The eReferral and eConsult Model for Specialty Care

May 27th, 2015
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Webinar sponsored by:
The Center for Excellence in Primary Care and the Center for Care Innovations
Who Are We?
Facilitating Care Integration

Nearly half of adults with health issues report problems with the coordination of their care in the United States. As Community Health Centers (CHCs) and other safety net settings transform into Patient-Centered Medical Homes, their role in the larger medical neighborhood will become pronounced. However, challenges with care coordination are magnified in the safety net setting and continue to be increasingly complex.

In 2014, the UCSF Center for Excellence in Primary Care, with funding from the Blue Shield of California Foundation, completed a comprehensive literature review outlining strategies CHCs use to integrate into the medical neighborhood in the domains of primary care-specialty care, primary care-diagnostic imaging, primary care-pharmacy, primary care-oral health and primary care-hospital care. A conceptual model which was used to classify innovations and strategies for integration can be found in the full report here.

The UCSF Center for Excellence in Primary Care has partnered with the Center for Care Innovations to develop this online resource center. The purpose of this Care Integration site is to disseminate
eReferrals and eConsults
A New Model for Specialty Care

Delphine S. Tuot, MDCM, MAS

Asst. Professor of Medicine, University of California San Francisco
Director of eReferral, San Francisco General Hospital
Co-Director, Center for Innovation in Access and Quality
• No disclosures to report.
Overview

- Context – supply/demand mismatch of specialty care in the US
- What is the Medical Neighborhood?
- Enhancing the primary care – specialty care interface through electronic referral and consultation (eCR) systems
Specialty care trends

- Specialty visits comprise >50% of all ambulatory visits
- For patients <65, 1/3 patients referred to a specialist/year; for patients ≥ 65 avg of 2 referrals annually
- ~60% of U.S. physicians are specialists

Care coordination demands

Context
Primary care physicians are responsible for coordinating care that their patients receive from other physicians. This role will probably expand with the implementation of such models of care as the patient-centered medical home.

Contribution
Investigators analyzed survey data from 2284 primary care physicians who reported 41,092 Medicare patients they cared for in 2005. They estimate that, for every 100 Medicare patients a physician treats, the physician potentially must interact with 99 other physicians in 53 different practices.

Implication
To coordinate care of patients for whom they are the primary care physician, physicians must coordinate with a large number of other physicians.

—The Editors

Special Report

Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?

In five diverse cities, safety-net capacity was strained for specialty and pharmaceutical services.

by Suzanne Felt-Lisk, Megan McHugh, and Embry Howell

ABSTRACT: The safety-net providers that serve the nation’s thirty-nine million uninsured residents are vulnerable organizations even in good economic times, yet efforts to monitor their capacity have been limited at best. This study of the safety-net in five cities found that capacity was strained for specialty services and that access to pharmaceuticals was difficult, while primary care capacity was more often adequate to serve those who presented themselves for care. Also, free clinics grew during the 1990s, while many other safety-net providers focused on improving their efficiency and collecting more fees from patients.
Specialty care in the safety net

Access To Specialty Care And Medical Services In Community Health Centers

Lack of access to specialty services is a more important problem for CHCs than previously thought.

by Nakela L. Cook, LeRoi S. Hicks, A. James O'Malley, Thomas Keegan, Edward Guadagnoli, and Bruce E. Landon

ABSTRACT: Although community health centers (CHCs) provide primary health services to the medically underserved and poor, limited access to off-site specialty services may lead to poorer outcomes among underinsured CHC patients. This study evaluates access to specialty health services for patients receiving care in CHCs, using a survey of medical directors of all federally qualified CHCs in the United States in 2004. Respondents reported that uninsured patients had greater difficulty obtaining access to off-site specialty services, including referrals and diagnostic testing, than did patients with Medicaid, Medicare, or private insurance. [Health Affairs 26, no. 5 (2007): 1459–1468; 10.1377/hlthaff.26.5.1459]
Specialty care in the safety net

Access To Specialty Medical Services
Health Cent

Lack of access to specialty CHCs than previously thought.

by Nakela L. Cook, LeRoi S. Edward Guadagnoli, and Br

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Dr. Ted Mazer, an ear, nose and throat specialist in San Diego who treats people on Medicaid, with Oresta Johnson.

By ABBY GOODNOUGH
Published: November 28, 2013
Referral process characterized as...

