RubiconMD

CASE STUDY

Reducing Risk in the Primary Care Setting with Virtual Specialists

eConsult+ delivers improved quality of care for patients across a range of specialties.

Cardiology | Nephrology | Endocrinology

Summary

For patients in need of specialty healthcare, navigating the process of locating and accessing the desired specialist is overly complex and frustrating. Current data shows **up to 50% of patients don't complete their referral to a specialist.**[1] The downstream implications of this are poorly managed chronic patients, rising health risks, and higher-cost, avoidable emergent care.

Opportunity exists for care organizations to consistently foster high-quality patient interactions that promote patient engagement and improved outcomes. This opportunity lies within a standardized primary care delivery model that integrates virtual specialists into the care team.

Virtual specialty consults allow the primary care teams to stay at the center of patient care while rapidly accessing expert insights from top specialists within a few hours. This allows the specialist to inform the care plan and improve the speed to care for the patient. Data from thousands of RubiconMD eConsults shows that this model is effective across **140+ specialties and sub-specialties.**

Key areas of impact

Clinical performance

improved care plans deliver a higher quality of care

Cost savings

reduce unnecessary medications, referrals, and services

Speed to care

top of licensure practice with more in-clinic care

Continuity of care

risk mitigation for multi-condition/ chronic patients

Patient experience

removes access challenges to high-quality specialist insights

Clinical education

clinicians learn and earn CME while utilizing virtual consults

The Challenge

There is a pervasive pattern of communication breakdown between primary care teams and specialists. Due to systemic challenges like health plan coverage variability, incompatible technology, long wait times, and staff burnout, getting a patient to the right specialist is often overly complex. Patient referral coordination is convoluted, ineffective, and frustrating for clinicians and their patients.

Primary care teams may assume that it's easier and less time-consuming to refer a patient to a specialist versus first seeking a virtual consult. But, the traditional referral process is broken. **For patients, the average wait time for specialty care access is 24 days, but sometimes it can be months.**[2] Data also shows referrals without a preliminary consult lead to gaps in care when patients own the burden of navigating the health system. This is on top of pre-existing access challenges, and why up to 50% of patients do not complete their referral to a specialist.[1] Coordinating care with a specialist is complex and overwhelming for patients, especially for patients with multiple comorbidities who need to see multiple specialists. When patients with an untreated or poorly managed condition delay or avoid care altogether, their risk level rises along with the likelihood of poorer health outcomes and ER utilization.

Fragmented care and missing information is another challenge with specialty referrals. About 70% of specialists report being unsatisfied with the information they receive and up to 50% of the time, they receive no information from the referring clinician.[3] This can impact time to care, the quality of the care plan, and costs. Low-quality referrals place additional, unnecessary burdens on care teams, patients, and the health system.

For specialty referrals:

70%

of specialists report being unsatisfied with the information they receive

50%

of the time, specialists receive no information from the referring clinician

When a PCP has limited knowledge of a specific specialty or current guidelines for that specialty, there is an opportunity for mismanaging the patient referral. Gathering needed information for the referral, ordering appropriate workups prior to the specialty visit, and using the latest evidence-based guidelines for an interim care plan requires a level of knowledge specific to the specialty that a primary care clinician may not have.

The Solution

To close gaps in care, especially for patients who are disproportionately affected by chronic conditions and face major access challenges, virtual specialists should be integrated into the primary care model.

Creating a new standard of care that encourages the submission of a virtual specialty consult prior to a referral offers the following benefits to the care team and their patients:

