will be a fee to participate in and graduate from the defined track. Individuals who complete the entire track, with assignments, will receive a certificate. Track development is now underway with a targeted completion date of late 2016.

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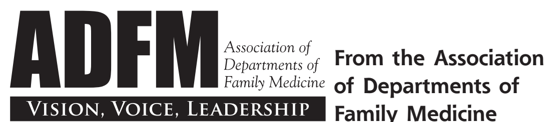

From the Association of Departments of Family Medicine

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ADVANCING THE PRIMARY/SPECIALTY CARE INTERFACE THROUGH ECONSULTS AND ENHANCED REFERRALS

As academic health centers (AHCs) respond to value-based purchasing, they are embracing a transformed role for primary care. As a case in point, 5 AHCs have formed a collaborative organized by the Association of American Medical Colleges (AAMC) to extend a model developed at the University of California, San Francisco (UCSF) that addresses the referral process between primary care and specialty care providers. This program, known as Coordinating Optimal Referral Experiences (CORE), incorporates 2 EMR-based innovations into the clinical workflow: (1) specialty- and problem-specific templates that provide pre-referral decision support to the primary care physician and establish a co-management agreement between providers,[1] and (2) "eConsults" which involve provider-to-provider asynchronous messaging.

With eConsults, the primary care physician sends a focused clinical question to a pre-identified subspecialist who then responds within 48 to 72 hours. The eConsult allows the primary care physician to provide care for the patient directly, provides specialist input in a convenient and timely manner for the patient, and reduces expensive specialty-driven care for minor issues, which in turn frees up the specialist for more complicated patients. Upon completion of each eConsult, both the primary care physician and the specialist receive a productivity (RVU) credit for their efforts. Overall, the model emphasizes and supports the role of the primary care physician as the primary provider for the patient, and emphasizes the rational use of services.

The AAMC received a Health Care Innovations Award from the Center for Medicare and Medicaid Innovation (CMMI) to disseminate this model in partnership with UCSF across 5 partner institutions (University of Wisconsin, University of Iowa, University of California San Diego, University of Virginia, and Dartmouth-Hitchcock). With the 3-year grant, each AHC will implement the program in 15 or more medical and surgical specialties. Departments of Family Medicine are deeply involved in this program, and have identified several early learnings.

Joint Learning and Defining "Borders" Between Primary and Specialty Care

Learning goes 2 ways between specialists and primary care physicians. For instance, cardiologists thought they were seeing all patients with palpitations, unaware of how many were being managed in family medicine and not referred. Primary care physicians receive education on best practices for common problems with a focus on "just-in-time" education. This educational effect is being extended through several efforts including newsletters featuring best eConsults; face-to-face inservice meetings between primary and specialty care faculty and residents; and through development of a searchable "best eConsults" archive.

More Effective Referrals

The program is facilitating more effective referrals as both the primary care physicians and specialists learn and clarify what information needs are present and which situations benefit from referral, continued monitoring, or management by the primary care physician.

Patients

Patient dissatisfaction with eConsults has not been a challenge. Providers are encouraged to give patients the option of seeing a specialist rather than having an eConsult placed if they prefer it. Most patients prefer the convenience and savings of avoiding an extra appointment, as well as the rapid receipt of specialist input via eConsults.

Payment

RVU credits for each completed eConsult are paid internally by the health systems. Additionally, UCSF and 2 of the new AHCs have already initiated pilots to have commercial payers and/or their own health plans reimburse for eConsults. Long-term, the model is best suited to value-based payment systems.

Health System Buy-In

Obtaining buy-in from health system leadership is essential to lay the necessary ground work, align priorities across many of the silos common to AHCs, and to provide payments. Valuing this exchange of cost-effective

coordination and communication in the ambulatory setting aligns financial incentives with good medicine.

Low Threat

Subspecialists must see enough patients face-to-face for eConsults to succeed in the current funding environment. The study sites report that their specialists are not threatened because demand is still substantial. Since eConsults provide for greater efficiency, specialists feel like they waste less time on referrals of marginal value.

The concept of improving communication between specialists and primary care physicians to achieve better care coordination and more appropriate use of specialty services is not new, but it has been hard to implement among busy clinicians whose incentives are not well aligned. To date, the CORE Program appears to be effectively working across a wide range of specialties. It is a user-friendly, scalable, and mutually beneficial method carried out in the current EMR environment. Greater alignment between primary care and specialty care is critical to building value-based health care systems. The CORE model supports the development and continual adjustment of this provider interface, and can serve as a real-time continuous educational source for the best practices of medicine. Evaluation of this innovation is ongoing across the collaborative, but published evidence on similar models has been promising.[2]

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References

1. American College of Physicians. The patient-centered medical home neighbor: The interface of the patient-centered medical home with specialty/subspecialty practices [Policy paper]. Philadelphia, PA: American College of Physicians; 2010.

2. Chen AH, Murphy EJ, Yee HF. eReferral: a new model for integrated care. *N Engl J Med.* 2013;368(26):2450-2453.

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PROGRAM DIRECTORS AND CERA: AN IMPORTANT RELATIONSHIP

How many acronyms do you know where one of the acronym letters stands for an acronym? An acronym within an acronym? We hope most family medicine program directors think of CERA right away. CERA stands for CAFM Educational Research Alliance; CAFM is the Council of Academic Family Medicine.

Program directors are critical to the ongoing success of CERA for 2 reasons. CERA facilitates about 5 surveys every year. Only the program director population is surveyed twice every year and receives more proposals than all the other surveys combined, which tells us that we hold the answers to a lot of important questions from the rest of the "family" of family medicine organizations.

CERA surveys contain questions that are submitted by a variety of family medicine researchers and educators. For example, the last CERA program director survey contained submissions from medical schools, community programs, program directors, residency faculty, social scientists, and pharmacists.

CERA understands that program directors have limited time; therefore, they accept only proposals that include a good hypothesis, are related to what program directors do, contain decent questions, and finally, will likely end up in a published paper. Additionally, the results are archived to help others answer their research questions.

For these reasons, responding to CERA surveys should rank as a high priority for program directors. This seems to be the case, as the PD response rate, at 38% for the first CERA survey of program directors, has increased to over 60%. This is great; but clerkship directors' response rate is more than 90%!

Another reason program directors are critical to the ongoing success of CERA is *relevance*. As program directors, we know the relevant questions to ask in order to advance family medicine education. We are in the midst of tremendous changes in both our clinical and educational infrastructures, and there is very little evidence to support any of the educational changes. We as program directors need to do our part to ensure our residents are still learning how to provide high-quality care to patients in the face of changing environments. CERA surveys can be excellent tools along these lines.

Most program directors think of themselves as clinician-educators, and CERA gives us the means to ask questions in a rigorous way. Once a proposal is accepted, CERA provides institutional review board approval through the American Academy of Family Physicians (AAFP) as well as experienced mentors. This collegial support from the rest of our family medicine community through CERA is invaluable as program directors expand our scholarship into the realm of educational research. An added benefit of CERA involvement is that it also provides an excellent opportunity to help you and your faculty meet the