“often incomplete and needlessly inefficient”
Kunkle 1964

“often falls short of its goals”
Lee, Pappius and Goldman 1983

“not consciously designed and leaves much to be desired”
Gandhi et al 2000

“perilous journey through the health system”
Bodenheimer 2008

“long-standing source of frustration among physicians”
Mehrotra, Forrest and Lin 2011
PCMH-Neighborhood

• PCMH: team of providers centered around patients’ needs, with care functions and team processes coordinated through HIT
  - Greater delivery of high-quality medical care
  - Enhanced patient experience
  - Greater efficiency

• Neighbor: specialists who offer effective bi-directional care communication, coordination, integration and patient-centered care

• PCMH-N: home + specialty care + acute care
Won’t you be my neighbor?

Specialist responsibilities:
1. Pre-consultative exchange
   • Reviewing/triaging referrals
   • Prioritize care
2. High-quality communication
   • Recommendations
   • Follow-up schedule
   • No-shows
   • Secondary referrals
   • Discharges to primary care
3. Co-management if patient can safely stay in PCMH

American College of Physicians, 2010
123,500 patients/clients
37% uninsured; 35% Medicaid; 17% Medicare
23% White; 18% Black; 30% Hispanic, 28% Asian

14 primary care health centers
70,000 primary care patients

comprehensive ambulatory
specialty and diagnostic services
331,000 visits in 2013-2014

behavioral health services
acute and trauma care
jail health services
long term care

10 independent PC clinics
87,000 PC patients
eReferral development

- Home grown, HIPAA compliant, web-based consultation and referral system (eConsult + eReferral = eCR)
  - Tightly integrated with hospital EMR
  - Auto-population of demographic, clinical data
  - Free text consultative question
- New model of primary-specialty care collaboration
  - Individualized review and response by designated specialist reviewer (MD or NP)
  - Iterative communication between referring and reviewer clinicians until issue is addressed – with or without a specialty clinic visit
SFGH in 2005

- Paper, telephone, and fax based referral system
- Clerical process of first referred, first scheduled
- Significant inefficiencies
  - referral to wrong clinic
  - unnecessary referrals
  - premature referrals
  - inability to discern referral question
  - lack of equitable triage
- Wait times up to 11 mo
eReferral Workflow

PCP submits electronic referral

Consult reviewed electronically by specialist

*Includes all relevant clinical data from EMR*
eReferral Workflow

PCP submits electronic referral

Consult reviewed electronically by specialist
Includes all relevant clinical data from EMR

Appropriate specialty referral
AND
Pre-referral work-up complete

Nonurgent
Schedule Next Available

Urgent
Overbook
eReferral Workflow

PCP submits electronic referral

Consult reviewed electronically by specialist
*Includes all relevant clinical data from EMR*

Appropriate specialty referral
AND
Pre-referral work-up complete

- Nonurgent: Schedule Next Available
- Urgent: Overbook

Consult question unclear
Pre-referral work-up incomplete
PCP can manage with guidance
eReferral Workflow

PCP submits electronic referral

Consult reviewed electronically by specialist
*Includes all relevant clinical data from EMR*

Appropriate specialty referral
AND
Pre-referral work-up complete

Consult question unclear
Pre-referral work-up incomplete
PCP can manage with guidance

Nonurgent
Urgent

Schedule Next Available
Overbook

not scheduled and more information requested
eReferral Workflow

1. PCP submits electronic referral
2. Consult reviewed electronically by specialist
   *Includes all relevant clinical data from EMR*
3. Appropriate specialty referral
   AND
4. Pre-referral work-up complete
5. Nonurgent
   - Schedule Next Available
6. Urgent
   - Overbook
7. Consult question unclear
   - Pre-referral work-up incomplete
   - PCP can manage with guidance
8. Consult question unclear
   - Eventually Scheduled
9. Consult question unclear
   - Never Scheduled
10. not scheduled
    and more information requested
**Medical Specialty Clinics**
- Allergy Adult Clinic
- Cardiology Clinic
- Chest Clinic (Pulmonary)
- Diabetes Services
- Endocrinology Clinic
- Gastroenterology Clinic
- Geriatrics Clinic
- Hematology Clinic
- Infectious Disease at LHH
- Liver Clinic
- Neurology Clinic
- Oncology Clinic
- Renal Clinic
- Rheumatology Clinic
- TB Clinic

