

NCTRC Webinar - Increasing Acc... Via Virtual Curbside Consults

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Aria Javidan, Mary Butler Fleming, Reid Plimpton

Aria Javidan

Hello. My name is Aria Javidan, and I'm the project manager for the National Consortium of telehealth resource centers. Welcome to today's webinar increasing access to specialist expertise in rural Maine via virtual curbside consults. Today's webinar is hosted by the Northeast telehealth Resource Center. These webinars are designed to provide timely information and demonstrations to support and guide the development of your telehealth programs. Just to provide a little bit of background on the consortium located throughout the country, there are 12 regional telehealth resources and two national one focused on telehealth policy and the other on telehealth technology assessment. Each serve as focal points for advancing the effective use of telehealth and supporting access to telehealth services in rural and underserved communities. The consortium is collecting success stories from organizations, patients and providers who have benefited, who have benefited from telehealth, with support from a telehealth Resource Center, share how your TRC helped make telehealth work for you, for a chance to be featured along with your organization in the consortium newsletter. And then a few tips before we get started today, your audio has been muted. Please use the Q and A function of the Zoom platform to ask questions. Questions will be answered at the end of the presentation. Please only use the chat feature for communicating issues with technology or communication access issues. Please refrain using chat to ask questions or make comments. Please note that closed Captioning is available and that is located at the bottom of your screen. Today's webinar is also being recorded, and you will be able to access today's and past webinars on the NCTRC YouTube channel and the NCTRC website@telehealthresourcecenter.org with that, I will pass it over to Reid Plimpton, program manager for the Northeast telehealth resource who will introduce our speaker for today.

Reid Plimpton

Thanks, Aria. Yeah, as ARIA mentioned, I'm Reed Plimpton. I'm the program manager for we call it NCTRC, the Northeast telehealth resource center. We serve all of New England and New York. And if you haven't met me or my colleagues, we would certainly love to hear from you thrilled to be joined by Mary Butler Fleming here and letting her have a chance to share some of the awesome work that they're doing up in Maine. Mary serves as the chief operating officer of Community Care Partnership of Maine. Since joining the organization back in 2018 she's held multiple roles, including serving as the organization's compliance official. She holds degrees in both public health and business from Brown University as a Bangor native and a lifelong Mainer. She's deeply committed to advancing public health and community well being. Recently, in 2025 she's recognized by Maine businesses, 40, under 40, and in early 2026 she completed a capstone project on implementation of artificial intelligence, or AI in healthcare through the Harvard Medical School's executive education program, and was selected as one of by her peers and faculty, is one of the top projects. Is the top project. Mary's contributed to a number of national and regional discussions on value based care policy, and presented a number of forums across the nation and across our region, and I think has a really powerful use case here that is serving a bunch of residents in Maine in need. And I think with that, I will turn it over to her to share some of her wisdom.

