM To:

For patients with post-acute COVID related dyspnea what are pulmonologistsrecommending for treatment? I am recommending an increase in Advair Diskus to500mcg-50mcg today as he has noticed improvement with the lower dose. Would you adda LAMA if he is still not well controlled?Should he have PFTs/echo/chest CT completed or are you seeing relatively normalworkup in patients with dyspnea s/p COVID? Thank you so much for your time!

PCP's Clinical Question

Patient with post-acute Covid dyspnea. What are pulmonologists recommending for treatment? I am recommending an increase in Advair Diskus to 500mcg-50mcg today as he has noticed improvement with the lower dose. Would you add a LAMA if he is still not well controlled? Should he have PFTs/echo/chest CT completed or are you seeing relatively normal workup in patients with dyspnea s/p COVID?
Thank you so much for your time!

Example

eConsult response

Pulmonologist's Response:

I have reviewed the attached clinical information for your patient. Please see below for my recommendations

History review: 26 yr old male with Hx of Covid Jan 2022 with persistent Sxs now of SOB and brain fog and fatigue. He is a non smoker. He has no Hx of lung or heart disease. His exam was normal with an 02 sat of 99% a BMI of 26 with clear lungs and no edema. Labs showed a normal CXR and normal spirometry although the peak flow was low. He has slowly been improving and the Advair has helped. I didn't see if he was vaccinated for Covid.

PMH: fatigue, mood disorder, vitamin D deficiency and Covid. Medications and allergies reviewed

Problem discussion: His story is common and there is no single treatment to resolve his sxs. Time is the best healer but we can move it along. You need to be sure there are no pulmonary emboli or cardiac dysfunction. Pulmonary fibrosis would be unlikely with normal spirometry and a normal CXR. Vitamin D deficiency needs to be corrected and I agree with using an ICS - LABA or just an ICS. There is not much of a role for LAMAs. There is some data that vaccination after Covid can help with post Covid sxs.

Assessment:
Post Covid dyspnea, vitamin deficiency

1. get the Vit D level to above 35
2. continue Advair 500/50 bid
3. check a D-Dimer and if elevated he would need a CTA
4. No LAMA
5. No chest CT for now
6. I would get an echocardiogram
7. Hold on PFTs for now but do if without better in 6-8 wks
8. get him vaccinated if he has not done so - it might help

thx for the consult

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ConferMED
Connecting Primary Care to the Future

eConsult Example
Infectious Disease Specialist

INFECTIOUS DISEASE eConsult Request — **Current Status:** Submitted

Referral Information		
eConsult ID: **Status:** Submitted **Dialog Status:** Initial Dialog **Auth Number:** **Decision Date:** **Appointment:** **Priority:** ☐ Expedite ☐ Routine	**Diagnosis:** **Procedure(s):** **Additional Notes:** **Message to Referrer:** If you have any questions or feedback on this consult, please email support@confermed.com	**ICD Code:** **Qty:**
eConsult Dialog	If you would like to rate this consult please click here	
Date/Time:	**From: PCP Name**	**To: INFECTIOUS DISEASE SPECIALIST**

eConsult:
Referring for vaccine consult.

Patient tested positive for COVID-19 in 05/2021 without severe respiratory sxs but shortly thereafter onset with acute CVA and was hospitalized. Writer recommends patient get COVID-19 vaccine now (has not been vaccinated yet from this) but patient would like eConsult with Infectious Disease to verify Infectious Disease recommends the vaccine in the context of recent CVA/COVID-19.

Do you recommend COVID-19 vaccination now?

Please refer to notes.

Date/Time:	From: INFECTIOUS DISEASE SPECIALIST	To: PCP Name

Diagnosis:
Thanks for this consultation on your 50 yo female patient with HTN, hypothyroidism, and morbid obesity who contract COVID-19 in May of this year without severe respiratory symptoms but then developed an acute CVA requiring hospitalization. That affected the MCA, with speech deficits requiring ongoing therapy.

Certainly COVID-19 caused the stroke—I have no doubt about that; and probably her primary risk factor is the morbid obesity. Since May was 3+ months ago, and we're heading into the cooler season now when COVID could be expected to flare up more significantly, immunization makes very good sense. If she wanted to wait for 1 or 2 months more, I would be fine with that since natural infection does provide some protection. What we KNOW, is that 'more immunity' is certainly better and given she had this devastating stroke, she cannot afford to get 'sick' again. The Israeli's are going on a 5 month 'rebooosting' after the 2 primary series shots, and I think immunologically this makes good sense. In her case, maybe the primary infection is the initial immunological event and the vaccine administration at 5 months out would mirror this strategy.

So, to summarize: YES—I strongly recommend immunization. She should reflect on how bad her stroke was because of this. The next stroke could be as severe or even fatal (I hate to even say that) if she gets it again.

I think there is certainly some flexibility in terms of the timing but 5 months out would be my time limit to get this done. Hope this helps.

eConsult:
Referring for vaccine consult.
Patient tested positive for COVID-19 in 05/2021 without severe respiratory sxs but shortly thereafter onset with acute CVA and was hospitalized. Writer recommends patient get COVID-19 vaccine now (has not been vaccinated yet from this) but patient would like eConsult with Infectious Disease to verify Infectious Disease recommends the vaccine in the context of recent CVA/COVID-19.
Do you recommend COVID-19 vaccination now?
Please refer to notes.

ConferMED™ Connecting Primary Care to the Future

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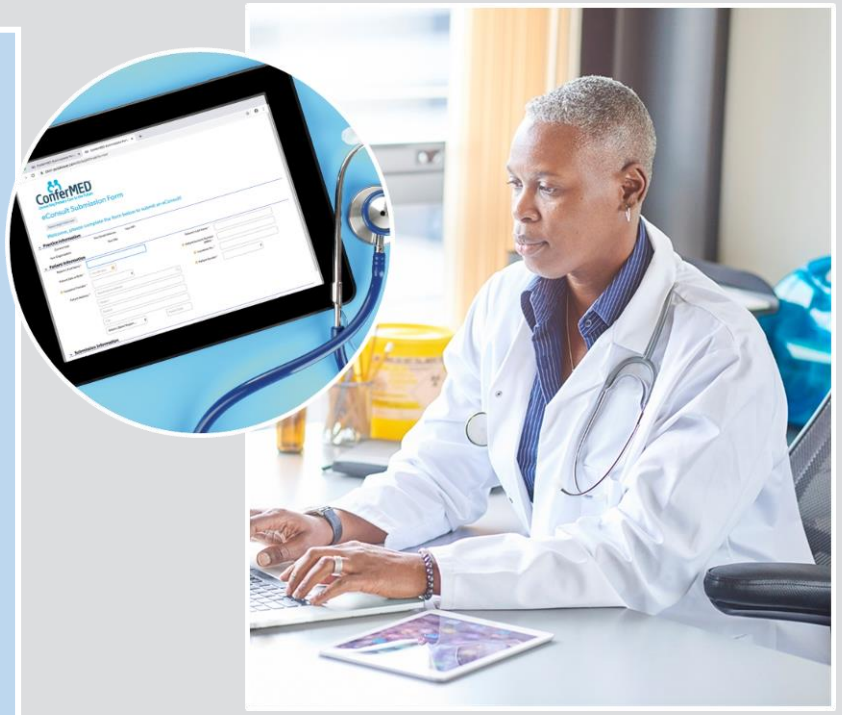


eConsult Submittal Form

Patient Name: Case 4	**Age/Date of Birth:** 12
ID #: *(If applicable)*	**Treating Clinician:**

Clinical Question:

This was a 12 year old girl I saw at the UNHCR relocation site. Her father brought her to me stating that they noticed the swelling in her neck for the past 6 days. She has low-grade fever. Mild difficulty with swallowing. No other associated symptoms.

Relevant Past Medical History:

No significant medical history

Medications:	**Social History:**
None	Negative tobacco, etoh or other illegal substance use

Relevant PE Findings:	**Ancillary Information** (Labs, Radiology, EKG):
Bilateral swelling of the Parotid glands that were non-tender to palpation. No peri-oral lesions or membrane noted.	None

Thank you for the excellent eConsult and for doing the wonderful work that you do. I do so appreciate seeing the photo of the child; not just the parotids, but the humanity.

Mumps is, by far, the most likely cause of parotitis in a febrile, unvaccinated child, or even in a vaccinated child surrounded by unvaccinated children. We have had other eConsults for the same presentation from your site. Typically, it begins with a few days of fever, headache, myalgia, fatigue, and anorexia, followed by parotitis. These symptoms weren't mentioned in the eConsult, but, even in their absence, this is still the most likely diagnosis. Many people who get the infection never become symptomatic at all. Though parotid swelling may begin on just one side, 90% of patients will develop it on both sides within several days. Parotid swelling usually lasts up to 10 days.

Mumps is usually self-limited; most individuals recover completely within a few weeks. Mumps is highly infectious and is transmitted by respiratory droplets, direct contact, or fomites (objects or materials in contact with infected individuals). Mumps spreads rapidly among susceptible individuals living in close quarters. Viral shedding in respiratory secretions precedes the onset of symptomatic illness. The incubation period is usually 16 to 18 days from exposure to onset of symptoms. Individuals with mumps are typically infectious from three days before until nine days after onset of symptoms

Lunch

Video Provider Perspectives

Yamilett Medrano, MHA,
Program Director, Digital Health, Loma Linda University Health

Alyssa Spencer, Physician Assistant
Associate Medical Director, WellSpace Health

Scott Dzurella, Family Nurse Practitioner
Chapa-De Indian Health

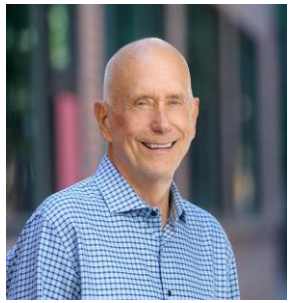
Please take a moment to respond to our 3-question poll on the Whova app.

https://whova.com/portal/webapp/ewam_202211/Agenda/2590661

E-Consult Policy Path Forward

Robby Franceschini, JD, MPH
Director of Policy
BluePath Health

Meaghan Quinn, MHSA
Program Lead
Association of American Medical Colleges

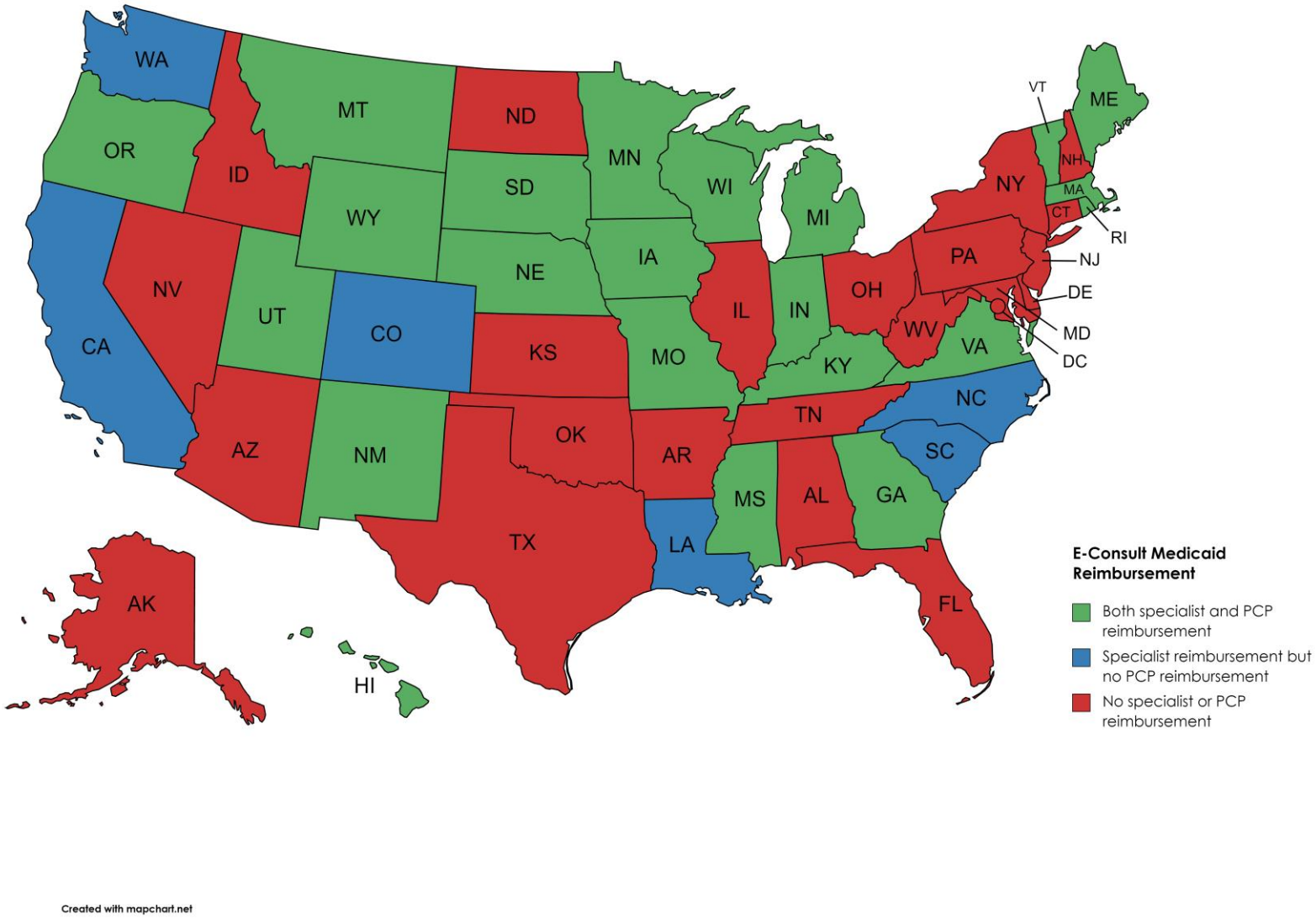


Mike Witte, MD
Chief Medical Officer
CA Primary Care Association

Allie Budenz, MPA
Director of Population Health Management
CA Primary Care Association

Jacob Quinton, MD
Medical Officer
Center for Medicare and Medicaid Innovation

E-Consult Medicaid Fee Schedule Update 2022



Additional state reimbursement since 2021 includes Missouri, South Dakota, Wyoming, Mississippi, and Delaware

The Right Care at the Right Time: Recommendations for California to Support E-Consults in the Medi-Cal Program

- **Coverage and reimbursement**
  - Add an e-consult code to the Medi-Cal fee schedule for treating providers.
  - Allow for FQHCs and RHCs to receive higher fee for service and managed care payment for encounters supported by e-consults.
- **Grant programs**
  - Create a technical assistance fund through the new Department of Health Care Access and Innovation.
- **Network adequacy**
  - Acknowledge e-consult in timely access.
  - Create a standardized reporting mechanism for MCPs to report on their e-consult provider networks and utilization.
  - Develop a framework for granting credit to MCPs for e-consult, using alternative access standards.
- **Rate-setting**
  - Develop a rate adjustment methodology that rewards MCPs for investments made to improve outcomes and increase access to care.
- **Performance measurement**
  - Revisit quality and performance metrics that incentivize timely turnarounds for specialty care requests and the management of specialty care through telehealth.