**Womens Health Specialty Clinics**
- 5M Breast Evaluation Clinic (Non Surgical)
- Gynecology Clinic
- Obstetric Clinic

**Other Programs**
- 1M Anticoagulation Clinic (No Review)
- Anticoagulation FHC (No Review)
- Comprehensive Pharmacy Care
- Asthma and COPD Group Education Classes (No Review)
- Cancer Risk Program (Genetic Counseling)
- Financial Fitness Program (No Review)
- Health At Home (Home Health Services)
- Neuropsychology Service (New!!)
- Respite Program
- Stop Smoking Program (No Review)
- Transgender Health Services
- Wellness Center (No Review)
- CRANIUM (PCP for Citywide Focus ONLY)
- Primary Care Psychiatry Service (Maxine Hall Health Center ONLY)
- SFHN Primary Care (5M, 6M, 6C, 6G, UCC, & Respite ONLY) (New!!)

**Surgical Specialty Clinics**
- 3M Breast Surgery Clinic
- Anesthesia PreOp Clinic (No Review)
- Cardiothoracic Surgery Clinic
- Concussion Clinic (No Review)
- Diabetes Teleretinopathy Screening Service (New!!) (No Review)
- General Surgery Clinic
- Neurosurgery Clinic
- Ophthalmology/Optometry Clinic (No Review)
- Orthopaedic Surgery Clinic
- Otolaryngology (Head and Neck Surgery) Clinic
- Plastic Surgery Clinic
- Podiatry Clinic
- Radiology- Interventional Radiology (No Review)
- Urology Clinic
- Vascular Surgery

**Diagnostic Services**
- Audiology Clinic (No Review)
- Echocardiography (No Review)
- EEG (No Review)
- Ambulatory ECG Monitoring (Zio Patch) (No Review)
- Exercise Treadmill Testing (ETT) (No Review)
- Sleep Study
- Radiology- CT
- Radiology- Fluoroscopy
- Radiology- Mammography Screening (No Review)
- Radiology- Breast Mammography Diagnostic
- Radiology- MRI
- Radiology- Ultrasound

**Rehabilitation Services**
- Aquatic Therapy (New!!) (No Review)
- Occupational Therapy
- Physiatry (Physical Medicine & Rehabilitation) Clinic (New!!) (No Review)
- Physical Therapy
- Speech Therapy
47 year old female with fatigue and family history of thyroid disease. THS < 0.1 with T3 and T4 high. Alk phos is also high at 230. GGT si high at 57 all other LFT normal. THyroid nonpalpable on exam. I am thinking of gettin antibody tests. Does she need a iodine uptake scan? Can alk phos be elevated in thyroid disease? Thanks Annette
Most patients with hyperthyroidism have a high alkphos due to increased bone turnover (doesn't exactly explain the slightly up GGT however). So would recheck when she's euthyroid. So if no clinical findings (eyes/bruit) suggestive of Graves, very reasonable to get a TSH Receptor antibody with next labs. No need to get a scan at this point. Typically do that prior to ablation or if for some reason we can't make dx of etiology of hyperthyroidism otherwise. So assuming her gland isn't tender on exam/no recent URI (so no evidence thyroiditis) would be reasonable to start methimazole at 5 mg daily (or if she's clinically symptomatic/tachy etc could do 10 mg daily). And then would recheck a TSH/FT4 with the antibody in 4 weeks or so. Wasn't clear if you wanted us to see her or not. Happy to do either way. If you want us to see her just please give lab slip for above for right before the visit. Otherwise, just let me know when f/u labs back.

As a reminder to review with a patient when prescribing methimazole or PTU, both drugs have a very rare but real SE of agranulocytosis. Patients should be instructed to come in immediately for any sore throat, fever, or other sign of infection to have a WBC with diff checked.
Consultant Note To Scheduler:  ENDO 1 Feb 4

1/22/2013 4:14:11 PM entered by elizabeth murphy
Actually those labs were from November. Now (today) they are very different and her TSH is very normal. There is a big lag between euthyroid and TSH recovery so with labs like these we would typically consider decreasing methimazole so the patient doesn't get hypothyroid. Fatigue no doubt is due in part to no normal thyroid function (or maybe even low). So can't explain the tachycardia. It was regular/and persisted after patient had been in clinic a bit? So agree with beta-blocker but wouldn't increase methimazole and we can see patient in 3-4 weeks. Please have patient get another TSH and Free T4 before the visit with us and we'll like go down on methimazole then.