Mary Butler Fleming

Thanks, Reed. Good afternoon everyone. As Reed said, my name is Mary Butler Fleming. I serve as the chief operating officer of Community Care Partnership in Maine, and I'm excited to be here with you all and to share a little bit about our organization's journey implementing virtual curbside consultations over the last three years. This initiative is something that's been really well received by primary care providers across our state, and I think the main reason for that is that it's helping to address one of rural Healthcare's most pressing challenges, which is very limited access to specialist expertise. So in the next hour or so, I'll walk through how we've leveraged Curbside Consult technology to connect primary care providers with specialists in real time, and I'll also talk through some of the metrics that we've tracked as part of this intervention, which has improved both curbing avoidable utilization and improving patient outcomes. So I think with that, we can advance the next slide, and I've just got a couple of disclosures here. So before we begin, just want to acknowledge and the funding and support that made this work possible. So this presentation was supported by awards from the office for the Advancement of Telehealth. I personally have no conflicts of interest related to the products or services that are discussed today, and the information that I'll be sharing is for informational and educational purposes only. And just want to extend my thanks to all the colleagues on the line who are taking time out of their schedule to attend this session next slide. So by the end of this presentation, you will be able to accomplish for the learning objectives here, so you'll be able to understand some of the unique challenges that are facing healthcare delivery and how virtual, curbside consults and similar interventions can help address critical gaps and access to specialist expertise. Second, you'll get some insight into CCP, Ms implementation approach and the operational model that we've used for this program. You'll also be able to evaluate the evidence based benefits and outcomes from multiple different stakeholder perspectives. And I'll also share some strategies for sustaining and scaling these programs, which is, can be a challenge and is really essential for long term success. Next slide please. All right, so before I dive in, I just wanted to provide a little bit of context about our organization, community care partnership in Maine, we are a clinically integrated network and accountable care organization with a really strong focus on public health. We're substantial in scope and have a statewide presence. So we have 22 member organizations in our network that so I said 22 in total, and 17 are federally qualified health centers, and five are community and critical access hospitals that span 163 service locations across the state. Together, the network participates in 12 different value based payment arrangements, including the Medicare Shared Savings Program. We've generated about \$100 million in gross savings and MSSP since 2016 about 350 primary care providers and the members in our network collectively serve about a quarter of the state's population on an annual basis, so pretty significant presence across the state. So as an organization, we are primarily focused on implementing and scaling innovative care delivery models that improve patient outcomes and focus on effective cost management. And the virtual curbside consults that I'll talk about today are one example of that approach and action. So next slide, so to understand why the virtual Curbside Consult model has been so impactful for us, we first need to understand, you know, Maine's unique health healthcare landscape. So Maine is both the oldest in the most, most rural state in the nation, so about a quarter of our population is over the age of 65 in more than 60% of our residents live in rural areas, and we're facing a really dire lack of access to specialists, particularly cardiologists, rheumatologists, endocrinologists in particular. And wait times routinely exceed nine to 12 months for those specialties in particular. Additionally, much of our clinician workforce consists of new to practice, nurse practitioners and physician assistants who are sometimes working without a medical director on site. And unlike a lot of the large health systems, our network is comprised of mostly primary care focused, federally qualified health centers, so they don't always have co located specialist colleagues that they can do, you know, quick hallway consults with. So these factors create challenging circumstances for both of our providers and our patients. So you know when we know, and it's well documented in the literature, that when there's not enough access to meet demand for for specialists, care is delayed, which has pretty substantial negative impacts, not only on total cost of care, but more importantly, on on care quality and health outcomes. So that brings us pretty well into our next slide. So the approach, so what exactly are these curbside consults that I keep mentioning? So they are real time, secure, digital

interactions that connect primary care providers directly with specialists through a mobile app, a laptop or an EMR interface. So the platform we use is called PicassoMD, providers get access to a specialist within 30 seconds. So in CCPM's case, our data says about 14 seconds for a PCP to connect with a specialist, and they're able to engage in a synchronous dialog and get actionable guidance and recommendations right on the spot to help them resolve challenging cases. So when I describe the interface, it's a lot like getting on a ride share app like an Uber or Lyft, believe it or not. So you could select the specialist that you'd like to consult with, and in seconds, you're pulled into a synchronous HIPAA compliant messaging platform. You have the ability to send photos, to do voice to text transcription. It's intuitive. It's pretty easy to use, and the providers have really loved it for our pilot with PicassoMD, as you saw on the previous slide describing CCPM's got quite a few sites, and so we wanted to narrow in our focus for, you know, who should start with first? So we focused first on ultra rural sites. We have some FQHCs that are located, you know, on, on a little literal Island. You have an hour so, very, very right away from from the mainland. So we focus on sites like that, practices that had a high proportion of new to practice, NPs and PAs, sites without co located specialists and sites without co located medical directors. So those were the priority sites for the first phase of the intervention. We do tend to see three years into this work that NPs and PAs are using the tool at about a rate of 2x the medical directors are MDs and DOs rather and the utilization of the tool does tend to be higher at locations without a medical director on site. In terms of the use cases for providers using the tool, many of them are using the tool at the point of care. So when they're contemplating whether to send a patient to the emergency department or refer them to a specialist, maybe they're unsure about what labs or imaging to order or what medications to prescribe. So we see the bulk of the interactions happening at the point of care, but they are sometimes using the tool in advance of or following a patient visit, so it'll afford some flexibility for when they're using it as well. It looks like we may have lost the slides.