California FQHC APM

eConsult Policy Priorities

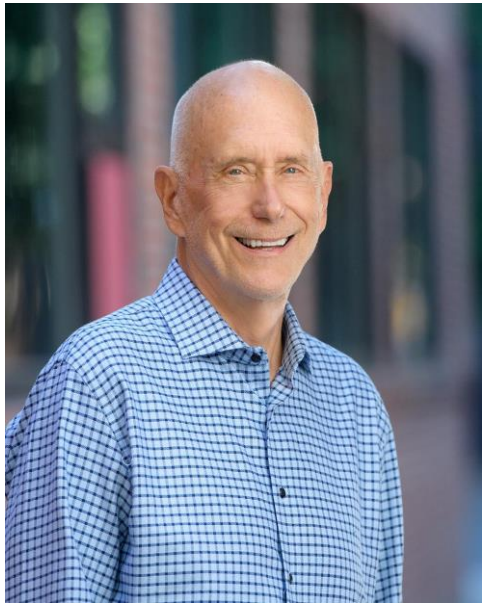
California Primary Care Association

Contact Information

Allie Budenz

Director of Population Health Management

abudenz@cpca.org



Mike Witte

Chief Medical Officer

mwitte@cpca.org

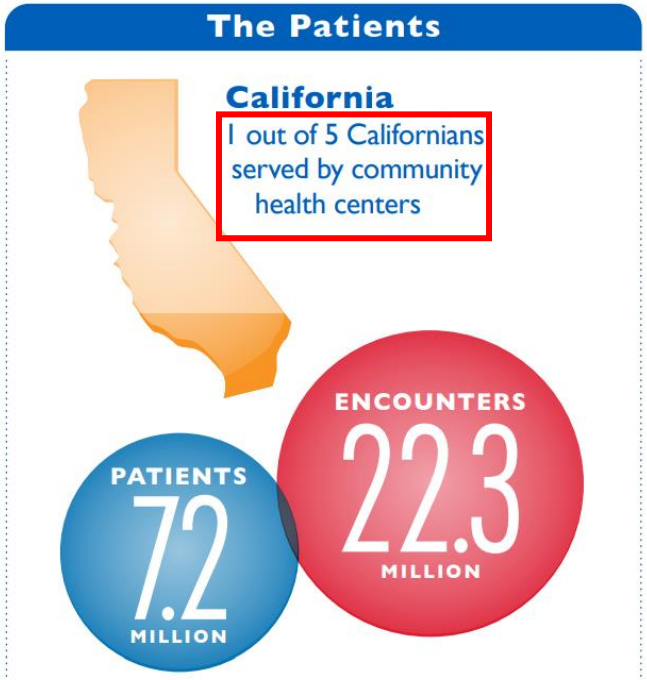
About California Primary Care Association

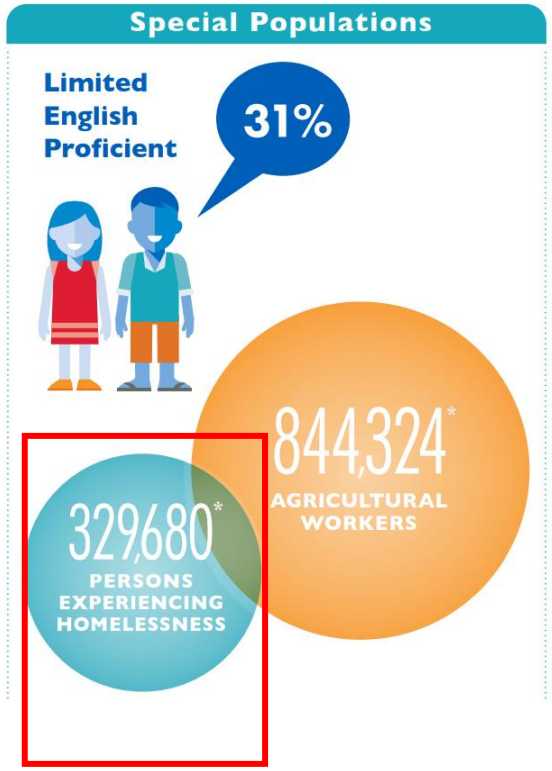
Mission and Members

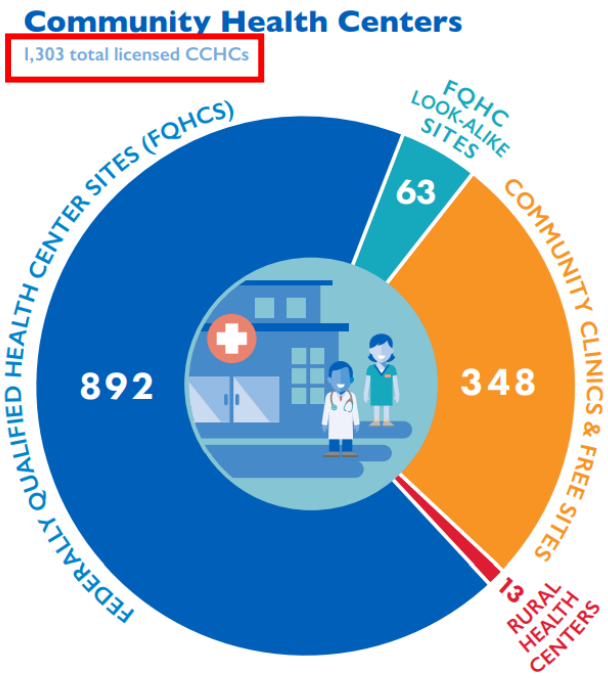
- To lead and position community clinics, health centers, and networks through advocacy, education and services as key players in the health care delivery system to improve the health status of their communities.
- CPCA was founded to create a unified, statewide voice for community clinics and health centers.

- Community Clinics
- Free Clinics
- Federally Qualified Health Centers (FQHCs)
- FQHC Look-Alikes (FQHC-LAL)
- Rural Health Clinics
- Migrant Health Centers
- Indian Health Service Clinics
- Planned Parenthood Affiliates of CA

2021 State Profile for Community Health Centers







Data is based on 2020 OSHPD AUR.

**Special Populations data is specific to Federally Qualified Health Center (FQHC) collected data only.*

Overview of FQHCs and RACs

Federally Qualified Health Clinics

- Provide comprehensive services, including integrated behavioral health services
- Serve a designated medically underserved area or medically underserved population
- Can turn no one away – offer a sliding fee schedule for uninsured, underinsured patients under 200% FPL
- Governed by a majority-consumer board
- Teaching health centers and residency programs
- Quality infrastructure, including QI and data staff, 100% EHR adoption

Regional Associations of California

- CPCA works closely on policy and program issues with a statewide coalition of regional clinic networks that represent clinics at a local level
- The individual consortiums vary in size, for example CCALAC serves two counties (LA and OC) while Central Valley Health Network services 17 different counties
- There are 15 different CA consortiums

CalAIM - STRUCTURE

Better aligning systems and providers for outcomes.

Additional resources and support for high cost and high need utilizers.

Address the SDOH.

PHMI - DELIVERY MODEL

Without PHMI, CalAIM is just a structure.

Without APM, population health is not properly incentivized and can only be moderately realized.

PMHI brigns the theory to life.

APM - PAYMENT

Build on benefits of PPS.

More flexibility in how care can be delivered.

Opportunities for broader, more robust care models.

Improved cash flow and financial stability.

DATA – DATA – DATA - DATA

Alternative Payment Methodology (APM)

A payment reform tool in the FQHC tool box.

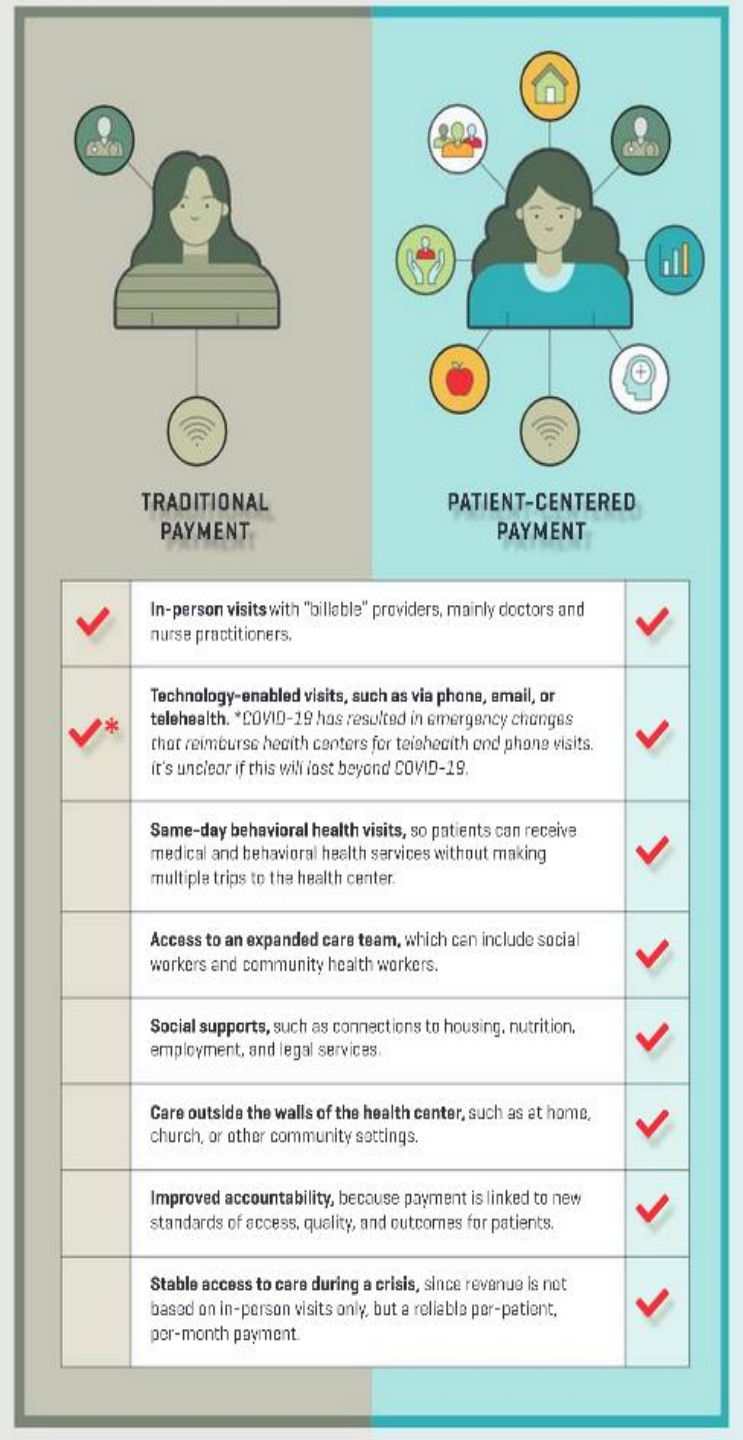
- Congress allows use of an APM as long as:
  - It "results in payment to the center or clinic of an amount which is **at least equal** to the amounts otherwise required to be paid to the center or clinic" under Prospective Payment System (PPS)
  - It is agreed to by the state and the individual FQHC (i.e. **voluntary**)
- This is our second attempt at securing an APM option for California.

Source: Social Security Act 42 USC §1396a(bb)(6) and January 2001 State Medicaid Directors Letter (SMDL #01-014

APM Purpose

Equivalent Resources, More Flexibility

- Predictable, stable payment to FQHCs
- Flexibility for FQHCs to enable care transformation
  - Visit not required to receive monthly capitated payment
  - New care team members other than “billable providers”
  - New visit types other than individual, face to face
- Improve care quality, access, and equity



List of Alternative Engagement

Access will be measured by a set of Alternative Engagement Encounter Codes reported to payers.

Domains:

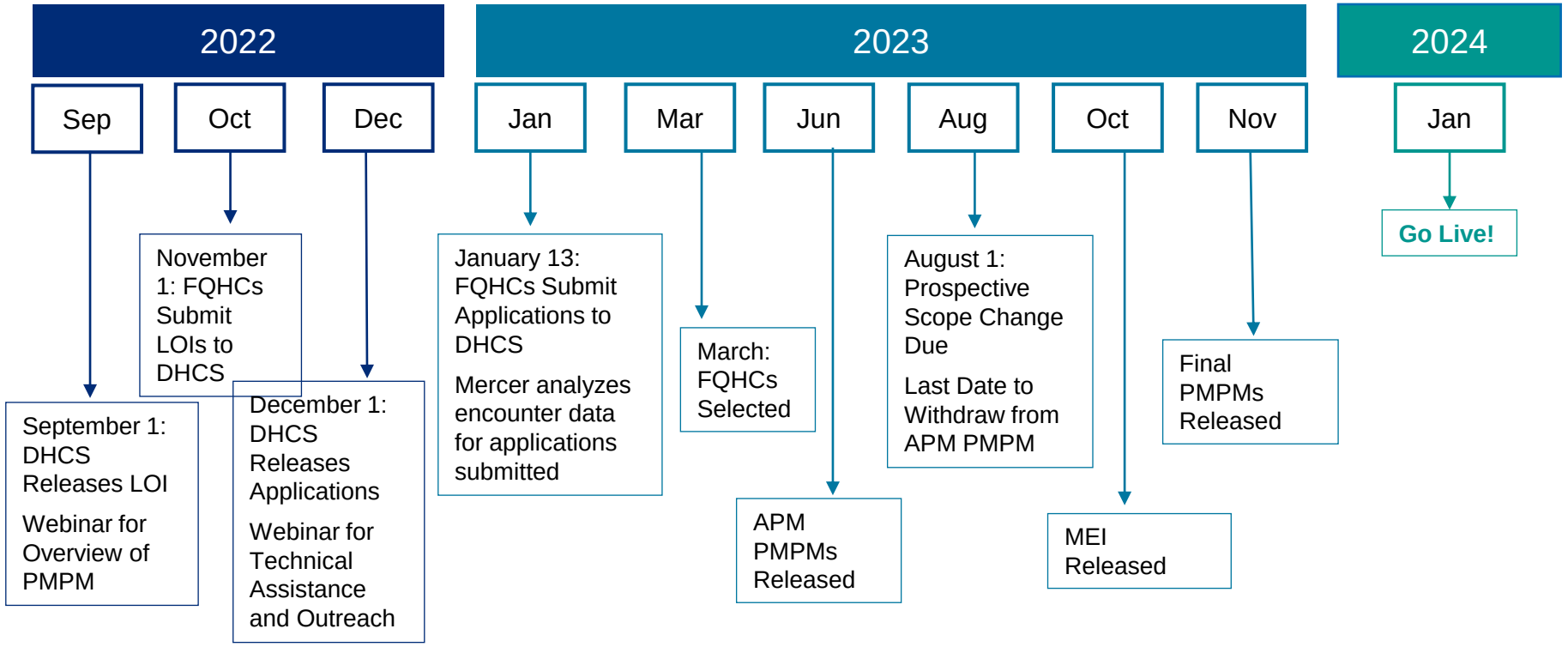
- Care team support
- Case management
- Communication
- Education
- Telehealth

Appendix C: Alternative Engagement Coding			
Domain	**Code**	**Mod**	**Description**
Care Team Support	90791		Psychiatric diagnostic evaluation by non-physician
Care Team Support	90832		Psychotherapy, 30 minutes with patient
Care Team Support	90833		Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Care Team Support	90834		Psychotherapy, 45 minutes with patient
Care Team Support	90836		Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Care Team Support	90837		Psychotherapy, 60 minutes with patient
Care Team Support	90838		Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Care Team Support	90839		Psychotherapy for crisis; first 60 minutes
Care Team Support	90840		Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
Care Team Support	90845		Psychoanalysis
Education	90846		Family psychotherapy (without the patient present), 50 minute
Care Team Support	90846		Family psychotherapy (without the patient present), 50 minute
Care Team Support	90846		Family psychotherapy (without the patient present), 50 minutes
Education	90847		Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
Care Team Support	90847		Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
Education	90849		Multiple-family group psychotherapy
Care Team Support	90849		Multiple-family group psychotherapy
Education	90853		Group psychotherapy (other than of a multiple-family group)
Care Team Support	96127		Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
Care Team Support	96156		Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
Education	96167		Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
Care Team Support	96167		Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
Education	96168		Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
Care Team Support	96168		Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

Changes in Scope to Promote Value Based Care

Allowed Costs in the Numerator

- Peer support specialist costs
- Behavioral health services
- Medication monitoring (and pharmacy ingredient costs if selected by the FQHC)
- Remote patient monitoring beginning July 1, 2021
- Expenses associated with texting/messaging health information to the patient.
- Tele-psychiatry and other telehealth costs compliant with federal HIPAA requirements
- Disease management, screening of assigned members, arranging transportation/visits is included
- MSWs, ASWs costs
- Clinical pharmacists costs
- Nutritionist/dietitian costs
- Health coach costs
- RN/LVN costs
- Case manager costs outside of the ECM benefit
- Doula services starting January 1, 2023
- CHW benefit costs outside of the ECM benefit starting July 1, 2022, are under the PPS/APM but are not eligible as an encounter under the FQHC benefit


2022
2023
2024
Sep
Oct
Dec
Jan
Mar
Jun
Aug
Oct
Nov
Jan
September 1: DHCS Releases LOI
Webinar for Overview of PMPM
November 1: FQHCs Submit LOIs to DHCS
December 1: DHCS Releases Applications
Webinar for Technical Assistance and Outreach
January 13: FQHCs Submit Applications to DHCS
Mercer analyzes encounter data for applications submitted
March: FQHCs Selected
APM PMPMs Released
August 1: Prospective Scope Change Due
Last Date to Withdraw from APM PMPM
MEI Released
Final PMPMs Released
Go Live!