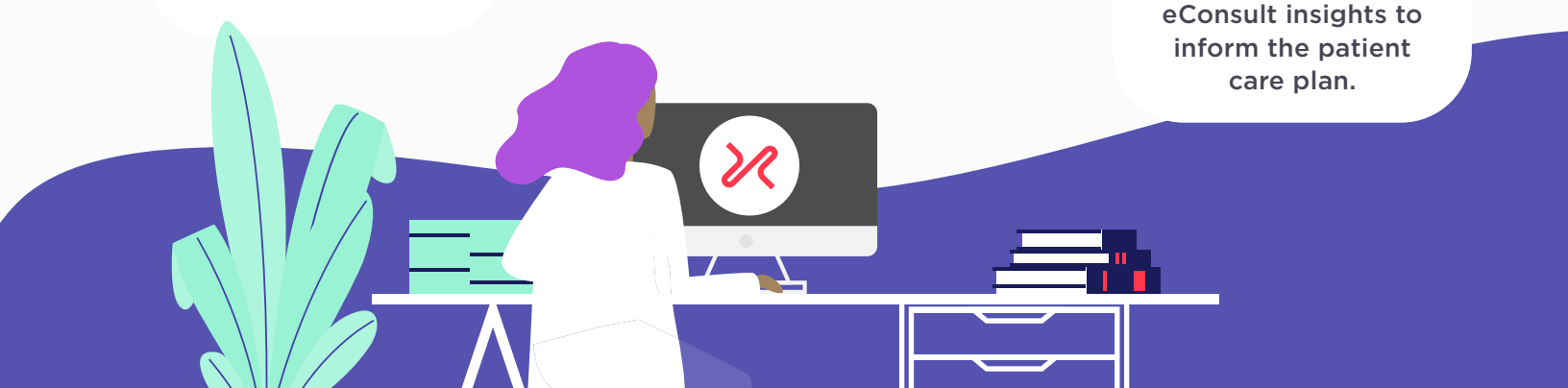
- Keep the primary care team at the center of care
- Deliver care plans with the latest evidence-based guidance from each specialty
- Improved referral handoff
- Avoid unnecessary services to reduce costs
- Create a seamless clinical workflow proven to help patients
- Improve patient outcomes

Since 2013, RubiconMD has been empowering primary care teams to access over 140+ specialties and sub-specialties. Our leading eConsult+ platform delivers specialist insights to clinicians in just a few hours.

70%
of the time, a referral is avoided

How eConsult+ works

1. **The clinician submits a question in the RubiconMD platform.**
2. **RubiconMD specialist responds within in ~ 2 hours on average and answers follow-up questions.**
3. **The clinician uses eConsult insights to inform the patient care plan.**



RubiconMD case examples:

These cases highlight the value of eConsult+ for the top three conditions affecting the Medicare and Medicaid population.

Case 1: Cardiovascular

73 y/o male

Clinical history:

- History of CABG in 2000
- No stents noted
- Still on ASA/Plavix and not sure why; only other cardiac hx is CAD
- Additional medications; lisinopril and metoprolol

PCP question:

Is there an indication for ASA/Plavix in the setting of CAD if CABG was 22 years ago?

Cardiologist response:

Hi, thanks very much for your question. There is no indication for the aspirin and Plavix at this time unless he has had a recent stroke or MI that would warrant the continuation of DAPT. Also given the new guidelines regarding aspirin use in the elderly over 70, there is no benefit in continuing aspirin as the risk of bleeding outweighs its benefits. Again, it should only be continued for secondary prevention, but it sounds like he does not have any recent events that warrant the continuation of either drug, so I agree with you that it is fine to discontinue at this time. Best of luck with his care and thanks again for your question.

Key outcomes of this eConsult:

- Specialist provided up-to-date guideline information
- Updated treatment plan to lower patient's risk of an adverse event
- Patient safety improved, discontinued use of unnecessary prescription
- Cost savings; health system and patient

Case 2: CKD

65 y/o female

Clinical history:

- Poorly controlled DM2 and HTN, now with CKD stage 4 (eGFR<25) and Cr=2.5 and nephrotic range proteinuria
- Now presenting to establish care with a new provider
- Not on ACE-I or ARB
- Hypertensive at visit

Recent labs

- Poorly controlled DM2 and HTN, now with CKD stage 4 (eGFR<25) and Cr=2.5 and nephrotic range proteinuria
- Now presenting to establish care with a new provider
- Not on ACE-I or ARB
- Hypertensive at visit

PCP question

My plan was to initiate lisinopril 5 mg and dapagliflozin 5 mg daily. Is it safe to start ACE-I for the proteinuria? The patient may not be able to fill (afford) SGLT2 inhibitor. Do you have any further suggestions on helping control proteinuria and the advancement of CKD?

Nephrologist response

Thanks for sharing this case. I suggest the following:

- Confirm not taking NSAIDS
- Check SPEP, hepatitis panel, urinalysis with sediment and renal US if not already checked
- He should be seen by a nephrologist. Discussion to include dialysis planning (typically done when eGFR is 20 but in this case with poor control of DM, HTN, and heavy proteinuria), he is at high risk for rapid progression to ESRD.
- SGLT2 inhibitor initiation at eGFR below 25 is not recommended. If patient was on SGLT2 inhibitor from before then doses can be continued even when eGFR below 25. I see that his eGFR is 25 and if dapagliflozin is going to be a new initiation of SGLT2 for him then I will likely hold off on that.
- He will need a robust diuretic for BP and volume control. Furosemide 40 mg daily will be a reasonable start with a plan to check chem-7, magnesium in 1 week after initiation.
- Confirm following low sodium diet
- If serum bicarb is low then start sodium bicarb 650 mg BID
- Check PTH, phosphate, calcium, Hg and iron studies. Abnormalities in these parameters will need further treatments to address CKD complications and also to reduce CKD progression risk.