Aria Javidan

Sorry about that. Looks like my internet cut off. I'm restarting. Okay. I

Mary Butler Fleming

think we can go right into the next one. All right, perfect. So getting into the benefits of this model, they're really extensive and sort of multi stakeholder benefits. So for patients, we're seeing improved access specialist expertise. Patients don't have to leave their community, which is huge in rural Maine, where going to a specialist visit means, you know, driving two to three hours each way and often incurring some significant out of pocket costs. Patients are getting faster diagnoses, more optimized therapy. You know, obviously this translates into improved health outcomes and enhanced patient safety. And then from a cost perspective, we're seeing significant improvements in avoidable referrals and emergency department visits. So I'll share a little bit about that later, which, of course, has significant financial implications, particularly their value based care model. And then, importantly, the providers, the PCPs, are maintaining their central role in the care coordination, which we feel is really important. So this isn't about replacing PCPs, it's about empowering them with specialist expertise when they need it the most. So I would say those are, those are some of the main benefits of this intervention. So on the next slide, who benefits from a model like this? So when we map out all the different stakeholders who benefit from Curbside Consults, the ecosystem is really remarkably broad. So obviously patients and their caregivers benefit directly. Primary care providers gain confidence and expertise. ACO is like CCPM that are in value based payment arrangements. Our member organizations, hospitals and health centers, health insurance payers, you know, health adjacent entities, even state and federal governments, benefit through reduced Medicare and Medicaid spending. And, you know, overall population health and specialists on and off the platform benefits. So when I say specialists off the platform benefit, I mean the cases that they are CIN, are sort of screened out if they're unnecessary by that Curbside Consult, and they're more appropriately worked up if they are indicated, they're getting guidance, the PCPs are getting guidance on what needs to be done in advance of the specialist visit to make it most efficient and effective. So specialists are benefiting as

well. So when I get into the numbers, I think they really tell the story on this next slide here, and they speak to some of the compelling outcomes. So since October of 2023, we now have 100% utilization across the 22 CCPM member organizations. So there are well over 300 primary care providers across the state using the tool, at this point, we've completed over 5700 consultations in that in that time frame, and our provider satisfaction rate is pretty darn close to 100% which is really extraordinary. Then, from a financial perspective, we've generated about 1.25 million in estimated cost savings through avoided utilization, and this is largely attributed to avoiding about 2000 unnecessary specialist referrals and about 168 emergency department visits. So you know, all those metrics and numbers are great, but I really like the testimonials on the right hand side, which are from two of our clinicians across the network. So Dr Megan Brewer, who practices in the Greater Portland, Area in Maine, said that it is really not an exaggeration that this tool has saved patient lives, and importantly, you can see that they feel a renewed sense of joy and that this is being used broadly as a recruitment and retention strategy for a lot of our FQHCs and hospital members. So transitioning to the next slide here, I pulled some more data. Just gives you a little bit of insight into the different specialties that are offered. I think it's about over 30 specialties offered on the platform at this point, and you can also see the consult volume by specialty of CCPM's providers over the last several years. So sort of intuitive finding here, which is that the specialties that have the highest volume of consults correlate directly with what we're seeing as the longest wait times for specialties. So it's been a game changer for PCPs to be able to consult with these specialists in real time without having to, you know, send their patient into a nine plus month queue. So some helpful information there. On the next slide, I'll talk a little bit about some outcomes overall. So have achieved, you know, some significant milestones over the last three years in terms of program sustainability and growth. So as I said a couple of slides prior, we now have statewide utilization. 100% of our members now have providers using the tool. Another thing that I get a lot of questions when I give presentations on this topic is who pays for this? So this is not something that the patient pays for out of pocket. It is free to the patient. So at the beginning of this intervention, CCPM had an arrangement where we were paying per consult for our members, and then we were successful in demonstrating the value of this tool to our payers. So we now have several payers that we have value based payment arrangements with who are covering the cost of this service for their patients and what we have not been able to cover with payer support, we have gotten grants to cover so there is no cost to patients and there is no cost to our members in our network, and that's something that we're really proud of. Another thing that we're really proud of is that this project has really been a springboard for additional collaboration opportunities to bring more specialist expertise into the state of Maine. And so this momentum is something that's, you know, translated directly into expanded partnerships and new initiatives, which I want to talk about on the next slide. So looking ahead to 2026, new and expanded directions for this work, the first thing that we're doing is we are working on establishing longitudinal collaborations between PCPs and specialists on the platform. We know that sometimes one Curbside Consult doesn't do it, particularly for patients with high risk chronic conditions, and having a sense of continuity in those conversations between the PCP and the specialist can be important. So that's one thing that we're building capacity to be able to do. The second thing that we're doing is we're proactively identifying high risk and or suboptimally managed patients for targeted short term specialists input, rather than waiting for the PCPs to engage in a consult and then as a clinically integrated network. The other thing that we do have is EMR access across our membership, as well as access to a statewide health information exchange so we're able to proactively identify and tee up the pertinent details of cases for review, almost like a sort of a mini me consult, in a way. And you know, like many organizations, we're thinking a lot about how to responsibly and effectively integrate artificial intelligence or AI into our work, and of course, this extends into the Curbside Consult initiative, so we're exploring how to potentially integrate AI clinical decision support tools into the workflow in order to reduce lower acuity specialist consults. And then concurrently to that, we're working to develop clinical decision support tools to help optimize timely, appropriate and prioritize specialist referrals. So that's work that we're doing as well. And then last, but certainly not least, we're working with PicassoMD to hopefully pilot direct telehealth visits via PicassoMD later this year for some