Next Steps

- Continue negotiation with DHCS on APM structure and support health centers with readiness activities
- Review and refine alternative touch code set for missing high-value alternative services (like e-Consult); advocate to include new codes
- Test change in scope with new allowed costs and productivity numbers

AAMC Project CORE: Promoting High Value Use of eConsults through Payment Policy

Meaghan Quinn, MHSA
Program Lead, Clinical Innovations

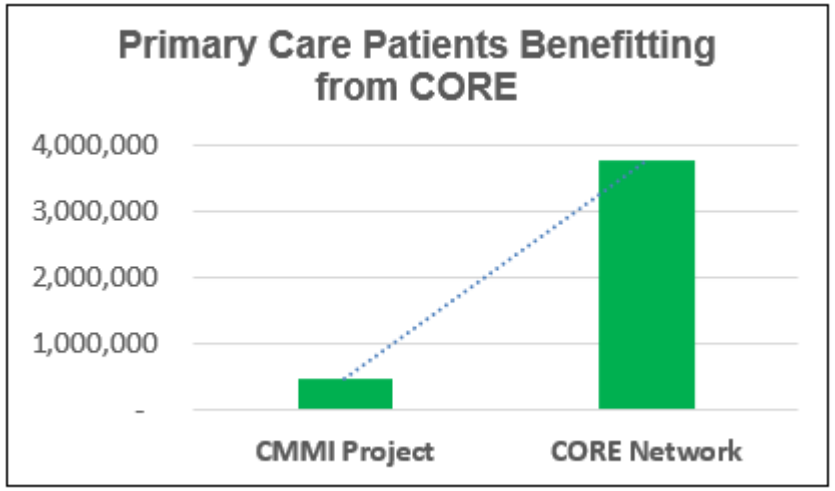
What is the promise of eConsults?

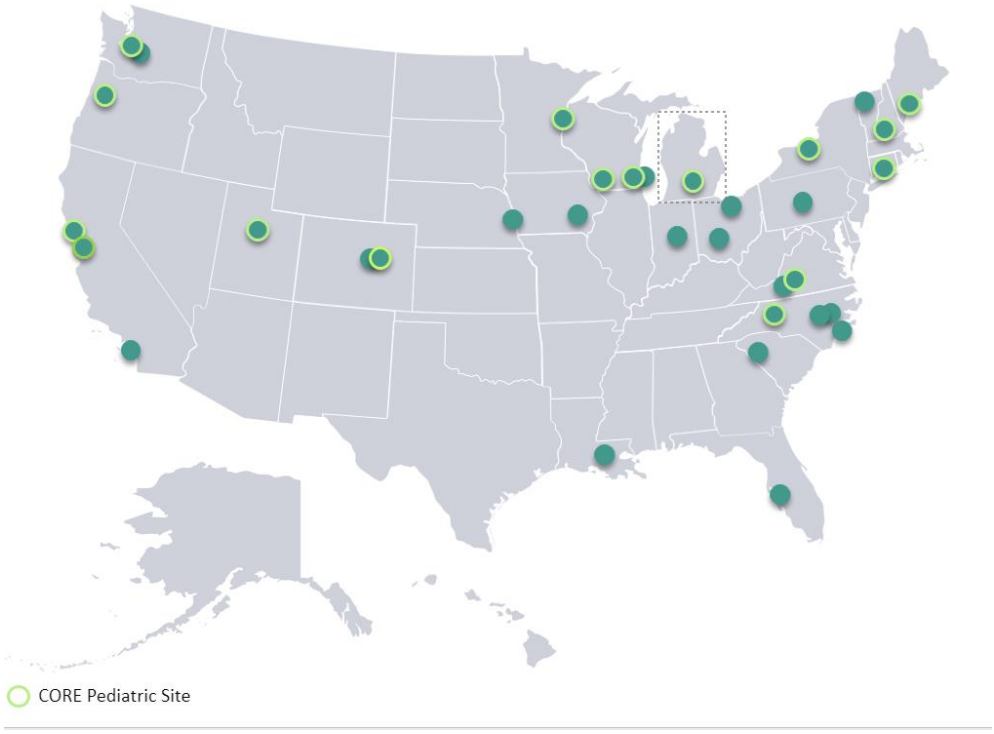
- More **efficient care, reduced costs of care**
  - Fewer unnecessary referrals
- Better **access**
- Better than **curbside consults**
- Expand **comprehensiveness of PCPs**
- Improve **relationships** between PCPs & Specialists

AAMC Project CORE Impact

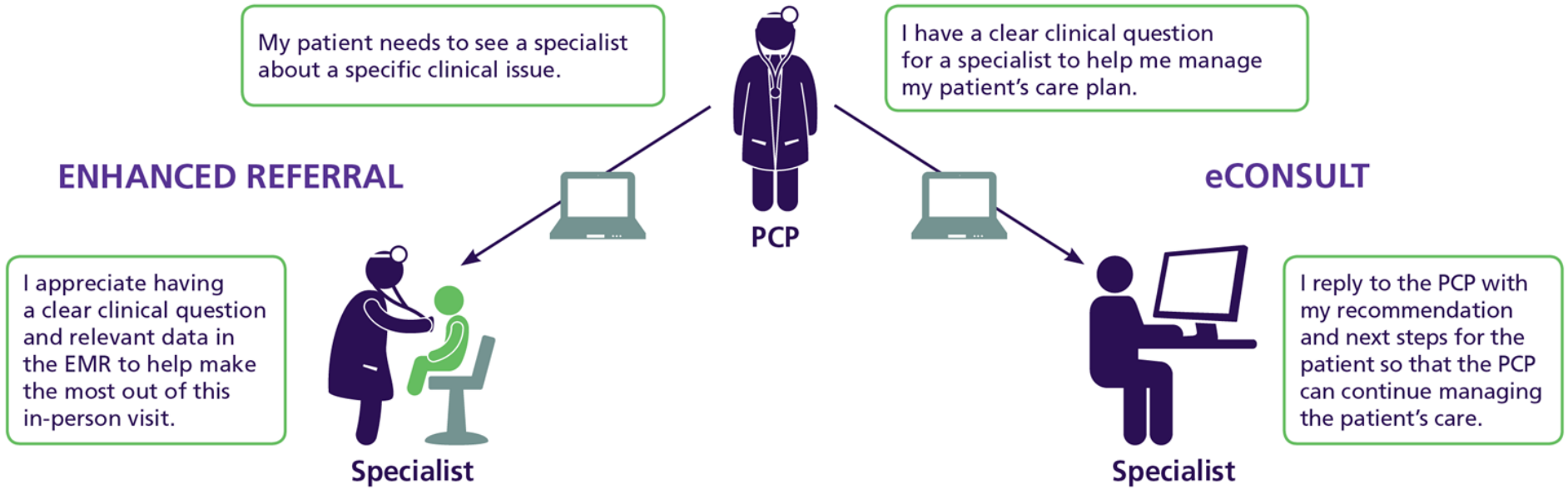
Launched at **5** academic health systems in 2014 through **CMMI HCIA Award (Round 2)**

Expanded 8-fold (>40 health systems and children's hospitals) **as of 2022**





The CORE Model



IMPLEMENTATION STRATEGY to engage providers and establish a culture of collaboration between PCPs and specialists leading to increased standardization in care delivery

What is the ROI case for eConsults?

eConsults Benefit Patients, Providers, Health Systems, & Payers

CORE

- **Improved access** to specialty care
  - **Timelier specialty input** for PCPs and their patients
  - Increased access for **new patients and higher acuity patients**
  - **Reduced no-show rates** for specialty visits
- **More comprehensive care** in primary care
  - **13% reduction in referral rates by PCPs** using eConsults at higher than median rate vs. peers
  - **46% of PCPs would have referred** if eConsult had not been available

**Summary of impact analyses from CMMI HCIA Round 2 Award (2014-2017) across 5 pilot AMCs*

AAMC

eConsults Benefit Patients, Providers, Health Systems, & Payers

- **More efficient care/ less burden** for patients
  - For every specialty visit averted, **eConsults saved patients ~$100** in avoided copays, transportation costs, and missed work
- **High satisfaction** for providers and patients
- Reduces **specialty utilization and associated costs**
  - Estimated $8.4M savings from net visits saved (~66K) to CORE specialties for the target population in Medicare*

Data from all 5 CMMI cohort sites, inclusive of all patients and providers

Communicating the ROI Proposition of eConsults

CORE®

"A Bridge to Value"

Fee-for-Service	Value-Based Payments
• Improved specialty access, less leakage • Enables more new patients, more high acuity patients to be seen in the specialty setting • Enables higher surgical/procedural yield • Reduced wait times lead to fewer no shows • Improves patient experience, loyalty	• Supports better care coordination • Supports greater comprehensiveness in primary care • Reduces unnecessary utilization • Ensures care is delivered more efficiently and promotes "right care, in the right place, at the right time" • Aligns with requirements of APMs

AAMC

Review of eConsult Payment Policy & Advocacy Efforts

Review of Medicare Physician Fee Schedule eConsult Policy Updates

CORE

- 2019 CMS approved payment for two new CPT codes for **eConsults (99451, 99452)**
  - 0.7 wRVU to both the treating provider and consulting physician
  - Minimum time requirements for both codes
  - Documented verbal patient consent required*
  - Medicare FFS beneficiaries are responsible for 20% coinsurance for each code when billing requirements are met
- **2020 PFS Final Rule – changes to the consent requirements**
  - *Changed per encounter verbal consent requirement to an annual patient consent for the service
- **2021 PFS Final Rule – additional update to 99452**
  - Allows teaching physicians to bill the 99452 code for resident activity under the Primary Care Exception

AAMC

Overview of CPT Codes 99451, 99452

CORE

CPT Code	Descriptor	Excerpt from CPT Instructions	Valuation
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a **consultative physician including a written report** to the patient's treating/requesting physician or other qualified health care professional, **5 or more minutes of medical consultative time**	Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc is included in the telephone/Internet/ electronic health record consultation service and should not be reported separately when reporting 99451…However, **the service time for code 99451 is based on total review and interprofessional communication time**.	0.7 wRVU
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a **treating/requesting physician or qualified health care professional, 30 minutes**	The treating/requesting physician or other qualified health care professional may report 99452 if **spending 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant.**	0.7 wRVU

AAMC

CPT Editorial Panel Guidelines for 99451, 99452

CORE

- For patients **with or without a relationship with the specialist**, if a new or exacerbation of existing problem
- **No use** of these codes if **patient sees specialist within 14 days before or after or "next available appointment date of the consultant"**
- Not to be used when "sole purpose" of communication is to arrange a referral for an in-person visit
- Only **one use** of the PCP code (99452) per patient (presumed: per specialty) **per 14 days; 99451** per patient **per 7 days** (presumed: per specialty)

Addressing Program Integrity: PCP Billable Service (99452)

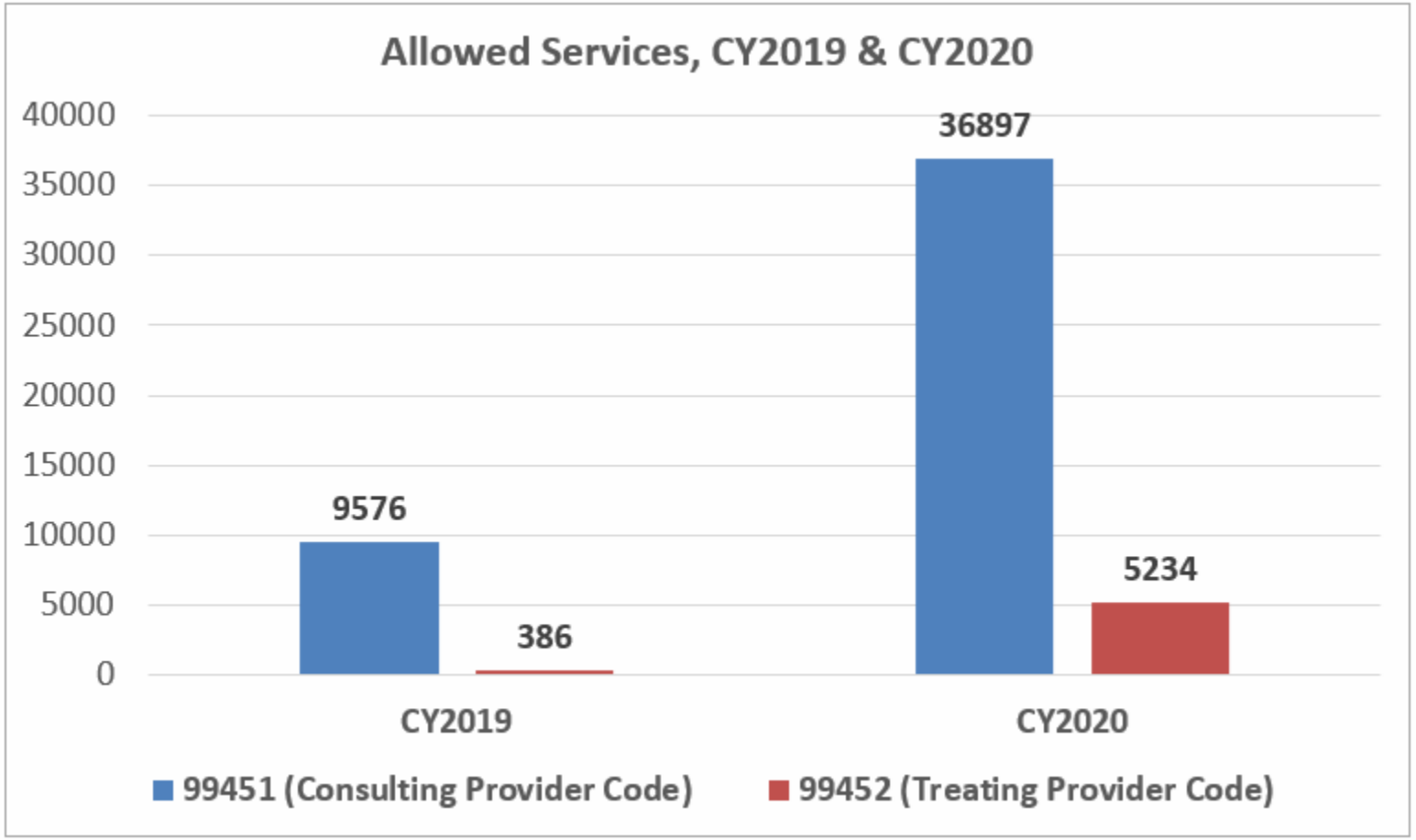
CORE

- Current language in code descriptor suggests that the service is tied to posing the question only (“front end” activities)
- Potential concerns of misuse:
  - Question never answered
  - PCP never looks at specialist response
  - No patient follow-through
  - Inappropriate question from PCP

Addressing Program Integrity: PCP Billable Service (99452) – cont.

