Knitting a Tighter Safety Net: Intersection between Health Equity and Virtual Care (eConsult)

By: Nida Javed, Desiree Sanchez, Sajid Ahmed, Stanley Frencher Jr. MD MPH, and the **BETTER*** collaborative

Inequities in health are large, persistent, and exist across multiple disease outcomes. Health disparities research has concluded time and time again that Blacks and other minorities receive unequal treatment across every class of medical procedure (IOM, 2003). The lack of access to healthcare precedes the discriminatory pattern of care that occurs once minorities are in the health care context. Racist policies and systems interlock with the redlining of the 1930s as a prime example of racial residential segregation and a visible manifestation of systemic disinvestment in black neighborhoods. Native American reservations, disproportionate incarceration of Black and Latino men, and biases against immigrants whose first language is not English serve as examples of how complex these racial inequities can be.

These inequities are exacerbated when focusing on access to specialty care in particular. Firstly, specialty care referral processes vary across private clinics, community centers and health plans. Moreover, lack of specialists within a certain area and their reluctance to take underinsured patients creates an additional barrier for patients. Patient factors such as lack of transportation, language barriers along with systemic complexities such as long wait times heighten the glaring area direly in need of improvement: *provider to provider communication.* Rarely do the independent community primary care physicians have access to the health plan approved specialists' EMRs/notes or vice versa for continuity of care. There is limited feedback for these PCP clinics on prior workup for certain conditions or aftercare and follow up instructions. Low income and minority patients' different physicians usually serve in silode. It leads to a further lack of trust between physicians and between patients and their PCPs.

eConsult functions on the premise that the patients' primary care physicians serve as their medical home. While telehealth addressed issues of transportation for the patient and eased one barrier to access, it neither increased the severe gap in the number of specialists available to underserved patients nor reduced the number of unnecessary referrals or referrals without adequate work up.

Efficient virtual specialty care is not Patient → PCP and then Patient → Specialist. If addressing health inequities truly is the center of our focus with a patient first philosophy, then the most conducive workflow starts with the patient visiting the PCP either virtually or in person and then the PCP placing an eConsult via HIPAA secure portal to the specialist with regards to this patient's specific medical history, needs, and clinical question. This creates a continuous and bidirectional stream of comprehensible and usable health information for the patient. If the primary care physicians operate in a vacuum from the specialist with lack of awareness of best

practices for certain medical conditions, prior workup recommendations, or after visit summaries, the patients will suffer. Full spectrum virtual care offering is most efficient when it consists of a virtual visit between patient and a primary care physician which results in an eConsult between the PCP and the specialist regarding that specific patient. The case specific exchange can result in either the specialist guiding the PCP to address the patient's concern thereby eliminating an avoidable specialty visit or the specialist guiding the PCP on completing necessary workup before a video or phone visit with the patient and the specialist occurs.

To bring it to completion, eConsult can be supplemented by initiatives such as DocGo, with certain tests, care management, medications and treatments administered to the patient in their own homes. Additionally, partnerships between virtual and local specialists, rather than replace, serve to align and enhance the management of complex specialty care needs (e.g., surgery, in clinic procedures, and in person/in depth evaluations) allowing for further refinement of the specialty access continuum. These newly formed *virtual networks*, analogous to a "hub and spokes," better meet the needs of patients while more equitably distributing resources. For example, complex surgical care could be regionalized to centers of excellence, guided by virtual specialty consults via local primary physicians and followed up by their surgeons through virtual visits. Resultantly, specialists need not be everywhere for care to be accessible and effective anywhere. Specialty care needs can thus be met from home to hospital, in between and bidirectionally. In order for eConsult and virtual care to succeed as a means of eliminating health inequities, policies and procedures must begin to reflect the harmony between the technological and the clinical. Physician licensure across multiple states, credentialing practices, and specialty care reimbursements as well as managed care incentives for primary care physicians must reflect the ever changing landscape of healthcare delivery.

All models that incorporate eConsult provide pathways to expand access to specialty care without increasing the number of specialists by coordinating care better and by providing care through the right modality for the right condition.

*__B.E.T.T.E.R__., __B__uilding __E__quity __t__hrough __T__elehealth __E__ndeavors & __R__esearch