of the highest demand specialties. So those involved in healthcare operations know this is no small task. You know, there's licensing and credentialing network status with the payers, all that fun stuff, but it's certainly an exciting proposition that could have a really meaningful impact on access in our state. So we're looking forward to continuing to build and plan towards that in the coming months. So that's what's what's planned for the year ahead. So I think I'm close to the end on my slides. So really appreciate everyone's time. I know I wasn't even close to the hour, so we've got a lot of time for questions, but really appreciate everyone taking the time to be here. I hope it's given you some, you know, practical insights about how this has worked for our organization. And I put my email towards the bottom if you have questions or would like to, you know, discuss further. I'm happy to connect.

Reid Plimpton

That was awesome. Thank you, Mary. Yeah, I think to Mary's Point, whether we have plenty of time for conversation here, we definitely. I've done presentations with Mary before. I think we both enjoy it when it's a little interactive. So please feel free to put question questions in the Q and A. We can revisit slides if folks need things like that. We do have a couple of questions coming in here, Mary and I will tackle them as they come in. I'll share them with you. I'll delegate that so you can just think about the answers. Um, so as a reminder, we do have the Q amp a function, I'm going to start with the question that came in in the chat, because I think it's easier for everybody I can I can mark whether or not we're answering them, live in the Q and A and everything else. So first question, does your work also support inpatient or acute specialist needs? You're muted?

Mary Butler Fleming

Mary, sorry about that. That's a good question. So right now, the tool is exclusively used in the outpatient setting.

Reid Plimpton

Yes, I will tack on there. Is that something that's sort of in the long term strategic plan for you guys to consider those other settings? Or do you think that you'll stick primarily to outpatient based off current utilization and need of your members?