- Recommendations:
  - Require PCP to follow-up with the patient and document the follow-up in the EHR
  - Allow time spent closing the loop (after receiving specialist consultation) to count toward total billable time
- Excerpt from CY2019 final rule discussion re: 99452 “We also agree with the commenters who suggested that the proposed work RVU of 0.50 for CPT code 99452 undervalues the work associated with aggregating patient information, communicating with the consulting practitioner, ***and implementing the results of the consultation.”***

Medicare FFS Part B E&M Data for 99451, 99452



Source: Evaluation and Management Codes By Specialty 2019 (cms.gov)

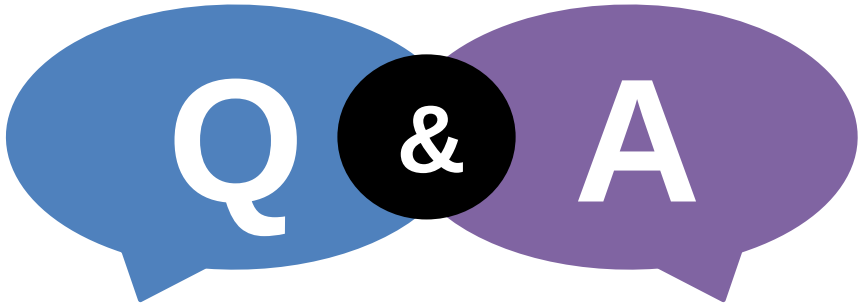
“Two Co-Pay” Issue

- Expressed concern that Medicare beneficiaries will be responsible for two co-pays for what is a single service when billing requirements are met by both providers
- Recognize CMS does not have the authority to waive coinsurance under the Medicare FFS program (requires legislative action)
- Advocated that CMS waive in circumstances where there is a more straightforward mechanism to do so, such as in CMMI APM demos
- Consider coinsurance issue where practical in developing new payment policies

Medicaid Policy Updates

- In March 2022, the Biden-Harris Administration stated its commitment in the SOTU to support integrating mental health and substance use treatment into primary care settings, including ***"payment models that support the delivery of whole-person care through behavioral health integration and authorize Medicaid reimbursement of inter-professional consultations so that primary care providers can consult with a specialist and provide needed care for patients."***

CORE



Meaghan Quinn, MHSA

Program Lead, Clinical Innovations

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AAMC

CMS Innovation Center

Jacob Quinton, MD, MS, MPH, FACP
Medical Officer,
Center for Medicare and Medicaid Innovation
November 09, 2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Overview

CMS Innovation Center Strategy Refresh

CMS Innovation Center Specialty Strategy

The CMS Innovation Center Statute

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles"

Three scenarios for success under Statute:

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

CMS Innovation Center Portfolio

Accountable Care

- *ACO Realizing Equity, Access & Community Health (REACH)*
- Comprehensive End Stage Renal Disease (ESRD) Care Model
- *Kidney Care Choices Model*
- Medicare ACO Track 1+ Model
- Next Generation Accountable Care Organization Model
- *Vermont All-Payer Accountable Care Organization Model*

Episode-based Payment Initiatives

- *Bundled Payments for Care Improvement Advanced Model*
- *Comprehensive Care for Joint Replacement Model*
- *End Stage Renal Disease (ESRD) Treatment Choices Model*
- *Enhancing Oncology Model*
- Oncology Care Model
- Radiation Oncology Model

Primary Care Transformation

- Comprehensive Primary Care Plus Model
- Independence at Home Demonstration
- *Primary Care First Model Options*

Initiatives to Accelerate the Development & Testing of Payment and Service Delivery Models

- Accountable Health Communities Model
- *Community Health Access and Rural Transformation Model*
- *Emergency Triage, Treat, and Transport Model*
- *Frontier Community Health Integration Project Demonstration*
- *Home Health Value-Based Purchasing Expanded Model*
- *Maryland Total Cost of Care Model*
- *Medicare Advantage Value-Based Insurance Design Model*
- Medicare Care Choices Model
- Medicare Intravenous Immune Globulin Demonstration
- Part D Enhanced Medication Therapy Management Model
- Part D Payment Modernization Model
- *Part D Senior Savings Program Model*
- *Pennsylvania Rural Health Model*
- Rural Community Hospital Demonstration
- *Value in Opioid Use Disorder Treatment Demonstration*

Initiatives Focused on Medicare-Medicaid Enrollees

- *Financial Alignment Initiative for Medicare-Medicaid Enrollees*
- *Integrated Care for Kids Model*
- *Maternal Opioid Misuse Model*
- Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport Model

Initiatives to Speed the Adoption of Best Practices

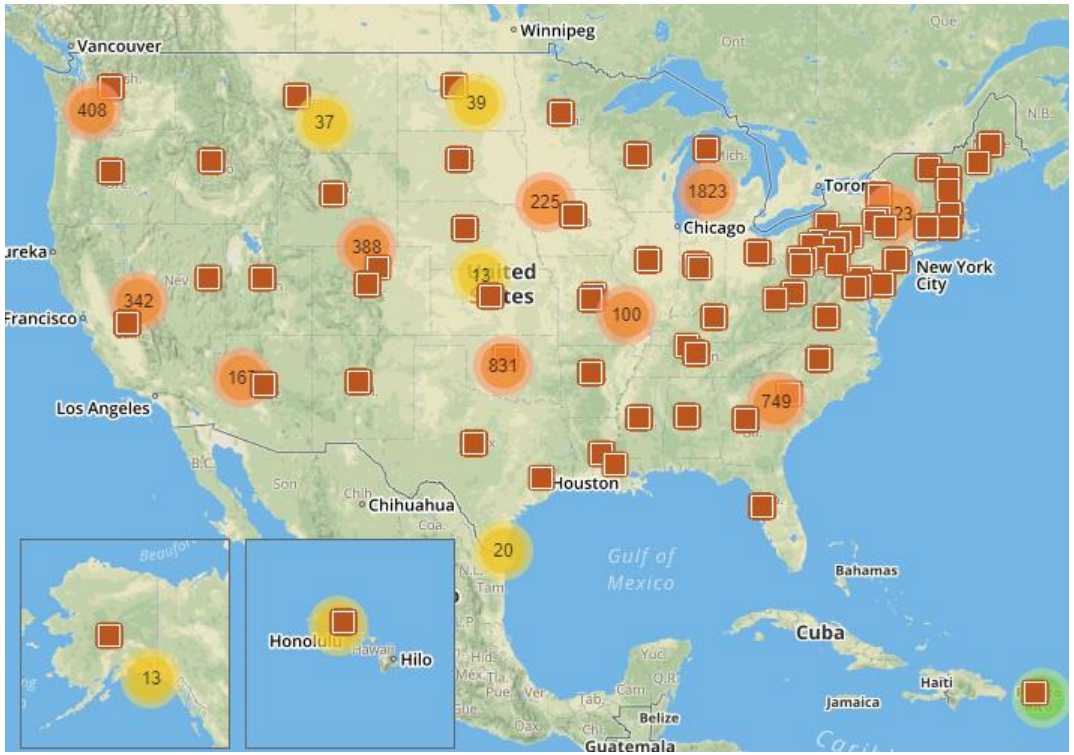
- Health Care Payment Learning and Action Network
- *Medicare Diabetes Prevention Program Expanded Model*
- Million Hearts® Cardiovascular Disease Risk Reduction Model

- *Announced and active models as of 8/4/22*
- Ended models with ongoing evaluations

Where Innovation is Happening

The CMS Innovation Center has engaged the health care delivery system and invested in innovation across the country.

Model participants include hospital systems, safety net providers, suppliers, payers, and community-based organizations, among others.

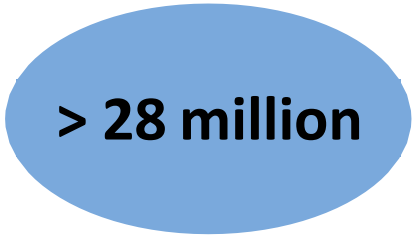


Sites where innovation models are being tested

Models run at the state level

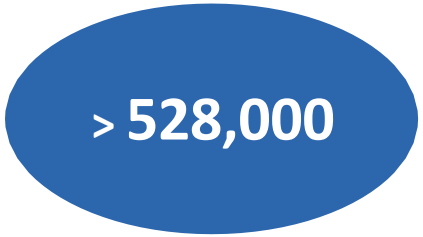
Source: CMS Innovation Center website, June 2020

CMS Innovation Center's range of impact



Beneficiaries touched *

CMS Innovation Center models impact more than 28M beneficiaries **in all 50 states**



Providers participating *

More than 528,000 health care providers and provider groups [2] **across the nation** are participating in CMS Innovation Center programs

* Source: 2020 **Report to Congress: Center for Medicare and Medicaid Innovation.** Represents two years of data. Includes CMS beneficiaries (i.e., individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage) and individuals with private insurance, including in multi-payer models

Looking Back, Looking Forward – Building a Strategy

EMBED HEALTH EQUITY IN EVERY MODEL	
ISSUES and CHALLENGES: • Full diversity of beneficiaries in Medicare and Medicaid is not reflected in many models • Models have not systematically evaluated impacts across beneficiaries with different demographic characteristics	**NEXT STEPS:** • Design models to target and increase participation among providers that care for underserved populations • Require a deliberate and consistent approach to assess model impacts on underserved populations and close disparities in care and outcomes
STREAMLINE MODEL PORTOLIO	
ISSUES and CHALLENGES: • Complex payment policies and model overlap rules can result in conflicting incentives for providers • Participants face difficulty in joining or continuing in models due to investment and administrative burden	**NEXT STEPS:** • Create a cohesive strategy for model development and evolution and ensure hierarchy of models is rational • Make model parameters, requirements, and other critical details as transparent and easily understandable as possible

Looking Back, Looking Forward – Building a Strategy

SUPPORT CARE DELIVERY TRANSFORMATION	
ISSUES and CHALLENGES:	**NEXT STEPS:**
• Accepting downside risk is challenging if providers lack tools to manage care and risk • Significant infrastructure investments are often needed to participate in models	• Make actionable data, learning collaboratives, and payment flexibilities available to participants • Send strong and consistent signals and expectations about CMS' commitment to value-based care for participants
MODEL DESIGN MAY NOT ENSURE BROAD TRANSFORMATION	
ISSUES and CHALLENGES:	**NEXT STEPS:**
• Model design features, including in some cases voluntary participation, can lead to selection bias • Multi-payer models designed for Medicare providers have not attracted Medicaid and commercial payers	• Reduce selection bias by improving model design (*e.g.*, benchmarking, risk adjustment, and transformation supports) • Consider multi-payer alignment opportunities earlier in model design process

Looking Back, Looking Forward – Building a Strategy

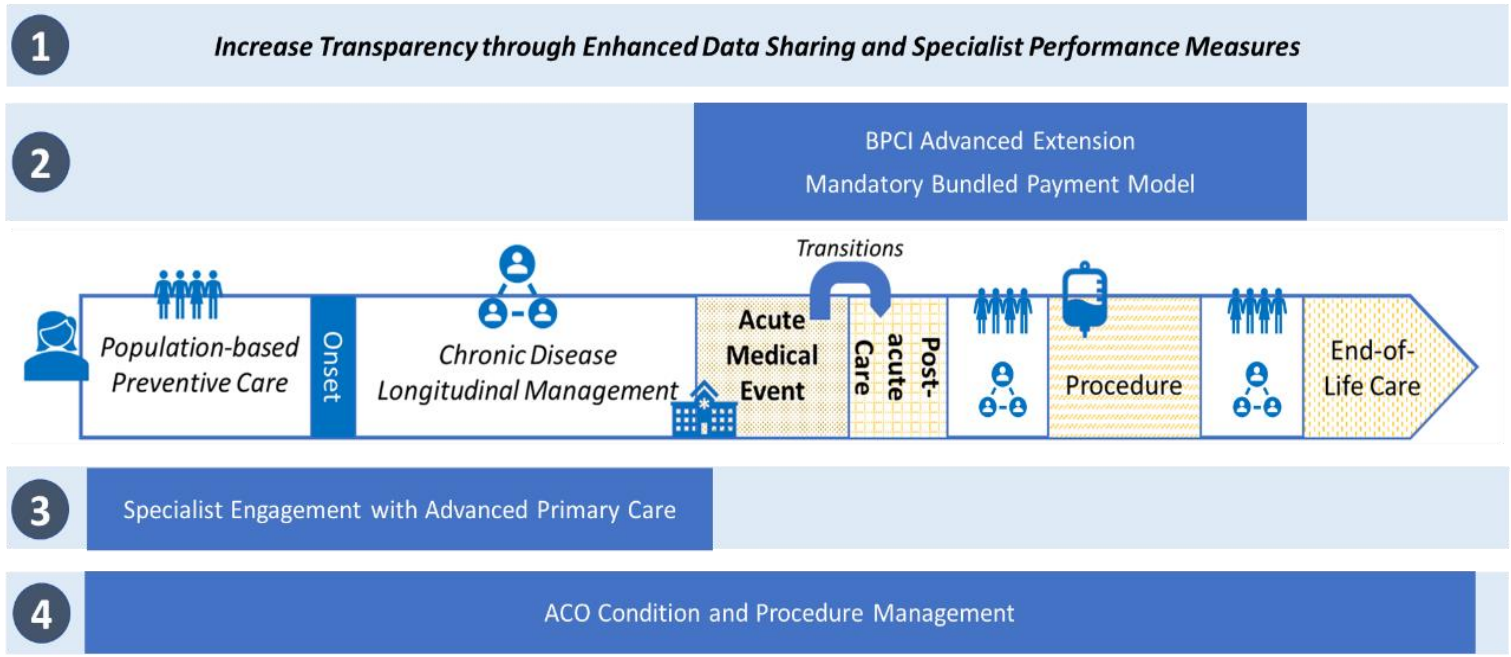
COMPLEX FINANCIAL BENCHMARKS UNDERMINE EFFECTIVENESS	
ISSUES and CHALLENGES: • Many financial benchmarks and risk adjustment methodologies have contributed to potential gaming and upcoding and reduced savings for Medicare	**NEXT STEPS:** • Set benchmarks to balance maximizing provider participation, while sustainably generating savings • Improve testing and analysis of benchmarks and risk adjustment methodologies prior to model launch
MODELS SHOULD ENCOURAGE LASTING TRANSFORMATION	
ISSUES and CHALLENGES: • Model testing has been focused on meeting the statutory standards for certification and expansion • Transformation can be limited to the duration of model test	**NEXT STEPS:** • In addition to statutory criteria for model expansion, consider a model's impact on system transformation • Align models and lessons learned across CMS, including Medicare FFS, Medicare Advantage, and Medicaid

Vision: What's to Come Over the Next 10 Years

CMS Innovation Center Strategy Refresh

CMS Innovation Center Specialty Strategy

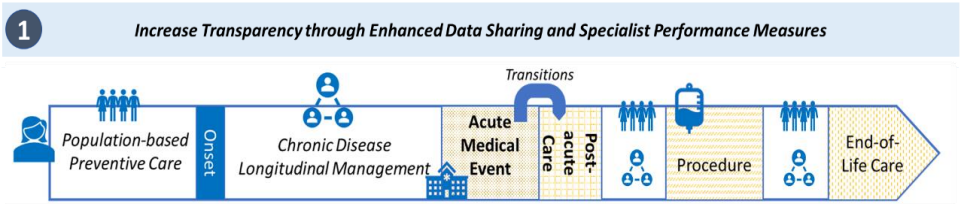
CMS Innovation Center Specialty Strategy



[The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care]

96

CMS Innovation Center Specialty Strategy



Key Learning: Providing data on specialist performance and enhancing data sharing across practices would facilitate integration with primary care and ACOs.

Element #1: Enhance transparency of specialist data and performance measures to increase access to high-quality, accountable specialty care and integration with primary care.

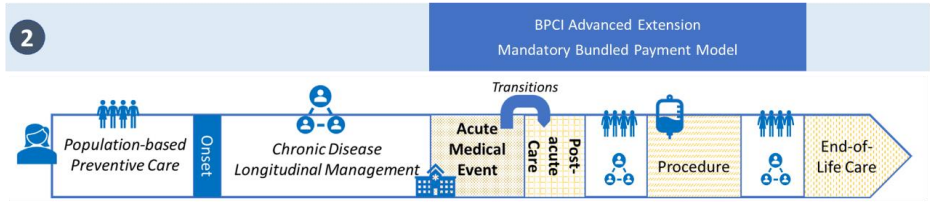
Short-term goal: Enhance specialty care performance data and dashboards to give population-based model participants the ability to compare quality and costs of procedural or acute episodes of care, as well as better information on specialist performance (shadow bundles).

Long-term goal: Develop and distribute industry standard definitions of condition-based episodes for ACOs to improve management of specialty care and to support sub-contracting efforts with specialists.

The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

97

CMS Innovation Center Specialty Strategy



Key Learning: Episode-based payment models can be designed to align incentives between specialists and ACO initiatives

Element #2: Maintain momentum established by episode payment models

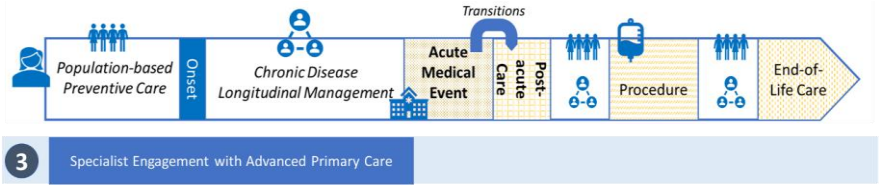
Short-term goal(s):
1) Extend BPCI Advanced for two years through 2025.
2) Launch a new model focusing on beneficiaries with cancer—the Enhancing Oncology Model.

Long-term goal: Test a new mandatory acute episode payment model that improves acute care and care transitions, while supporting the goals of longitudinal, accountable care.

The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

98

CMS Innovation Center Specialty Strategy



Key Learning: Beneficiaries with complex conditions may benefit from specialists integrated into primary care delivery pathways.

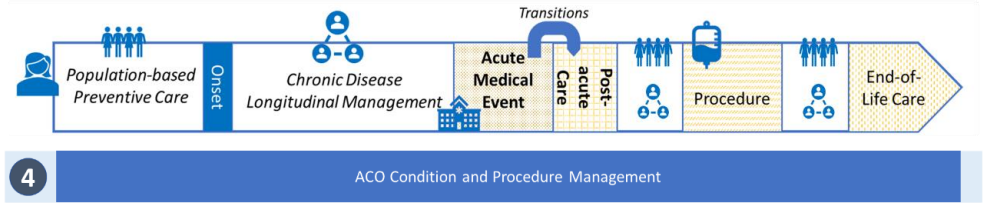
Element #3: Create innovations to improve coordination and collaboration, including at the point of referral, between primary care and specialty care physicians.