1/22/2013 11:04:26 AM entered by annette burns
TSH <0.01 T4 1.76 T3 4.84 after 6 weeks on Methimazole 10mg.
P - 105 and feels fatigue. no sore throat or fever. Thyroid nontender, sl. enlarged sym.
I would like to refer her to you to see.
I increased her methimazole to 15mg daily and started her on Propranolol 10mg 2 times a day

10/29/2012 5:50:24 AM entered by elizabeth murphy
Most patients with hyperthyroidism have a high alkphos due to increased bone turnover (doesn't exactly explain the slightly up GGT however). So would recheck when she's euthyroid. So if no clinical findings (eyes/bruit) suggestive of Graves, very reasonable to get a TSH Receptor antibody with next labs. No need to get a scan at this point. Typically do that prior to ablation or if for some reason we can't make dx of etiology of hyperthyroidism otherwise. So assuming her gland isn't tender on exam/no recent URI (so no evidence thyroiditis) would be reasonable to start methimazole at 5 mg daily (or if she's clinically symptomatic/tachy
27,604 new submissions/year (excluding diagnostics)

Specialist reviews

Appropriate and complete consults 60% (16,466)

Consult inappropriate or incomplete or clinic visit not needed 40% (11,138)

Scheduled need to be seen in clinic

50% (13,783)

10% (2,683)

Non-urgent routine appointment

Urgent overbook appointment

Not initially scheduled

specialist responds to request more information and/or make recommendations

Iterative communication as needed

PCP provides information, initial evaluation complete, visit needed

20% (5,641)

No appointment 6 months after last exchange

20% (5,397)

Scheduled

Never Scheduled

Adapted from Chen AH, Murphy EJ, Yee HF, “eReferral – A New Model for Integrated Care.” NEJM 2013;368(26):2450-3.
## Impact overview

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced wait times</td>
<td>Reduced wait times</td>
</tr>
<tr>
<td>High PCP satisfaction</td>
<td>Avoidance of incorrect referrals</td>
</tr>
<tr>
<td>Quick access to specialist expertise</td>
<td>Ability to clinically triage</td>
</tr>
<tr>
<td>Primary – specialty dialogue is recorded in real time in EMR</td>
<td>Improved clarity of consultative question</td>
</tr>
<tr>
<td>Case-based “CME”</td>
<td>Increased efficiency of in-person visits</td>
</tr>
<tr>
<td>Virtual co-management keeps patients in PCMH, reduces need for external care coordination</td>
<td>Formalization of curbsides</td>
</tr>
<tr>
<td>More “balls” in PCP court</td>
<td>Opportunities to educate, learn</td>
</tr>
<tr>
<td></td>
<td>Increased “case-mix” in clinics</td>
</tr>
</tbody>
</table>
Impact on wait times
Impact on primary care

PCP ratings of electronic referrals compared to prior referral methods.
81% response rate (298 of 368)

- Access for urgent issues: 35% Better, 49% No change, 16% Worse
- Access for non-urgent issues: 60% Better, 30% No change, 10% Worse
- Wait time for new appt: 54% Better, 37% No change, 9% Worse
- Answering clinical question: 57% Better, 30% No change, 13% Worse
- Guiding pre-visit work-up: 73% Better, 22% No change, 5% Worse
- Ability to track referrals: 89% Better, 5% No change, 6% Worse
- Overall clinical care: 72% Better, 21% No change, 7% Worse

Overall, how has eReferral changed clinical care for your patients?

81% response rate (298 of 368)

Impact on specialty clinics

HOW DIFFICULT WAS IT TO IDENTIFY the reason for the consultation or clinical question before interviewing and examining this patient today?

Percentage of specialists responding “somewhat difficult” or “very difficult.”