Mary Butler Fleming

I think there's certainly a use case for the inpatient setting because of our membership composition. We're mostly FQHCs. We've got, you know, some hospital presence, but only five out of the 22 are hospitals. So really, what we found the most pressing need was for was in the in the office visit setting, and that's why we focus on, you know, the outpatient side of things. I think if we were to design the intervention for the inpatient setting, the metrics would, would would be different. But I think that's it's something we've, we've talked a little bit about, and something I think we would certainly be open to exploring in

Reid Plimpton

the future. Sure. Thanks. All right, now we have some questions coming in, so I'm going to start at the top here is behavioral health included in the options for specialist referrals. Yes, it is. And how so do you have anything else you want to add there to move on to the next one? No, short, I'll keep it short and sweet. Yeah. Deal. How are your specialty providers credentialed with the FQHCs? Or does that work? Is that part of the credentialing goes through you guys? Or can you talk a little bit more about that process,

Mary Butler Fleming

yeah, so they're not credentialed through the FQHCs. That's something that's managed all by PicassoMD. So that's not something that we're directly involved in. And because they're not, they're not

billing from the FQHC either. It's less of a concern. Because it's a PCP to specialist interaction that makes sense, sure.

Reid Plimpton

Um, I think this question may be very similar in your answer, but, uh, who covers the malpractice insurance for these consults?

Mary Butler Fleming

Yeah, that's a really good question. It's something that we explored extensively when we were thinking about using, using this tool. And so the it's, it's, the way I frame it in my head is, is very similar to if a PCP did a hallway Curbside Consult with a specialist, right? Hey, I've got this patient not quite sure how to do, how to manage it. What would you recommend? They the specialist gives their input as part of the hallway consult, and then the PCP ultimately decides the plan of care, so the liability, the malpractice, etc, that still rests with the PCP, so it's not absorbed by the specialists on the platform. If that makes sense.

Reid Plimpton

Aria, it does, and I'm glad we came up, because it was the opposite of what I expected. So no, that me, um, I think you touched on this in your presentation. But could you talk a little bit about the the time lag between the console request and the specialty provider availability? Does that differ by provider type, so on and so forth.

Mary Butler Fleming

Yeah, that's a good question. The average is from when you click, you know, I would like to talk to a cardiologist, the first available cardiologist, it's about 14 seconds to when the chat pops up. On average for our data, for PicassoMD, Ashley, they say closer to 30, but of the 5700 or so that we have done, we found in about 14 seconds, is the average for the PCP to get connected to the exchange with the specialist,

Reid Plimpton

incredibly fast. Sorry. I was hoping the dog would stop barking by time I unmuted. Added curiosity to tack on that. What does it look like for the provider, is it on their laptop, where they're likely already taking notes, or is it on a secondary device? That's a

Mary Butler Fleming

good question. There are a couple of different options. There's a mobile app that they can use, and there's a web based version. And then there are different levels of integration with some EMRs. So some EMRs, they have a Picasso MD, you know, button that they can press and initiate the console in the cases where there is EMR integration. It's convenient, because the transcript can get automatically stored as part of the patient record. That's another thing that I get asked about a lot is like, how are you documenting the the transcript and pulling that in? There's a couple of different ways that we do it for the members that have I should preface my answer by saying all the different members have different EMRs and different instances of their EMRs. So it makes things a little bit complicated for the members that have an EMR that's integrated with PicassoMD that transcript being part of the patient record happens automatically behind the scenes for organizations that are using the web based version or the mobile version. We have coordinated workflows with the quality teams of each of the member organizations, and they're batch uploading the transcripts to the patient health records on a cadence, whether it's bi weekly, monthly. We set that up with each of our practices. So it's not a perfect workflow, but that's what we're doing for now, to have the transcript part of the record, and we advise providers to

just document and reference that they had a Curbside Consult via PicassoMD. And so that's generally what they're doing in their documentation.

Reid Plimpton

You kind of took two questions right, right out of the chat there. Thank you. Yeah, EHR, integration was one, and then documentation was one as well. And so, I mean, now that you know that those were also questions that were asked, Do you have anything else to add? I feel like that was pretty thorough.

Mary Butler Fleming

No no, nothing to add. But if people have more specific questions, I'm happy to answer it.

Reid Plimpton

Yeah, I think I'm glad the way this is working out is great. There are definitely still questions coming in. Is there any phi exchanged during the consult?