Short-term goal: Explore the use of e-consults and enhanced referrals in advanced primary care models to improve access to specialty care and reduce wait times for specialty visits.

Long-term goal: Test the potential to establish financial targets for high-volume, high-cost specialty care within population-based models.

The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

CMS Innovation Center Specialty Strategy



Key Learning: ACO incentives to reduce unnecessary hospital admissions or emergency room visits and low-value imaging and ancillary services need to be stronger, given competing incentives to increase volume for some ACOs.

Element #4: Create a targeted set of financial incentives for ACOs to actively manage specialty care, through possible beneficiary alignment changes and episode cost and quality measures specific to specialist-managed conditions.

Short-term goal: N/A

Long-term goal(s): 1) ACO incentives to reduce unnecessary hospital admissions or emergency room visits and low-value imaging and ancillary services need to be stronger, given competing incentives to increase volume for some ACOs.
2) For physician-affiliated ACOs, encourage specialists to meet sub-population condition and procedure-based spending targets with same risk and reward as hospital-affiliated ACOs.

The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

Our Goals

Lessons-Learned

CMS Innovation Center Specialty Strategy

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Comprehensive Primary Care Initiative: 2012-2016

Four-year multi-payer model designed to strengthen primary care

Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) build on the lessons learned in the CPC Initiative

BACKGROUND

439 practices in **7 regions** supported by **38 public and private payers;** ultimately serving **3 million patients**

Practices **enhanced care delivery** by providing risk stratified care management and engaging patient

Diverse supports: PBPM care management fees, shared savings opportunity, learning and data feedback

KEY FINDINGS

Reductions in Part A and B expenditures*, driven by reduced hospital inpatient and SNF spending

Reductions in hospitalization rates as well as **decreased emergency department visits**

Practices underwent **significant transformation** in the delivery of primary care

Comprehensive Primary Care Plus (CPC+) Model

CMS's largest-ever initiative to transform how primary care is delivered and paid for in America

Goals

1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Support clinicians to provide comprehensive care that meets the needs of all patients.
3. Improve quality, access, and efficiency of care.

Payment Innovations Supporting CPC+ Practice Transformation

- PBPM risk-adjusted care management fees to support augmented staffing and training for delivering comprehensive primary care
- Performance-based incentive payments reward practices on utilization and quality of care
- For Track 2 practices, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to reduce dependence on visit-based FFS

Evaluation Results (Years 1 and 2)

- Small favorable effects (<1.3%) on Medicare service use, including reduction in the rate of ED visits and slowing the growth of ambulatory primary care visits for practices in both tracks
- Small improvements (<1%) on selected claims-based quality measures, including increases in the percentage of beneficiaries who received various recommended services for diabetes, the percentage of female beneficiaries who received breast cancer screening, and the percentage of beneficiaries who received hospice services
- No change in Medicare expenditures when excluding CMS' enhanced payments provided to CPC+ practices in addition to usual payments for services; increase in expenditures by 2 to 3 percent when including those payments

Five Functions Guide CPC+

-Access & Continuity
-Care Management
-Comprehensiveness & Coordination
-Patient & Caregiver Engagement
-Planned care & Population Health

Participants & Partners

Cohort 1 (2017-2021)
2,655 practices in 14 regions
Cohort 2 (2018-2022):
154 practices in 4 regions

Track 1: 1317 practices
Track 2: 1493 practices

52 public and private payers in CPC+ regions

Health IT vendors partner with CMS and Track 2 practices

Primary Care First

Foster Independence, Reward Outcomes

Primary Care First (PCF) is a five year alternative payment model that offers greater flexibility, increased transparency, and performance-based payments to participants.

Goals:

1. **Reduce Medicare spending** by preventing avoidable inpatient hospital admissions
2. **Improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

KEY FEATURES

Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer.

Payment options for practices that specialize in **patients with complex chronic conditions.**

Building from Lessons-Learned

CMS Innovation Center models have provided valuable insights to inform the design and development of subsequent models or other models with common approaches.

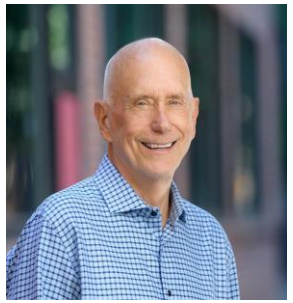
Early model testing at the CMS Innovation Center supported enhanced and **integrated care with minimal financial risk.**

Newer models include higher standards in **quality reporting**, more opportunities for **shared savings**, and **integration** of clinical treatment and social services.

Discussion

Robby Franceschini, JD, MPH
Director of Policy
BluePath Health

Meaghan Quinn, MHSA
Program Lead
Association of American Medical Colleges



Mike Witte, MD
Chief Medical Officer
CA Primary Care Association

Allie Budenz, MPA
Director of Population Health Management
CA Primary Care Association

Jacob Quinton, MD
Medical Officer
Center for Medicare and Medicaid Innovation

Value-Based Care and E-Consult

Paul Giboney, MD
Associate Chief Medical Officer
Los Angeles Department of Health Care Services

Eric Urquiza
Senior Vice President Operations and Client Experience
AristaMD

Suzy Goldenkranz
VP of Business Development
Rubicon MD

Sean Atha
SVP Business Development
River City Medical Group

Arista|MD

Overcoming value-based care transition challenges and measuring success

Eric Urquiza, SVP Operations & Client Experience

November 9, 2022

Provider group at risk for Medicare and Medicaid lives

Patient Population

38%
cardiovascular disease

32%
congestive heart failure

29%
diabetes

52%
3 or more co-morbidities

CHALLENGE

- Access to timely and effective specialist consultations - issues particularly for elderly and vulnerable dual-eligible patients
- Reducing unnecessary hospital and ED admissions

Provider group at risk for Medicare and Medicaid lives

SOLUTION

eConsult pilot at 3 centers with 6 PCPs with the goal of answering two questions:

- Is the platform capable of equipping a PCP to deliver more comprehensive care?
- Is the turnaround time and clinical workflow sufficient for PCPs to

Outcomes

- 73% replaced the need for an in-person visit
- 30% reduction of hospital admissions
- Downward trend of inpatient medical cost
- 85% significantly influenced care plan
- >50% had a response time under 6 hours
- Increased patient and PCP satisfaction

eConsult curation with RN service reduces staff burden

CHALLENGE
Provide a faster, lower-cost alternative to referrals to accessing specialist expertise

SOLUTION
AristaMD nurses create eConsult for providers via secure, HIPAA-compliant EMR access

Traditional Referral

- 70% resolution with 1 visit
- 30% follow-up visits
- Average patient wait time: 60+ days

eConsult First

- 80% resolution with no office visit
- 20% in-person follow-up visit
- Average patient wait time: 1-3 days
- ~60% cost savings per patient

FQHC achieves care efficiency for low-income population

CHALLENGE

- Low-income, working poor population
- Longer than average wait times for specialty care
- Only about 35% of patients complete referral

SOLUTION

- eConsults expanded from 3 clinic pilot to include:
  - 13 clinics
  - 70+ providers
  - 53 specialties
  - 10k+ eConsults conducted

82% of AristaMD's eConsults resolved patients' issues, rendering a specialist visit unnecessary.

96% of providers said the eConsult had a significant influence on the patient's care plan.

4.8 ★ out of 5 stars is the average provider rating of the response received from the AristaMD eConsult specialist.

Eric Urquiza

Sr. Vice President of Operations & Client Experience
at AristaMD

eurquiza@aristamd.com

Arista|MD

RubiconMD

140+

specialties & subspecialties

~70%

of eConsults help prevent unnecessary referrals & services

80%

of eConsults improve the quality of care plan

<2.5 hrs

Turnaround time for evidence-based insights

8000+

Active users, 75% are in full risk arrangements

4.93/5

provider rating

Value Based Care and RubiconMD

Three cases of supporting PCPs in full capitation

Medicare/Medicare Advantage

ACOs
Large clinics
Value-Based Care groups

Employer Onsite Clinics and Self Insured Employers

Employee Benefit

Direct Primary Care, Other Value Based Care models

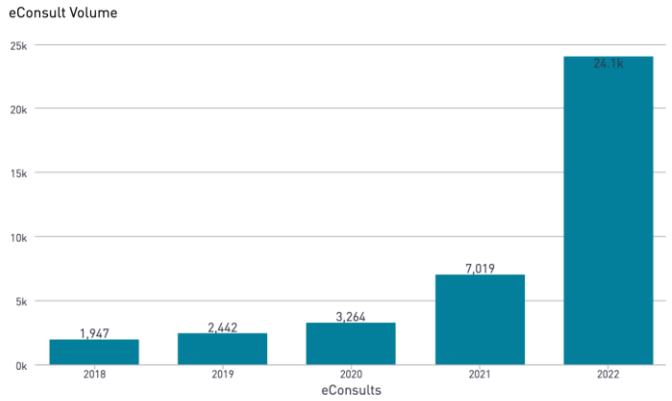
IPAs
Start ups
Direct Primary Care/D2C

Oak Street Health 2022 Impact to Date

Medicare and Dual Eligible Patients

140 centers | 20 states | 500+ clinicians

- Large Medicare and Dual Eligible Primary Care Primary Care group, founded in 2012
- Take full risk on sickest, neediest patients through Medicare Advantage and Medicare programs
- Partners with RubiconMD since 2018



38,722

total eConsults submitted

1 hr 55 min

median TAT for specialist response

4.9/5

average eConsult provider rating

$2M+

Patient Out of Pocket Savings

Case Study | Endocrinology Clinical Program

147 total patients. 97% of patients had improved care.

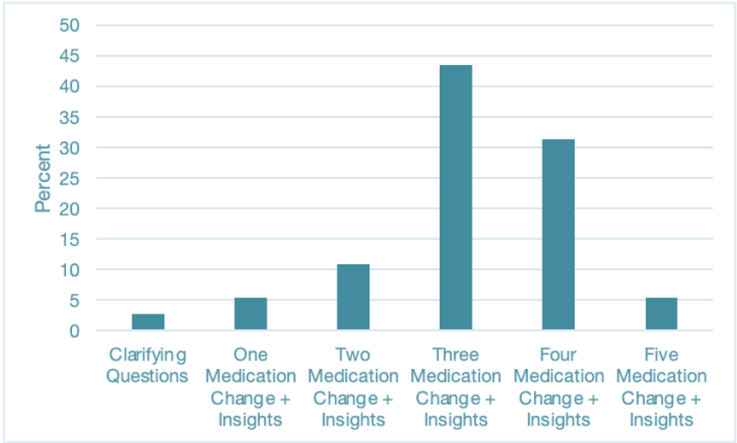
CRITERIA:
Last reading of HgbA1c >9 for patients >65 y/o
Last reading of HgbA1c >8 for patients <65 y/o

13% directly reduced injection burden and simplified regimen for increased adherence

7.4% directly addressed cost reduction such as stopping Januvia and Janumet for increased dose of Metformin

8% recommended dose adjustment of Trulicity or Jardiance

5% provided recommendations for other comorbidities such as hyperparathyroidism and optimizing hyperlipidemia regimen



The opportunity to optimize dosing or add metformin was identified in **41% of the patients.**

$210 cost savings per patient review.

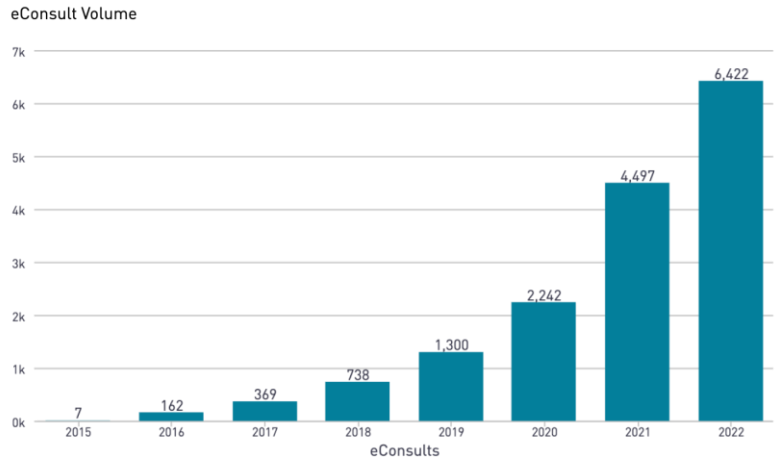
Data from large value based care client, serving MA patients., between DATE and DATE

Everside Health Impact

Employer onsite health group

375 centers | 34 states | 600+ clinicians

- Taking full risk for employers and unions on cost-of-care for workers and their dependents
- Providing primary care and behavioral health services for employees and their families
- Partners with RubiconMD since 2015



15,700

total eConsults submitted

1 hr 43 min

median TAT for specialist response

4.9/5

average eConsult provider rating

$1.2M+

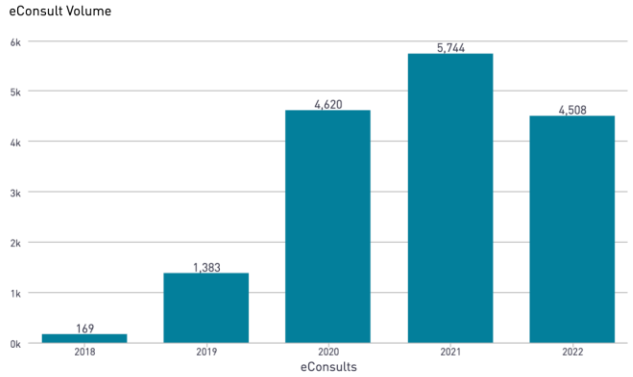
Patient Out of Pocket Savings

Sanitas Impact

Value Based Care, Direct to Consumer Primary Care

50 centers | 5 states | 300 clinicians

- Started in Columbia and expanded across Latin America in Peru, Venezuela, Brazil, and . Began expansion into the US in Florida in 2014, working with Spanish-speaking and immigrant communities
- Full risk across Commercial and Medicare Advantage patient populations
- Working with RubiconMD since 2018



16,424

total eConsults submitted to date

1 hr 28 min

median TAT for specialist response

4.96/5

average eConsult provider rating

$1M+

Patient Out of Pocket Savings

River City Medical Group

River City Medical Group Network eConsult Leaders

- WellSpace Health
- One Community Health
- Sacramento Native American Health Center
- Peach Tree Health

Why does RCMG Value eConsults?

- Avoid unnecessary specialty visits

  A large number of cases that would have been referred to a specialist in the past can now stay within the primary care setting. The patient receives more immediate service and is more likely to have the care managed without having to coordinate additional transportation and possible long distance travel.

tha, MHA
usiness &
Development

- Improved PCP Based Care

  With the assistance of eConsult based services, nurse practitioners, physician assistants as well as physicians can get the information needed to work at the top end of their license and treat an expanded number of conditions within the primary care setting. Only the cases most needing a specialist are referred to one. Further, the overall care plans seem to be more detailed from the process.

- Improved quality and outcomes

  eConsults have facilitated a more detailed examination process and documentation. This documentation is what has been needed to maximize the specialty eConsult. Between the detailed primary care notes and the eContult, care for the patients involved has been optimal and often results in identifying additional diagnoses that may have otherwise not been initially identified.