* p-value <0.05

1A. Medical Subspecialty Referrals

1B. Surgical Subspecialty Referrals

N = 618 (413 medical, 205 surgical)

Conditions benefitting from eReferral

**Rheumatology:** Osteoarthritis, gout

**Endocrinology:** hypothyroidism (includes subclinical), thyroid nodules

**Pulmonary:** asthma/COPD initial evaluation, cough workup

**Gastroenterology:** dyspepsia, GERD, hemorrhoids

**Cardiology:** short QT on ECG, management of stable CAD

**Neurology:** Headaches, initial dementia evaluation, peripheral neuropathy

**Hematology:** iron deficiency anemia, thrombocytopenia

**Liver:** proper biochemical evaluation for liver disease/hepatitis

**Gynecology:** fibroids

**Urology:** BPH, nephrolithiasis
# Impact on clinic complexity

## Endocrinology

### Fiscal Year 2011 - 2012

#### Top Ten Most Frequent Dx by Visit Count

<table>
<thead>
<tr>
<th>Count</th>
<th>%</th>
<th>ICD9 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>690</td>
<td>32%</td>
<td>Graves disease without crisis</td>
</tr>
<tr>
<td>376</td>
<td>17%</td>
<td>thyroid cancer</td>
</tr>
<tr>
<td>255</td>
<td>12%</td>
<td>nontoxic uninodular goiter</td>
</tr>
<tr>
<td>220</td>
<td>10%</td>
<td>thyrotoxicosis nos w/o crisis</td>
</tr>
<tr>
<td>140</td>
<td>6%</td>
<td>testicular hypofunction</td>
</tr>
<tr>
<td>114</td>
<td>5%</td>
<td>pituitary neoplasm</td>
</tr>
<tr>
<td>104</td>
<td>5%</td>
<td>nontoxic multinodular goiter</td>
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<tr>
<td>97</td>
<td>4%</td>
<td>anterior pituitary hyperfunction</td>
</tr>
<tr>
<td>93</td>
<td>4%</td>
<td>primary hyperparathyroidism</td>
</tr>
<tr>
<td>84</td>
<td>4%</td>
<td>hypothyroidism nos</td>
</tr>
</tbody>
</table>
## Variation among specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Reviewer</th>
<th>Referral volume (unique referrals/year)</th>
<th>Referral management</th>
<th>Referral management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>% immediately</td>
<td>% scheduled after pre-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>scheduled</td>
<td>consultative exchange</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy</td>
<td>MD</td>
<td>123</td>
<td>30.1</td>
<td>10.6</td>
</tr>
<tr>
<td>Cardiology</td>
<td>MD</td>
<td>1374</td>
<td>64.0</td>
<td>14.8</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>MD</td>
<td>806</td>
<td>54.1</td>
<td>20.2</td>
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<tr>
<td>Diabetes</td>
<td>NP</td>
<td>945</td>
<td>52.3</td>
<td>34.5</td>
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<tr>
<td>Endocrinology</td>
<td>MD</td>
<td>704</td>
<td>27.2</td>
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<td>2494</td>
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<td>MD</td>
<td>542</td>
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<td>Hepatology*</td>
<td>MD/NP</td>
<td>808</td>
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<td>24.1</td>
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<td>Neurology</td>
<td>NP</td>
<td>1622</td>
<td>76.6</td>
<td>15.7</td>
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<td>Oncology</td>
<td>MD</td>
<td>505</td>
<td>58.4</td>
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<td>Rheumatology</td>
<td>MD</td>
<td>576</td>
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<td>NP</td>
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<td>496</td>
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<td>NP</td>
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<td>1853</td>
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<td>Women's Health</td>
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<tr>
<td>Gynecology</td>
<td>MD</td>
<td>2206</td>
<td>64.7</td>
<td>20.0</td>
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<tr>
<td>Obstetrics</td>
<td>MD</td>
<td>387</td>
<td>53.7</td>
<td>17.8</td>
</tr>
</tbody>
</table>

Tuot DS, Murphy EJ, McCulloch CE, Leeds K, Chan E, Chen AH. Leveraging an electronic referral and consultation (eCR) system to provide high quality coordinated specialty care. Healthcare, 2015.
## SFHN Experience – lessons learned

### Strengths
- Closed network
- Investment in pilot
- Intuitive design
- Academic, salaried specialists committed to underserved patients
- Implementation team responsiveness through surveys, outreach, suggestion box
- Commitment to evaluation

### Challenges
- Home grown system requires tending
- Variability among specialist reviewers
- Variability in workflow and clinical expertise among PCPs
- Fragmentation with new ambulatory EMR
What drives successful implementation in other systems?