Mary Butler Fleming

There, the way we've designed it, you can customize it. What we did is so the short answer is yes, there is phi shared. Name and date of birth are shared to go into the console. No insurance information is shared because we didn't want to bog down the providers. We wanted to make it like as easy as possible and as frictionless as possible for them to initiate the consultation with a specialist, so they just put in name and date of birth, and we have, you know, all of the necessary protections and agreements in place with PicassoMD for us to be able to share data in that way, and then what we do on the back end is we have centralized quality staff that can identify that patient to a particular payer or health plan. So we know, you know, how many are anthem versus Medicare, etc, and we collect that data and use it to advocate to the payers for cost coverage for the service, but it's just name and date of birth that go into the inquiry.

Reid Plimpton

Sure, thank you. Um, I feel bad because there, I won't tack on this time because there are a lot of questions coming in, but I am curious about some of those conversations. Go with the payers. If we have time, we can revisit. I appreciate the familiarity with Maine in this next question, can you talk a little bit about your utilization, dispersal across the state? Is it primarily in like the locals, you know, the cities like Bangor, Portland, maybe Augusta or Lewiston? Are you seeing, you know, reach as far as Machias or Caribbean?

Mary Butler Fleming

Yeah, there. There's a slide that has a map with, like, these little bubbles on it, blue bubbles. Can't remember what slide it is, but we can pull the slides back up. It's actually like, I don't know the name of the graph, but it shows you

Reid Plimpton

the utility, yeah, Aria, if you are able to it is slide 11.

Mary Butler Fleming

Thanks, Reid, what we I'll speak to it while it's being pulled up. There's utilization across the state. What we tend to see drives utilization of the consults is not so much the geography of the PCP seeking the consultation, but the characteristics of the PCP and the practice in which they are providing care. So if they are an NP or PA, they are more likely to use the tool. If they're operating in a practice without a medical director on site, they are more likely to seek out the consultation. If they are operating in a practice that doesn't have specialties, more likely to seek a consultation. And then we see payer mix

informing the work a little bit as well. So you can see the biggest blue.in like Central Maine. That's the greater Bangor Aria. I think that that's probably just a product of that's where our largest member site, our largest hospital member, is sitting, so most PCPs on the tool. So I think there's a number of factors, but everybody's using it, I would say those are the factors that drive the variance in utilization. If that's how? If that helps?

Reid Plimpton

Sure, yeah, no. And I think the map is really helpful for those that maybe are less familiar with Maine. Down in the bottom there the bottom left corner, you can get from that corner of Maine to New York City faster than you can get from that corner of Maine to the top right bubbles. There it is. It is a tall state

Mary Butler Fleming

and read. People who aren't familiar with Maine might be wondering why, like, the upper left is no dots, and it's because, like, literally, no one lives there. Like, it's just trees.

Reid Plimpton

So trees and moose, yeah, yeah, no, thank you. Yeah. It's hopefully that's helpful context for some folks I do so I'm gonna hop a little bit out of order here and get some of the quick answers out of the way so you have time to dive into some of these more intricate questions. The specialty providers. Are they employees of PicassoMD? Are they like also working at health systems throughout the state or throughout the nation?

Mary Butler Fleming

I think it's a mixed bag. I know a lot of them are also employed by other organizations. So they're, you know, practicing cardiologists at a large health system, and they can sort of pick when they're on and available on the platform, so they can do it suboptimally to a full time job. It's my understanding that many of them are doing that store.

Reid Plimpton

Okay, back to behavioral health. Here for a second, it was the not clear on NRTRC slide right above this with the pie chart, it was not necessarily clear to one participant where behavioral health is fitting on your volume by specialty, is it in the other section? Is the first part of the question? And then any thoughts you have on why? Maybe that is a lower utilization, knowing the very real need for behavioral mental health services across Maine and across the nation?

Mary Butler Fleming

Yeah, I think it's fitting in the other, I think behavioral health is a newer specialty that they brought onto the platform, and this pie chart is reflective of, like, all time utilization. So it could be just that, you know, if it's newer, and these other specialties have had, you know, three years versus that worth of data, and the behavioral health is new, or it could be crowding it out, because I do agree with you, it's definitely, it's definitely a need. I will say a lot of the FQHCs in our membership offer pretty comprehensive care at their site. So many of them have integrated behavioral health co located with primary care oftentimes. So I think that may be why you're seeing lower than anticipated console volume, again, just a product of the unique membership composition of R CIN, sure.