Discussion

Paul Giboney, MD
Associate Chief Medical Officer
Los Angeles Department of Health Care Services

Eric Urquiza
Senior Vice President Operations and Client Experience
AristaMD

Suzy Goldenkranz
VP of Business Development
Rubicon MD

Sean Atha
SVP Business Development
River City Medical Group

Demonstrating Program Impact: E-Consult Data

Delphine Tuot, MDCM, MAS
Interim Division Chief of Nephrology
Associate CMO of Specialty Care and Diagnostics
Director of UCSF CIAQ, Zuckerberg SF General Hospital

Sarah Berk
Associate Director of Monitoring
Evaluation and Research
Peterson Center on Healthcare

Zahra Elmekkawy
Director
Healthcare Delivery System Innovations
Peterson Center on Healthcare

Erin Keely, MD
Co-Founder of the Champlain BASE eConsult Service
University of Ottawa

Waheed Baqai
Chief Operating Officer
WISE Healthcare

Project Arkansas Remote eConsultations

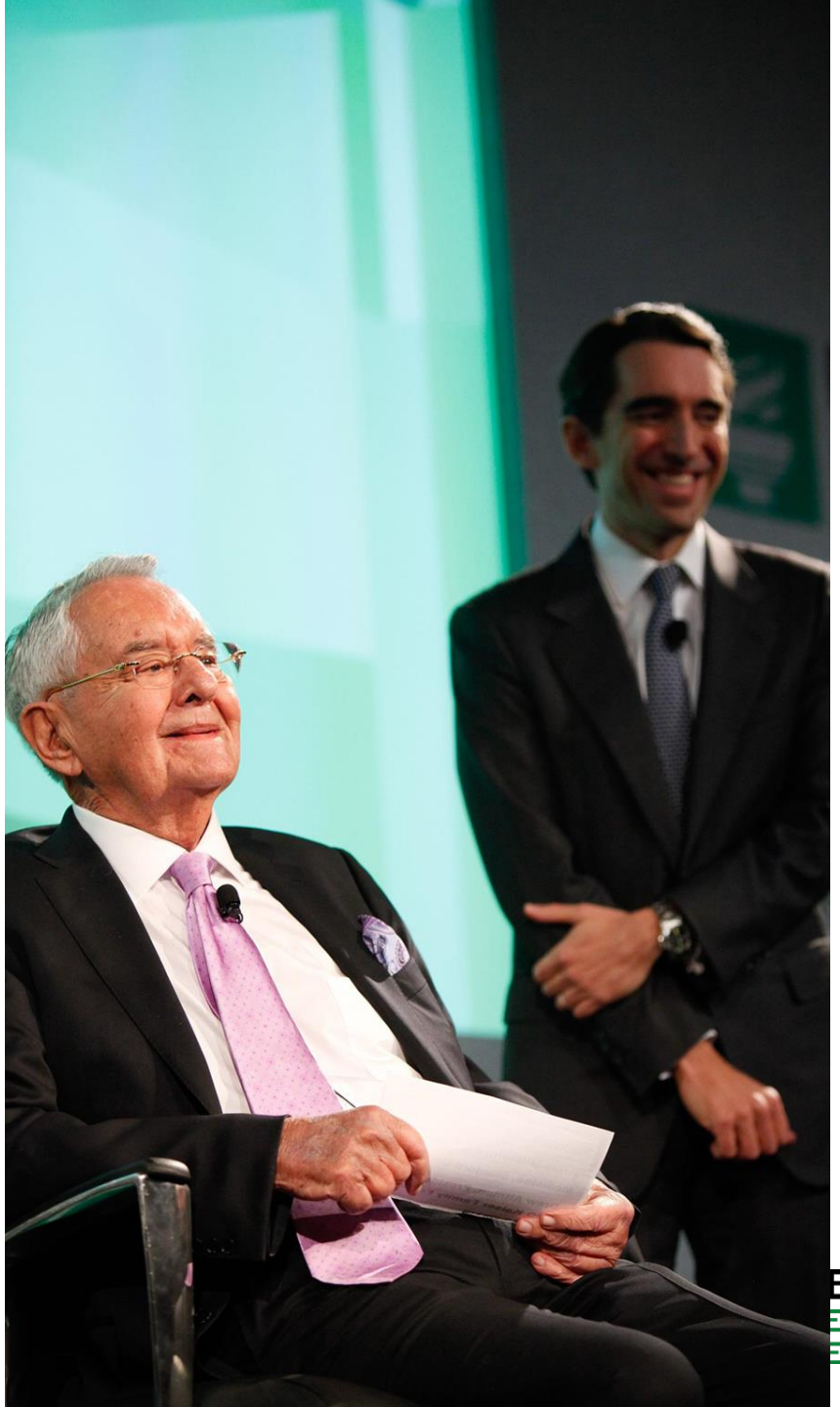
Evaluation Overview and Objectives

November 9, 2022

PETERSON CENTER ON HEALTHCARE

About Us

- **Mission:** To transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerate their adoption on a national scale
- **Established** in 2014 by the Peter G. Peterson Foundation
- **Areas of Focus**
  - Delivery system innovation
  - Healthcare data and markets
- **Evolution**
  - Initial focus on direct primary care service provision
  - Transition to greater focus on grantmaking: scaling innovation and addressing macro frictions



ETERSON
ENTER ON
EALTHCARE

Background

Accelerating the adoption of proven initiatives in primary care that can significantly reduce health care spending while sustaining quality outcomes was the Center priority

Research

- The Annals of Family Medicine paper indicates specialty referrals are a key driver of value

Implications

- Intersection between primary/specialty care is point of leverage
- E-consults as possible solution
- E-consults: Curb-side online consult between PCP and specialist; not patient-facing

Evidence Base

- Total cost of care reductions of $1,167 PP in Medicaid
- Savings of ~ $100 in avoided copays, transportation costs and time off work for every specialist visit avoided
- ~17% reduction in specialist appointment no-shows
- 86% of eConsults resolved without a specialty visit

Solution

- Pilot in Arkansas
- Dominant patient-focused payer
- Rural state
- Specialist shortages

Sources: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5683864/

PETERSON CENTER ON HEALTHCARE

Project Structure, Partners, and Timeline

Arkansas Blue Cross Blue Shield (ARBCBS)

Role
- Payer
- Strategic partner

Independent Practices ConferMED

Structure
- 8 practices (10 sites)

PCH Investment:
- PCPs: $40/eConsult
- Specialists: $90/eConsult
- $10k seed funding / practice

Health System Project CORE

Structure:
- One health system
- 18 practices,
- 13 specialties

PCH Investment:
- $70k seed funding

Mathematica

Role
- Evaluator

Timeline

Jan 2020 pilot begins	Feb 2021 independent go-live	Aug 2021 HS go-live	July 2022 independent pilot ends	Nov 2022 formative report	Mar 2023 summative report & HS pilot ends

PETERSON CENTER ON HEALTHCARE

Formative Evaluation Design

The formative evaluation will generate learnings about barriers and facilitators to eConsult adoption.

Themes

- Operational considerations *(ex: workflow; technical assistance)*
- motivators & barriers to adoption *(ex: financial incentives; leadership)*
- Specialist perspectives on eConsults *(ex: what worked well; suggestions for improvement)*

Methods

- 24 qualitative, virtual interviews and a specialist feedback request
- Interviewees include PCPs, clinical & administrative staff, heath system leads
- Evenly distributed interviews between health system and independent practices

Timing

- Study Design: March – May 2022
- Data collection: May – July 2022
- Analysis: Aug – Sept 2022
- Final Report: Nov 2022

Outputs

- Written report and accompanying slide deck describing findings
- 90-minute briefing

Target Audiences

- ARBCBS
- ARBCBS providers
- Other Arkansas health plans
- National and regional payers outside Arkansas

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Summative Evaluation Design

The summative evaluation will analyze cost and utilization impacts of eConsults.

Sample

- *Intervention group:* Patients who receive an eConsult from a pilot practice provider
- *Control group:* Patients who have a specialist visit in the same month as the intervention patient's eConsult and match the intervention patient on key characteristics

Analysis

Analytic
intervention against control patients

- *Data sources:* ARBCBS data on practice characteristics and performance, ARBCBS claims data, county-level ARF data, health system EHR data, ConferMED implementation data

Outcomes

- *Long term outcomes:* total expenditures; rate of hospitalizations; ED visits; specialist visits and certain expenditure categories (i.e. lab and imaging)
- *Leading indicators:* implementation metrics (e.g., number of eConsults over time by specialty, by practice type) will help to track eConsultation uptake

Timing

- Study design: Jan – July 2022
- Analysis: Aug 2022 – March 2023
- Final report: March 2023

Outputs

- Written report and accompanying slide deck that describe findings
- 90-minute briefing

Challenges and Implications

COVID

- Timeline implications for implementation
- eConsult utilization by July 2022:
  - Health system expected=155, actual=45
  - Independent practice expected=461, actual=274
- Feasibility of data collection

Context

- Shifts in external landscape
- Impact of practice culture on adoption
- Reimbursement necessary but not sufficient
  - Increased relative value of formative evaluation over summative
  - Changed the primary audiences from providers to payers

Formative Evaluation Initial Findings

Experience	Benefits	Barriers	Opportunities for Improvement
• PCPs, leaders and staff had a positive experience with e-consults ▪ Easy to learn and use • Fit well with existing technology and workflow • Timely, high-quality responses from specialists • Improved access to care for their patients • However, across both HS and IND overall utilization was low	• **Patients** have more timely, easier, and less costly access to specialty care • **PCPs** are better able to coordinate and document their patients' care and enhance their knowledge • **Specialists** can help PCPs and potentially strengthen relationships with other departments	• Tendency to forget ▪ Independent practices (except the highest-utilizing practice) had lower use after the first six months of implementation • Resistance to change	• Assess practice readiness for adoption • Designate practice champion • Multi-prong rollout to increase awareness • Build knowledge of best practices • Create feedback loops • Reinforce use

PETERSON
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eConsult BASE™
Ontario eConsult Centre of Excellence

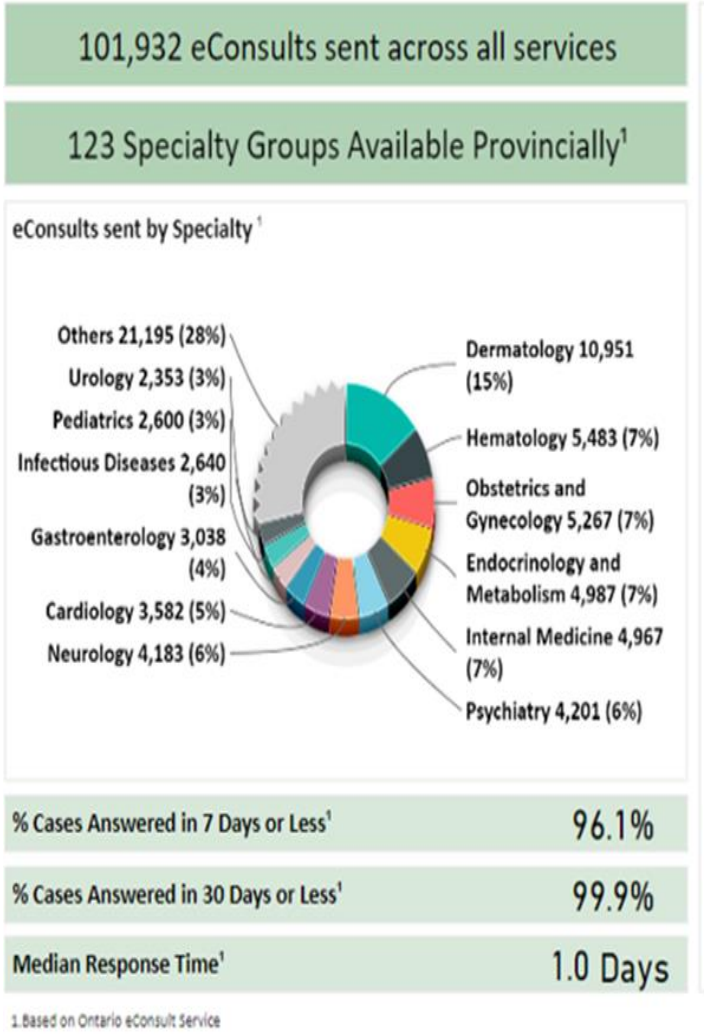
Using data to create individualized specialist reports

Erin Keely MD
Specialist Lead, Co-Executive Director
Ontario eConsult Centre of Excellence

Ontario eConsult Program

In past 12 months:

- Largest province in Canada, population > 15 million, publicly funded health care
- Two funded multispecialty eConsult services available across the province
- Voluntary participation, not currently linked to other referral options
- Specialist time based compensation
- Mandatory survey for referring provider to assess satisfaction/impact for each case



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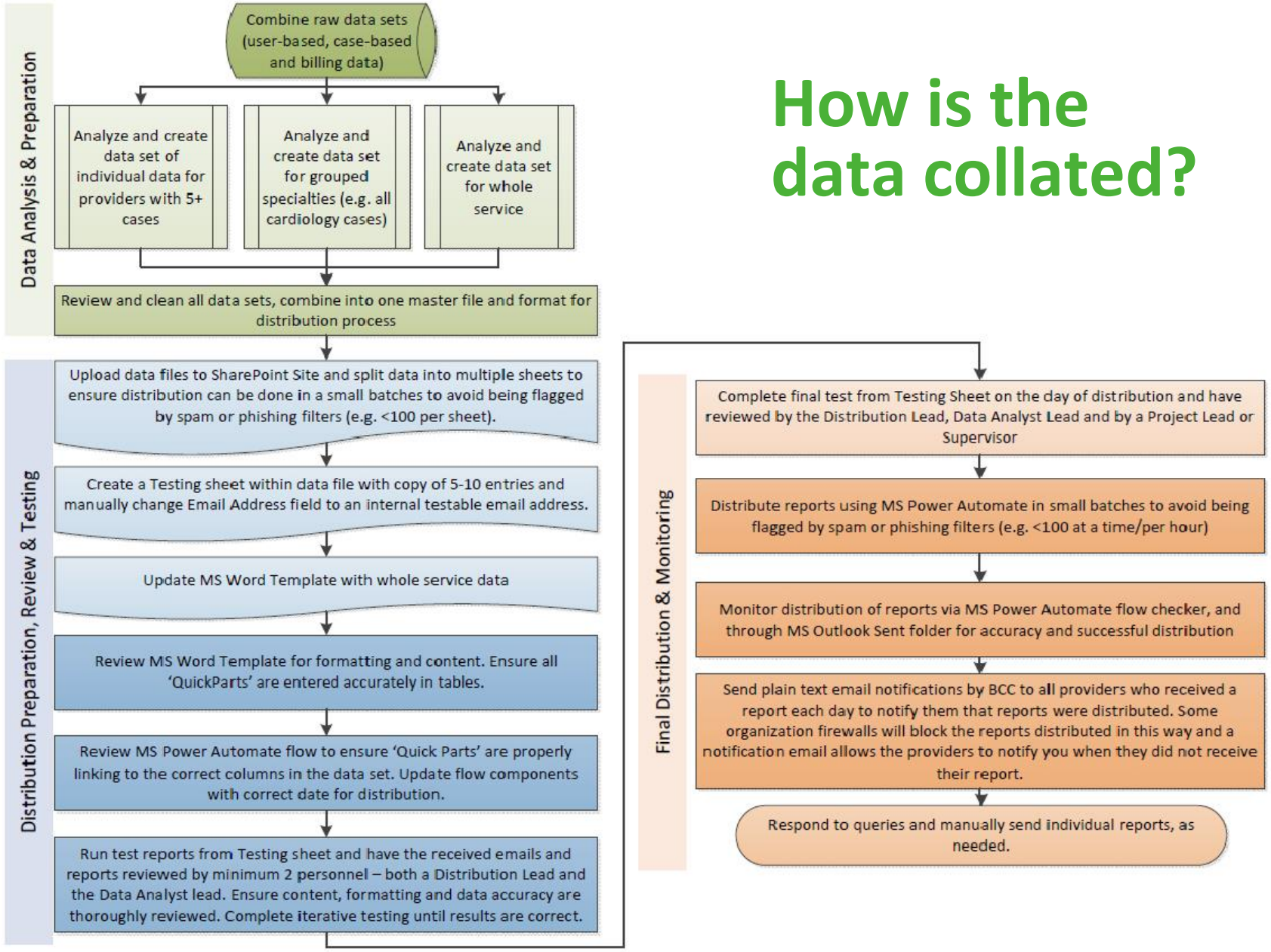
How is the data collated?



What is in the specialist report?

My Utilization Data

	My Data	Infection Prevention & Control Data	Champlain BASE™ Service Data
Number of eConsults Closed	54	80	9404
Percentage of eConsults provided within 7-day expectation	100%	100%	92%
Median self-reported billing time	10 minutes	5 minutes	15 minutes

Impact on Patient Care

Primary care providers (PCPs) complete a survey after completing each eConsult to evaluate the eConsults effect on the outcome for the patient and on the need for a referral.