Key informant interviews

- Drivers
- Facilitators/barriers to eCR implementation
- Best practices
- Evaluation metrics
# Study participants

## California
- AccessOC
- Alameda Health System
- L.A. Care Health Plan
- Los Angeles County Department of Health Services
- Marin Community Clinics
- Riverside County Regional Medical Center
- San Mateo Medical Center
- UCLA Health
- UCSF Medical Center
- Ventura County Health Care Agency

## United States
- Brigham and Women’s Hospital
- Community Health Center, Inc
- Denver Health
- Harborview Medical Center
- Hawaii Medical Service Association
- University of Massachusetts Memorial Health Care

## International
- Bruyere Research Institute (Ottawa, CA)
- National Health Service (England)

Drivers of implementation

Electronic referrals
- Operational efficiency
  - Tracking
  - Legibility
- Clinical efficiency*
  - Redirection
  - Triage
  - Preconsultative diagnostic evaluation

Electronic consults
- Access to specialty care
  - Supply/demand mismatch
  - Long wait times
- Decrease leakage
- Formalize “curbsides”
- Improve communication
- Enhance PCP capacity

*requires administrative screening or templates

Integrated eCRs: culture change; population approach
Facilitators and barriers

**Facilitators**

- Engaged leadership
- Established relationships between PCPs, specialists
- Intuitive technology
- Attention to workflow and expected practices
- Dedicated project management team
- Ongoing funding

**Barriers**

- Clinician resistance
  - PCP workload and workflow
  - Specialist reviewer workload
- Lack of integration with EHR
- Liability concerns
- Lack of systems support
- Lack of reimbursement
Take home points

- Potential for health IT to improve communication and efficiency of primary-specialty care interface
- Primary care and co-management support (versus gatekeeper role) enhances medical home-neighborhood model
- Opportunity to train PCPs and specialists in new ways of interacting (medical neighborhood)
- Need for ongoing evaluation
eReferral Community

Management team
- Director: Delphine Tuot
- Program Manager: Tekeshe Mekonnen
- Specialty Director: Lisa Murphy
- Applications Manager: Kjeld Molvig
- Senior Software Engineer: Peter Cheng
- Analyst: Whitneye Kidd
- SFHN CMO: Alice Hm Chen

Medicine Reviewers
- Cardiology: Mary Gray
- Chest/Pulmonary: Adithya Cattamanchi, Antonio Gomez
- Diabetes: Mimi Kuo, Audrey Tang, Debbie Heuerman, Sarah Kim
- Direct Endoscopy Access: Lukejohn Day
- Endocrinology: Lisa Murphy, Jennifer Park
- Gastroenterology: Justin Sewell
- Geriatrics: Anna Chodos
- Hematology: Brad Lewis
- Infectious Disease: Sarah Doernberg
- Liver: Mandana Khalili
- Oncology: Judy Luce
- Renal: Sam James
- Rheumatology: Judy Imboden
- TB: Julie Higashi, Chris Keh

Diagnostic Services Reviewers
- Diagnostic Mammo: Diane Robbins, Kelly Ross-Manashil
- MRI, CT, U/S, Fluoroscopy: Nancy Omahen

Other Programs Reviewers
- Genetic Counseling: Robin Lee
- Health At Home: Jane Drobot
- Neuropsychology: Chris Weyer-Jamora and faculty
- Respite: Shannon Smith
- Transgender Health Services: Barry Zevin

Surgery Reviewers
- Breast Surgery: Diane Robbins, Kelly Ross-Manashil
- ENT: Marika Russell
- General Surgery: Danielle Berthold
- Neurology: Sean Braden
- Neurosurgery/Neurotrauma: Sean Braden with Geoff Manley
- Orthopedics: Dorothy Christian, Diane Putney
- Plastics: Kim Esther
- Podiatry: Michelle Afzali, Erica McDaniel
- Urology: Ben Breyer and Amjad Alwaal
- Vascular: Shant Vartanian, Allicia Elias

Women’s Health Reviewers
- Breast Evaluation: Kristen Sligar, Dana Russ
- Gynecology: Rebecca Jackson and faculty
- Obstetrics: Naomi Stotland, Rebecca Jackson

Rehabilitation Services Reviewers
- PT: Dave Snyder, Bernadette Currier
- OT/ST: Karen Pitbladdo

Pediatric Services Reviewers
- Peds Developmental and Behavioral: Shon Jain, Janis Mandac-Dy, Amy Whittle
Thank you

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Questions

Care Integration Resource Center