Reid Plimpton

Yeah, no, that makes sense. Aria, if you don't mind, I'm just looking through the questions here. You the question about acronyms, and I'm often guilty of doing acronym soup. Could you just throw another question in there that highlights the specific ones you want us to thoroughly explain? Mary back to you. I two different questions on the referral realities. First one, are providers kind of randomly assigned to

the first specialist in that care Avenue, or are they able to, you know, kind of establish a rapport with a specialist and request that specialist the next time they need that's a

Mary Butler Fleming

really good question. The default is first available, and providers can set preferences. So say, I was a PCP read and you were a cardiologist, and we had a really great interaction. You were really helpful to me. I can set my preference to say anytime read is on the platform and accepting consults go to him first or anybody else. So it defaults to the first available, but you can customize your preferences.

Reid Plimpton

Very cool. Okay, yeah, no. And, I mean, it also is great that, you know, you're not stuck if, like, you know, in that scenario, if I'm not available, it's gonna immediately try to patch it with somebody else. Is sort of the way I'm understanding it.

Mary Butler Fleming

Yep, yep. So sort of preference based

Reid Plimpton

algorithm from your experience and from you know the work that you're currently doing, what percentage of like traditional referrals for specialties that are currently considered under econsults could be achieved through this more virtual, virtual Curbside Consult type encounter that you're utilizing.

Mary Butler Fleming

That's a hard one. I don't know if I'd be able to assign a percentage to it, but I would say a significant percentage of the referrals that go through to specialists right now are unnecessary. One of the nice things about the PicassoMD tool is when a PCP opens up the consult, it asks you, What was your plan going into this case? Were you going to manage in the primary care setting for to a specialist and or set go to the ED right? Those are the three options. And then it asks you that same question at the conclusion of the consult. So how we get that cost savings estimate and the counts of the avoidable referrals to specialists is by tracking that pre post data, and so I'd have to go back and look at our data to see how many PCPs went in with the intent to refer to a specialist versus afterwards. I know we've avoided about 2000 but I don't know what percentage of the total referrals that would represent. My friend is a pulmonologist, and he practices in Bangor, and he said his patients that he sees follow a rule of thirds. 1/3 probably don't need to be seen by him. Could be managed in the primary care setting. 1/3 probably do need to be seen, but they're not worked up appropriately. So something else, labs, imaging, something else needs to be done to have an effective visit. And then 1/3 are clinically indicated and ready. So I think there's probably some ebb and flow by by specialty, but I think his, his adage, is probably not, not all that far off.

Reid Plimpton

So sure, yeah, no, that is interesting. And I mean, the other kind of pro, if you will, for this encounter, depending on how you're doing your eConsult is just the timeliness, right? Like some a lot of E consult models utilize, like, a 24 hour response rate or things of that nature, as opposed to getting it in real time while the patients still directly in front of you, right?

Mary Butler Fleming

Yes, exactly. That was something that we had conversations about early on. And thinking about piloting this intervention was like, Oh, well, like a lot of our members are already using econsults, and our with the conclusion that we came to relatively quickly is like, these are differentiated use cases, and there's space for both of those tools, because there are many things that are maybe Too complicated. There's

too much complex medical history. It would not be appropriate for Curbside Consult, right? You can only distill so much information into this synchronous chat. You know that may be one, if you can be patient for, you know, the the day or so, a Curbside Consult or an E consult rather, would be more appropriate versus like, I'm gonna send this patient to the ED right now, unless I get, you know, advice otherwise, and you know, an eConsult not going to help you there. So we did a lot of education with our medical directors across the network on like, what are the differentiated use cases for the different tools in your toolbox, whether it's an eConsult, Curbside Consult or otherwise? So I think that that helped people decide which which tool they were going to seek out?