Outcome for the Patient	My Data	Infection Prevention & Control Data	Champlain BASE™ Service Data
PCP was able to confirm a course of action that they originally had in mind	44.4%	43.8%	35.2%
The PCP received good advice for a new or additional course of action	53.7%	53.8%	60.5%
The PCP did not find the response very useful	0%	1.3%	1.6%
None of the above	1.9%	1.9%	2.7%

Effect on Need for Referral	My Data	Infection Prevention & Control Data	Champlain BASE™ Service Data
Referral was originally contemplated but now avoided at this stage	44.4%	41.3%	41.6%
Referral was originally contemplated and is still needed	9.3%	15%	21.2%
Referral was not originally contemplated and is still not needed	40.7%	38.8%	31.0%
Referral was not originally contemplated, but eConsult process resulted in a referral being initiated	1.9%	1.3%	2.7%
Other	3.7%	3.8%	3.5%

Effect on Patient Care	My Data	Infection Prevention & Control Data	Champlain BASE™ Service Data
Question: How helpful and/or educational was this response in guiding the ongoing evaluation or management of the patient?			
Very helpful and/or educational	68.5%	66.3%	63.6%
Moderately helpful and/or educational	20.4%	21.3%	27.2%
Somewhat helpful and/or educational	11.1%	10.0%	7.6%
A little helpful and/or educational	0%	2.5%	0.8%
Minimally helpful and/or educational	0%	0%	0.8%

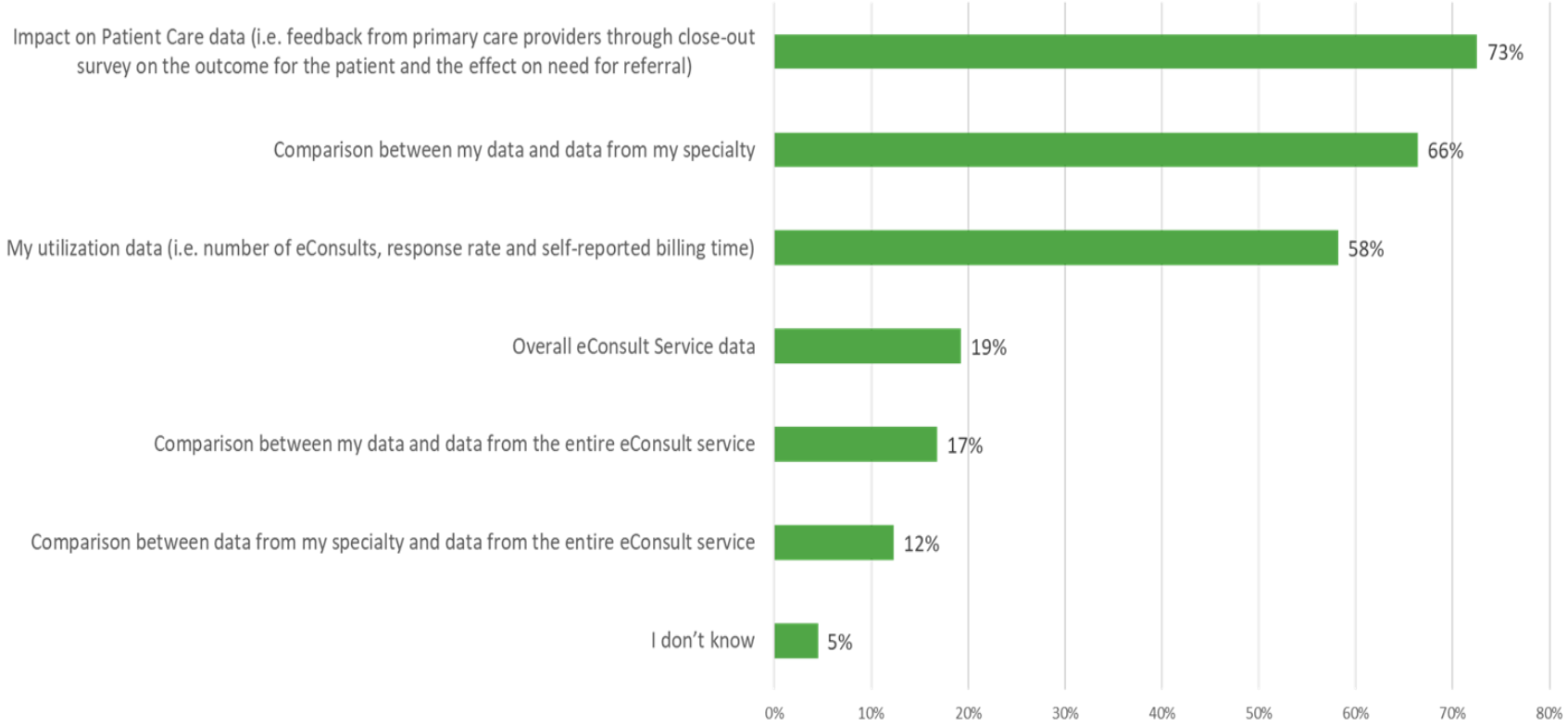
Overview

- **Objective:** To evaluate the impact and usefulness of the bi-annual specialist reports by collecting feedback on the impact, content, format and process from eConsult specialists who have previously received a report.

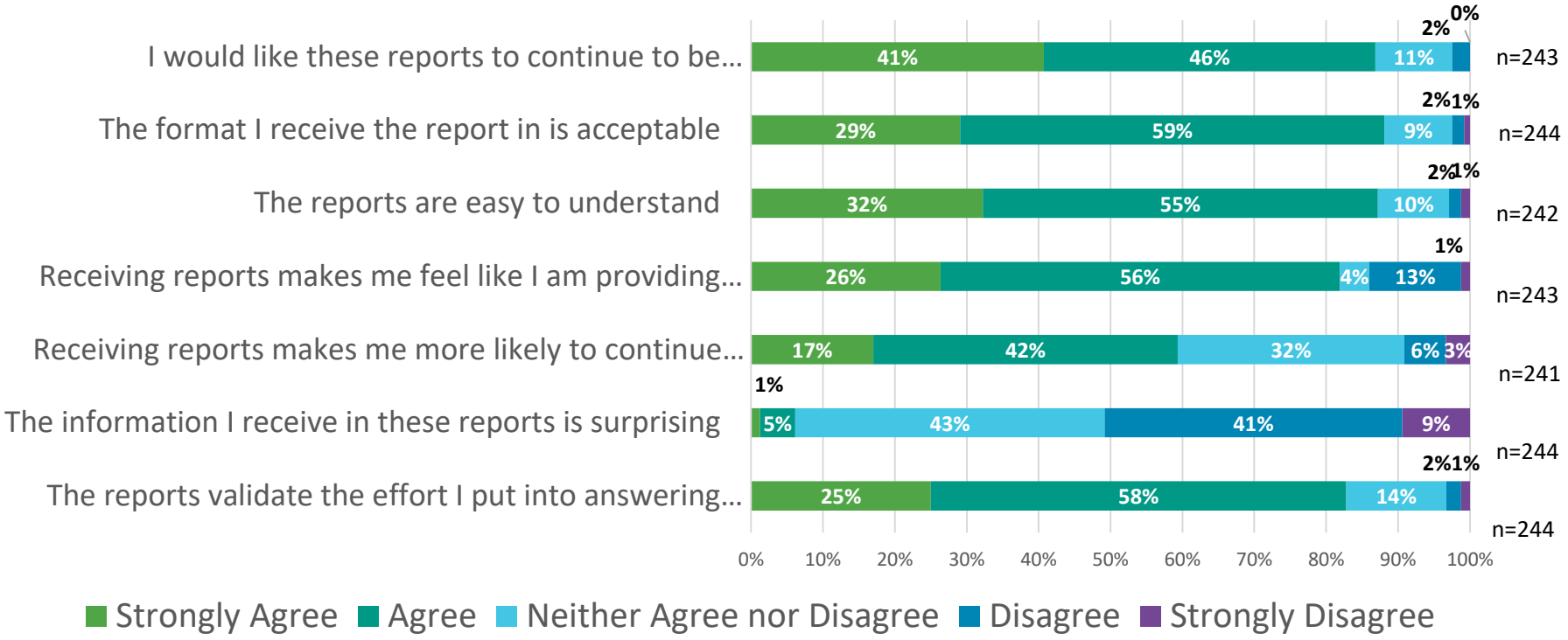
- **11 item survey sent to all specialists who received a specialist report (n=754), 33% response rate**

Key findings of survey

- **Specialists look at the reports** – 50% review in detail, 36% review and submit for CPD credits, 32% glance at it, 2% don't use it
- **Most useful components -**



Are the reports valuable?



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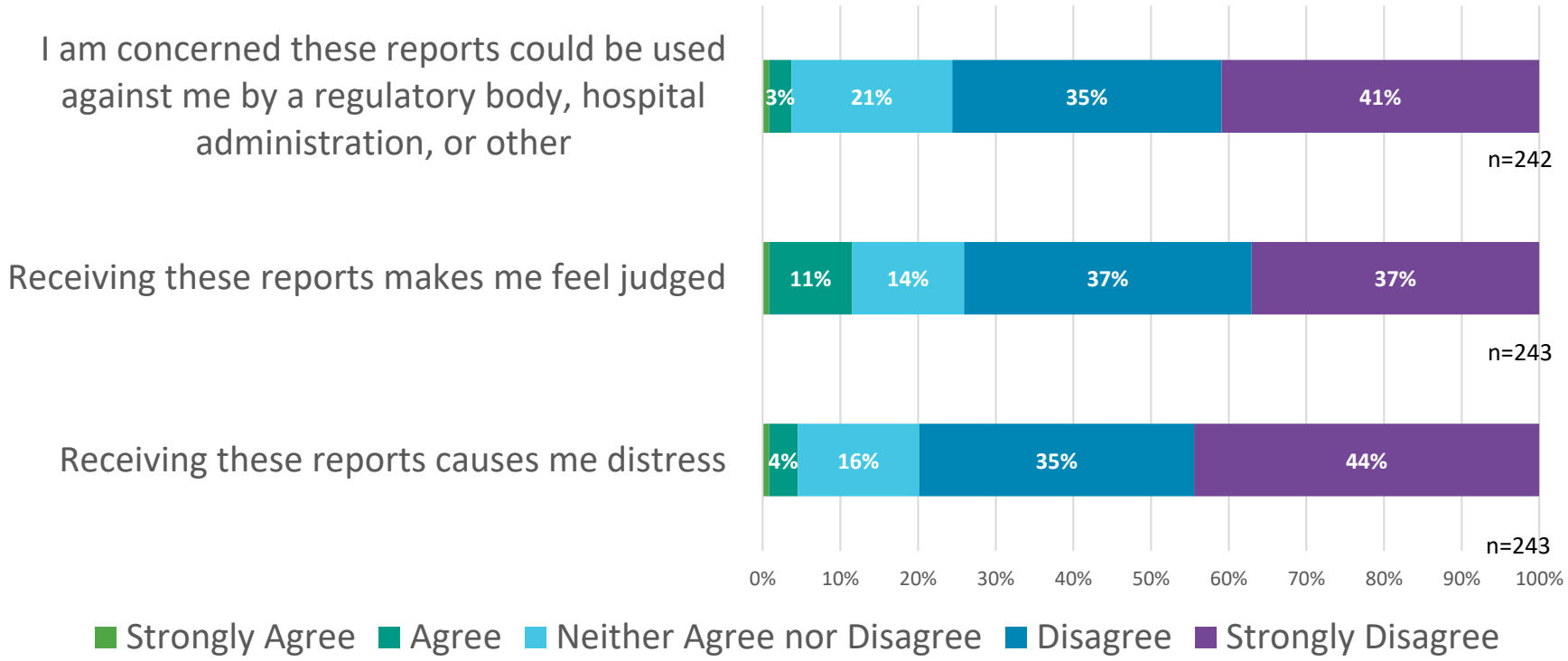
What about unintended consequences?



Summary

- eConsult services provide unique opportunity to collect, collate and distribute data
- Specialists receive little feedback and appreciate receiving it (especially impact on patient care) Linking reports to CPD credits is appreciated
- No unintended negative consequences
- Plan to continue q 6 months

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EUROPEAN CME Forum
Taylor & Francis
Taylor & Francis Group

BRIEF REPORT
OPEN ACCESS
Check for updates

Benefits of Providing Feedback and Utilisation Metrics to Specialists on Their Participation in eConsult

Erin Keely[a,b,c], Rhea Mitchell[a], Sheena Guglani[a,d], Douglas Archibald, Amir Afkham[e] and Clare Liddy[a]

eConsult BASE™
Ontario eConsult Centre of Excellence

The BASE eConsult Team

An initial collaboration between:

- The Champlain Local Health Integration Network
- The Ottawa Hospital
- Bruyère Research Institute
- Winchester District Memorial

Initial Seed Funding

- TOHAMO AFP Innovation Fund
- eHealth Ontario

Service Funding

- Champlain Local Health Integration Network
- Ontario Ministry of Health

Current Research Funding

- Canadian Institutes of Health Research
- Ontario Ministry of Health
- University of Ottawa Brain-Mind Institute

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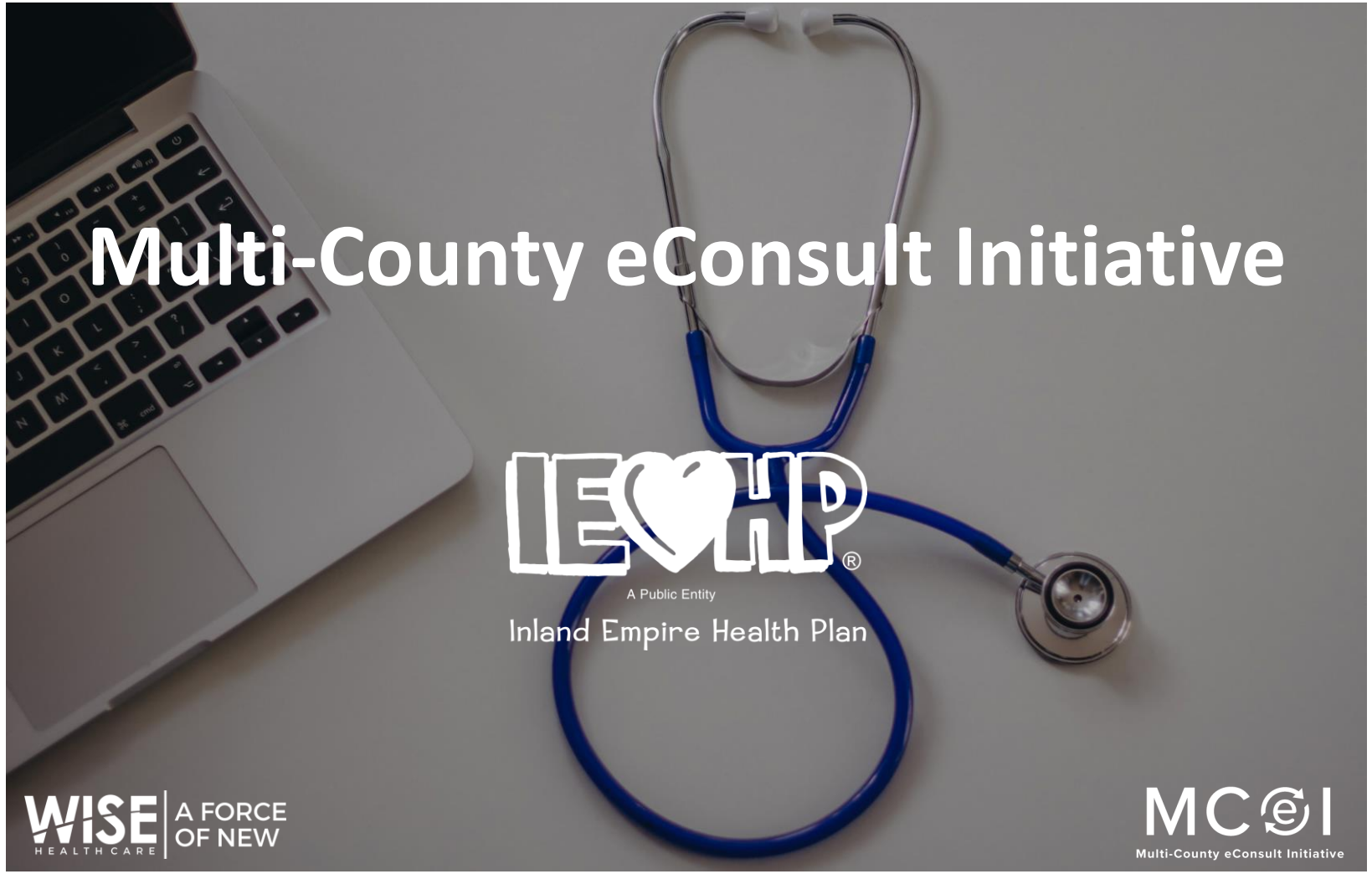

Multi-County eConsult Initiative
IEHP
A Public Entity
Inland Empire Health Plan
WISE HEALTH CARE
A FORCE OF NEW
MCeI
Multi-County eConsult Initiative

Access to Specialty Care in the Inland Empire

The Inland Empire is the 3rd largest safety net population in the U.S..

