

Response to “e-Consult Implementation Success: Lessons From 5 County-Based Delivery Systems”

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An article in the January 2020 issue of *The American Journal of Managed Care*[®], “e-Consult Implementation Success: Lessons From 5 County-Based Delivery Systems,” provided insight into the complexity of integrating partnerships for specialty care and the contributing factors for successful implementation.¹ The authors’ takeaways for working through smoother technological partnerships—and not only physician-clinician partnerships—are critical for understanding barriers that delivery systems are likely to encounter when innovative strategies using telehealth meet with myriad challenges toward implementation in the wake of e-consults alone.

The first point to address from this study has to do with the team approach within systems that use e-consult platforms to transmit communications between physicians. The authors emphasize the extensive efforts of a larger group working with each physician, in which the physician-driven “success” of implementation (beyond curbside consults) for communicating information relevant to a patient’s care saves time and money without compromising payment, which is prorated by the rates that physicians are accustomed to receiving for services. The point of a team, however, includes having many other compensated individuals who work in project management, coordination of patient communication and scheduling, and working through technology that is compliant with the Health Information Portability and Accountability Act (HIPAA) but also interoperable between platforms (if delivery systems are not internal to a larger corporation), as well as having other clinicians in direct contact with patients for delivery of services. Specialty consults between physicians alone privilege the understanding between physicians to the question “Whose patient is this?” where the primary care physician is considered the primary point of contact. However, as delivery systems of care continue to evolve in integrated care settings, continuity of care may necessitate asking a new question at the core of all delivery systems seeking to use any form of telehealth to overcome barriers. Can the e-consult problem-solving mind-set inspire a team (or teams between 2 delivery systems) to consider this: “What communication for overall quality access to whole patient care can be implemented so that a

TAKEAWAY POINTS

- ▶ Team care requires e-consultation and health delivery collaboration between systems that use video conferencing and telemedicine.
- ▶ Health policy can be informed by implementation cases, based on lessons from successful specialty care consultations.
- ▶ Disparities can be reduced with new strategies, overcoming barriers to access.

patient has a consistent advocate to coordinate information from multiple members of their care team?” Asking this new question between systems privileges behavioral health care specialists in new ways, by changing the integrated system overall, directing new models for communication, and using telehealth (and coordinated care codes) for bridging the access gap and the barriers that exist between systems making referrals.

The authors also make a very important contribution in their suggestion that healthcare systems can benefit from prioritizing e-consults as electronic health record (EHR) vendors offer functional integrations. Identifying workflows, especially between partnering healthcare systems, will bring a greater ease of access “even if integrated solutions require trade-offs such as greater project expense or longer implementation timelines.”¹

Hypothetically speaking, more learning can occur on mapping out how partnering teams overcome systems’ communication barriers. This is the case especially when video delivery of services and video consults between community behavioral health specialists already seeing patients weekly (although *consumers* is the title given in state-funded agencies) are coordinated with video consults when appropriate to promote continuity of care with distant primary care physicians. This is a primary care behavioral health model² that leads with the community behavioral health therapist assisting with in-home video consults with primary care providers (PCPs). Satcher and Rachel³ asserted that integrated care models for partnering state-/federal-funded behavioral health agencies and primary care (based on an earlier study at the Grady emergency

department⁴) can reduce emergency department costs. We seek to follow this partnership pathway to assess how an intervention that leads with telehealth physicians in a clinic that is patient-centered medical home–certified⁵ can offer a solution across Georgia for implementation successes that can be equity driven, with prevention for crisis reduction in emergency departments in mind when behavioral health and primary care delivery of services are implemented in newly coordinated ways, beyond e-consults alone; however, e-consults and 2-way referrals help identify barriers and increase services where flow between systemic teams enhances quality of care for the consumer/patient.

Specific lessons will address:

- e-Consult notes
- HIPAA-compliant interoperable third integration where solutions of a third bridging technology make 2-way HIPAA-compliant communications more feasible between EHRs
- Codes for collaborative care management
- Primary care–referred patients receiving services in home from community behavioral health therapists
- Community behavioral health–referred consumers receiving services in home, as well as receiving services from primary care physicians via video e-consults, mapping those possible variations and new trainings from community therapists to meet the billable sessions for PCPs
- Informed consent and partnering contracts between healthcare delivery sites
- Need for broadband and video equipment to implement telemedicine services
- Information technology team outline for identifying all hurdles for billing and collection, via specific telehealth policies that apply to delivery of services to in-home patients in Georgia

We expect to add to the literature a follow-up road map, based on the e-consult work from the California team and a more extensive literature review, to identify care coordination and team-building successes beyond relationships of physicians alone. With a lens toward equity and access for coordinated delivery of services to overcome the barriers evident by both

healthcare systems' (primary care clinics and behavioral health agencies) high incidence of no-shows for clinic appointments, we hope telehealth services can decrease disparities in a frame where the Quadruple Aim is considered. With continuity of care being mostly with state-funded agency in-home delivery of behavioral health services, remote primary care physicians can assist with overall better outcomes for consumer/patient health and a decrease in no-shows because a healthcare team partners to support both systems, with the consumer/patient in the center. Overcoming barriers of access—which we also seek to understand and name, downstream, for policy makers to more swiftly address to make the coordinated care more relevant—will help meet the Quadruple Aim.⁶ ■

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