Key outcomes of this eConsult:

- Specific recommendations provided by the specialist to properly manage a rising-risk patient
- Highlighted the need for a nephrologist visit and guidance on preparing for that visit
- Optimized care plan for aggressive CKD management, inclusive of dietary recommendations
- Provided guidance on the next steps for follow-up

Case 3: Diabetes

40 y/o male

Clinical history:

- Longstanding obesity (BMI 39), DM, and HTN with poor compliance with treatment over the years
- No prior records are available, but he reports being well-controlled on metformin and Trulicity in the past
- He reports Trulicity was stopped due to insurance and he stopped the metformin on his own
- He came to me in April 2021 with an A1c of 15. I ordered him a CGM and restarted his metformin and placed him on Lantus starting with 10 units and titrating up based on fasting glucose
- He took it for about 2 weeks then stopped, no reason given. He also stopped using the CGM.
- Recent repeat labs show an a1c of 14.3. He has started to work on diet and exercise. I restarted metformin 1000mg bid and Lantus titration again and he will follow me monthly.

PCP question

Should I have restarted the Trulicity and metformin or was starting the Lantus appropriate with an a1c of 15? Should I have tried multiple oral medications instead? What treatment would you recommend for this patient? Thank you.

Endocrinologist response

Thank you for this consult. If a patient like this walked into my office, I would consider/do the following: Clinical history and relevant data noted. Based on this, I feel that in this scenario, you raise an excellent point/question. As per the guidelines, with an HbA1c of 15, he likely needs all the above.

If I saw this patient, I would suggest first that he check blood sugars before meals and bedtime or have a CGM that you have done. I would also then start him on weight-based insulin- and a basal bolus regimen- we use 0.3-0.5 units per kg depending on how insulin resistant we think the patient is- so if the total calculation comes to 60 units, then 30 units would be given as basal insulin and the remaining 30 units would be divided into 10 units before meals TID AC - plus a 2:50 scale for example.

While he is on insulin, I would look at adding metformin, a GLP-1 agonist, and a SGLT2 inhibitor down the line, if no contraindications. This way as the other agents build-up, blood sugars are being controlled with insulin and as blood sugars improve, insulin can be weaned down if possible. Multiple oral meds will not bring the patient to target with an HbA1c of 14% or 15%. So, here I feel you should add pre-meal insulin and later withdraw it once the patient is doing better. I also strongly advise patients to check blood sugars because it can be dangerous to give insulin without checking blood sugars- this can predispose them to severe hypoglycemia or hyperglycemia. Patients should also be counseled on the signs and symptoms of hypoglycemia and treatment of this as per the rule of 15. I hope that this helps. Please do not hesitate to contact me with any questions or clarifications. Thank you.

Key outcomes of this eConsult:

- Specific recommendations provided by the specialist to properly manage a rising-risk patient
- Highlighted the need for a nephrologist visit and guidance on preparing for that visit
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Conclusion

Bridging access gaps means seamlessly integrating primary care with specialty care. For patients to successfully receive the specialty care they need, we have to make access to specialist insights easier — from the convenience of a primary care setting.

RubiconMD eConsult+ is proven to increase access to specialty care, lower costs, and improve clinical performance through virtual collaboration amongst care teams. The new standard of care should include a virtual specialty consult prior to a referral. This can be put into practice with eConsult+.

80%

of the time when an eConsult is submitted, the care plan is improved

About half of the time, insights obtained from an eConsult remove the need for a specialist referral. Not only is this far more convenient and less stressful for a patient, but it also saves both the patient and the health system money. When referrals do take place, patients are more likely to have an appropriate interim care plan before their specialist visit. RubiconMD data from over 7,000 users shows that 80% of the time when an eConsult is submitted, the care plan is improved. Patients who are seen by a clinician with access to virtual specialist insights are far more likely to be following an evidence-based, optimal care plan for their condition. For patients with multiple conditions, the benefits of this type of care are immense.

There are many aspects of healthcare that are in dire need of improvement, but actionable solutions aren't always within grasp or easy to implement. Access to specialists through eConsult+ offers a clear solution that can be enacted immediately. Success with implementation requires a customized approach to educating clinical teams, integrating with existing systems, and removing any friction points.

To learn how RubiconMD can help your organization, visit www.rubiconmd.com

References

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