The Inland Empire (made up of San Bernardino and Riverside counties) is the 3rd largest safety net population in the U.S. and is particularly sensitive to the shortage and inaccessibility of specialty care. Respectively, Riverside County and San Bernardino County are the 4th and 5th most populated in the state; as of 2014 residents consisted of a 43% and 40% safety net population (Connolly et al.).

From 2015 to 2017, both counties were significantly above the state average for deaths due to female breast cancer, coronary heart disease, and chronic liver disease. San Bernardino county alone was reported to be in the top 5 counties with reliable data to be well above the state death rates for diabetes, colorectal cancer and prostate cancer. Overall, these heightened health concerns which pertain directly the Inland Empire, compounded with the fact that much of the population is safety net, speaks to the unique challenges facing the region (County Health Status Profiles).

40% Safety Net Population

Program Overview

Mission:

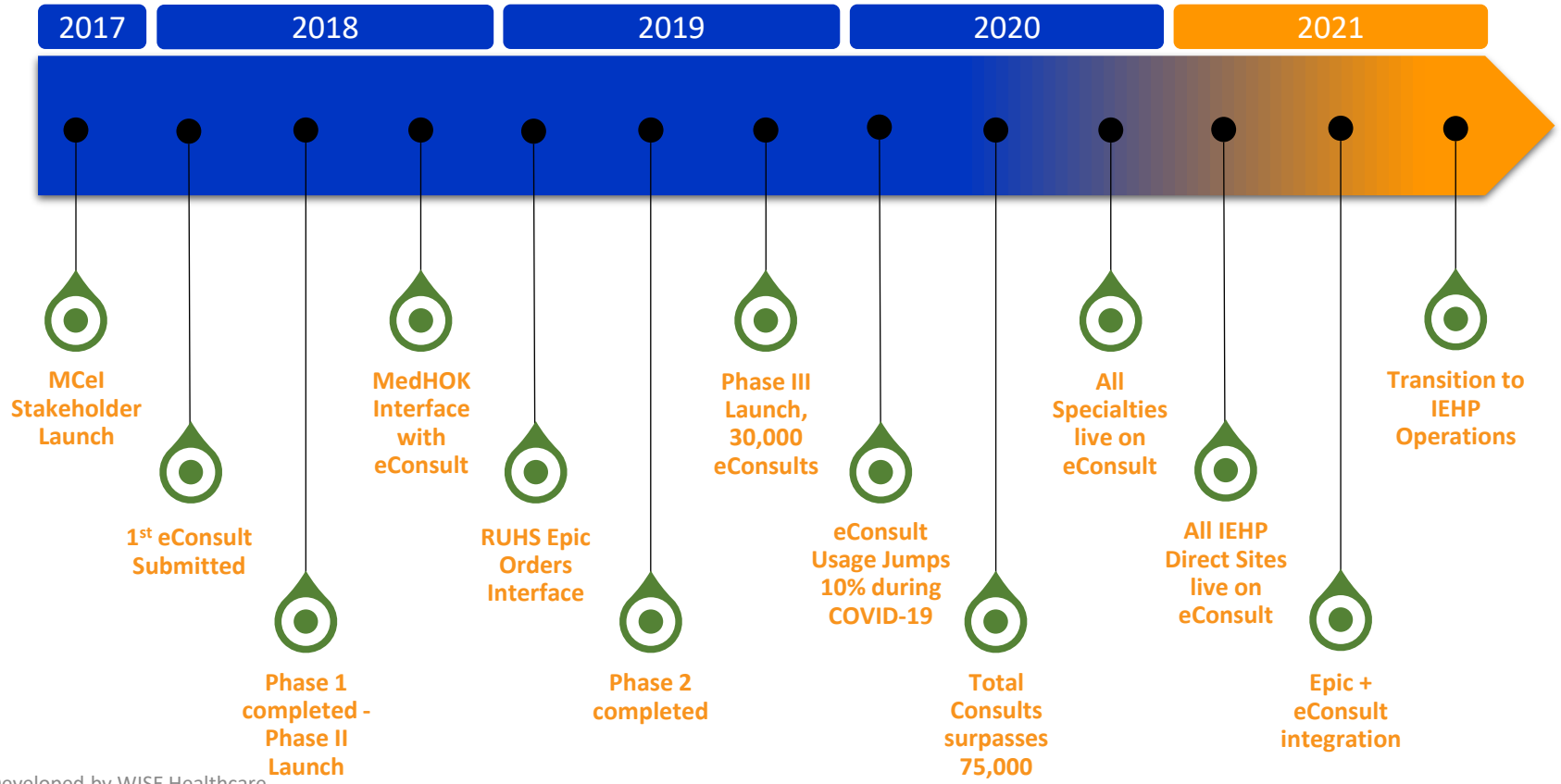
- Increase access to specialty care
- Align payer resources with provider know-how to address the specialty care needs of low-income populations

Vision:

- Provide eConsult to the Safety Net, for all primary care direct providers, across all specialties

The Multi-County eConsult Initiative (MCeI) aims to improve access to specialty care for the Safety-Net population in San Bernardino and Riverside counties through allowing clinical dialogue between Primary Care providers and Specialty providers to coordinate care.

MCeI Milestones



Program Structure

"The MCeI team, also known as the WISE Healthcare ("WISE") team, was contracted as an outsourced department of IEHP to represent IEHP with stakeholders, providers, and staff in the field, providing training, clinical site implementation, support, re-training, project management, integration support, Primary Care Provider engagement and support, Specialist Reviewer recruitment, training, support and management."

SafetyNet Connect
eConsult Technology Vendor

SNC is a software developer selected via RFP 17085 to provide the eConsult and eReferral Management platform.

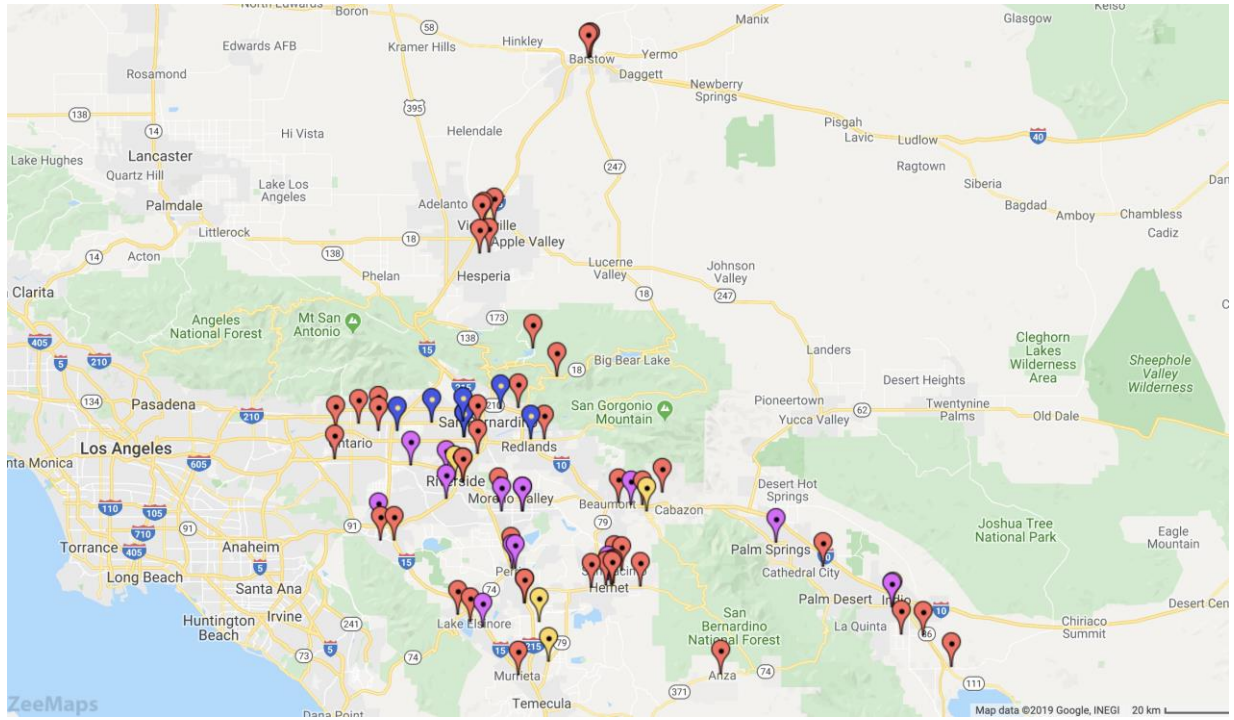
WISE Healthcare
Implementation, Management, Support, Training

WISE has expertise in Virtual Care and eConsult. WISE represents IEHP in the field as an agent of IEHP.

HubMD P.C.
Provides Specialist eConsult Reviews

HUBMD P.C. Provides eConsult reviews for RUHS, ARMC, IEHP, RCCHS, and SBCSD.

Clinic Sites Live



"We have been delighted to see firsthand how the eConsult program increases patients' access to care. We are committed to the expansion of our eConsult initiative"

Jarrod B. McNaughton
CEO at IEHP

MCEI Dashboard

Metric	Current Number
# of eConsults Closed	220,000+
Clinic Sites Onboarded	163
Specialties/Services	44
Primary Care Providers (including PAs/NPs/Residents)	800+
Specialist Reviewers (Active)	110

WISE HEALTH CARE | A FORCE OF NEW

Data through October 2022

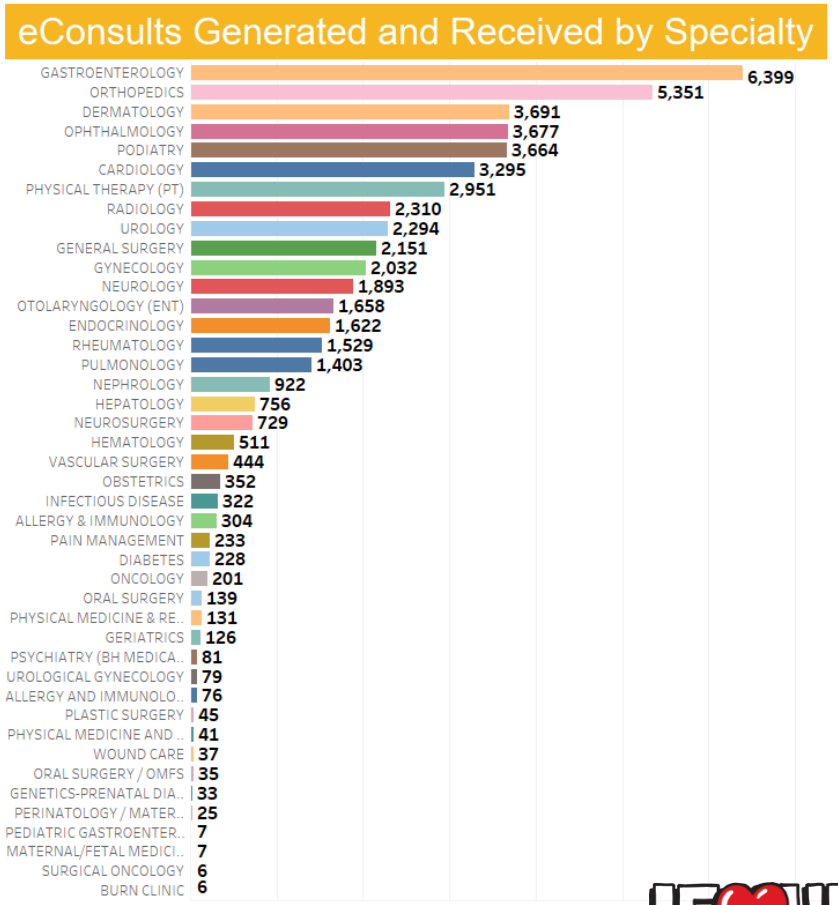
IEHP A Public Entity
Inland Empire Health Plan

MCeI Dashboard

Specialist response time: **1.1 days**

Non-Face-to-Face Referrals: **13.4%**

Consults with actionable care events: **51%**

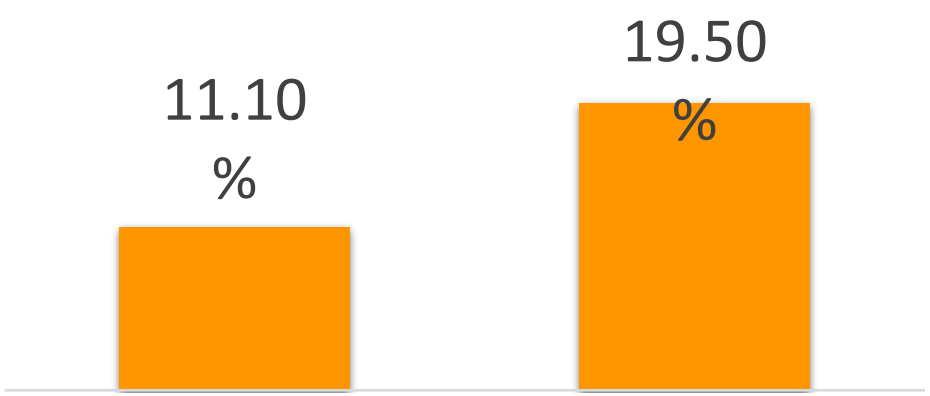


WISE HEALTH CARE | A FORCE OF NEW

IEHP A Public Entity
Inland Empire Health Plan

eConsults and COVID-19

eConsults ending without a recommendation for a face-to-face visit



***Source:** https://www.mdedge.com/jcomjournal/article/226184/coronavirus-updates/econsult-data-shed-light-care-coordination-decisions

"COVID-19 exposed the ills of our health care system. It didn't create them. Lack of equitable care, under-insurance, maldistribution of medical resources, racial disparities and social injustice existed before the pandemic. Those of us who dedicate our careers to the safety net, know this all too well because we live it daily. Our patients deserve better."

- Dr. Stanley Frencher Jr.
CMO at WISE Healthcare

E-Consult Workgroup in 2023

Diana Camacho, MPH
Senior Program Officer
Improving Access
California Health Care Foundation

Timi Leslie
Founder and President
BluePath Health

Libby Sagara
BluePath Health

Next Steps

Please take a moment to respond to our 3-question poll on the Whova app.

https://whova.com/portal/webapp/ewam_202211/Agenda/2590661

2023 Objectives:

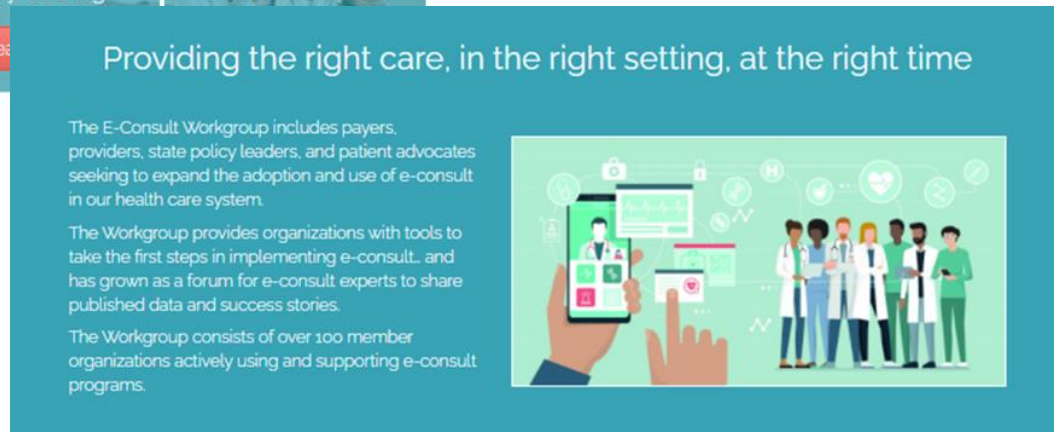
- Support models for engaging primary care providers and their teams
- Address the need for treating provider reimbursement
- Incorporate e-consult in alternative payment methodology (APM)
- Encouraging consistent coverage across plan business lines
- Share e-consult program data to address health disparities

Questions or comments?
econsultworkgroup@bluepathhealth.com

We Thank our 2022 E-Consult Workgroup Sponsors

Please join us for a reception at Cafeteria 15L.

- Monthly newsletters
- Continuing Medical Education (CME)
- Policy tracking
- E-Consult Playbook
- Published research
- Case studies
- Resources in response to public health needs



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