Reid Plimpton

Sure, yeah, that's really helpful. So you just touched on, I'm really going out of order here, but you just touched on a question that was asked that I'm going to paraphrase slightly on, but if the console, you know, results in them suggesting that they're they are in need of an in person specialty care, right? So you just reference Pulmonology. Maybe they need to go get some some workups done. Is there any sort of communication around severity, or, you know, timeline of that visit? Like, do they need to go to the emergency department right now? I agree with you, versus, you know, yeah, they can be on a waiting list, and this can happen anywhere from unfortunately, two to six months later. Type of deal, right?

Mary Butler Fleming

Yeah, we're working on that. That second piece, the like prioritization and urgency, etc, that's something that we're working on in 2026 right now, the specialists can one off advice right? Like, here's what should be done in advance of the visit. Here's, you know, the level of urgency. And we have anecdotally found that if PCPs include information in the referral note that they have consulted with another cardiologist or Pulmonology, and this is the recommendation that they got that they send it through. They've been getting less pushback on taking the referral. So I think that that's that that another colleague has served as sort of a gatekeeper and has vetted the case, I think helps a little bit, at least. That's what we're hearing anecdotally. Sure?

Reid Plimpton

Yeah, you've done your homework before you made the referral. Right type of thought process. Here's a here's a relatively light air lift than the last couple is there any video or audio video encounter? It's possible within the platform, within PicassoMD that you're using now, or is it all text based?

Mary Butler Fleming

It's all text based. You can do voice to text, which a lot of providers like, because that's like a lot to type out. So it does have that functionality, no audio visual right now, but I think that's something they're building towards as part of the infrastructure built out to be able to offer direct patient to specialist visits, but my understanding is not at present, sure.

Reid Plimpton

Okay, yeah, that's helpful. Are the specialty providers that are serving the main sites, specifically from Maine, other states across the nation? Do you have any international providers that you know of that are serving,

Mary Butler Fleming

to my knowledge, they're all US based. Some of them are located in Maine, but that is not necessary to go on to the tool. So some are in Maine, not all. Many of them are from across across the country,

Reid Plimpton

sure, and then they work with the vendor to deal with licensure considerations.

Mary Butler Fleming

Exactly, yeah, the vendor is vetting all of the all of that, credentials and licensing, etc, to bring them onto the tool.

Reid Plimpton

Who is the covered HIPAA entity in this model.

Mary Butler Fleming

So that's PicassoMD, so CCPM is a business associate of the covered NBS, which are our members? Great.

Reid Plimpton

Thank you. How are the fees structured for the consults? And I know this is a little bit different for you than if, like a health system took it on independently, right? It's a part of the ACO model and the collaborative, the membership model that you have. But could you talk a little bit about that? How are the fees structured? Is it per encounter, by specialist?

Mary Butler Fleming

We pay per consult, and we get, like, a volume discount and a nonprofit discount as part of the work, and then anything that is paid for by the payers. For their patients, they contract and negotiate directly with CAHs CIN. We don't step into that. We basically advocate for them to cover the service for their patients. We articulate the value to them as a payer, we show them the data, right? This is how many of your patients we have provided the service for. This is how many ED visits have been avoided. This is the cost savings to you. And then we do the warm handoff, and they negotiate. So we've done that three times successfully now. And for our case, we pay, like I said, per consult with a not nonprofit and volume discount, and then we pay under a master services agreement so the ACO or CIN holds the relationship with PicassoMD, and then any member of our network can get access To the platform for free.

Reid Plimpton

That's great. Yeah, and so just to be crystal clear, you're not limited by the amount of back and forth encounters, if you will, between in a singular console. The console's not time limited or question limited, or anything like that.

Mary Butler Fleming

No, they're typically like three to three to seven minutes long, depends on how complicated they are, but we pay like per consult, no matter how long or short they are, or the type of specialty they are, anything like that.

Reid Plimpton

Okay, that's great. Thank you. You talked a little bit about the quality team involvement, both between you and your member sites, and I'm imagining some of this falls in there. But how are you ensuring the specialist information they're providing is, you know, up to date with the newest guidelines or the newest expertise that's available in their in their topic?

Mary Butler Fleming

Yeah, that's a really good question. So our medical director does like batch reviews, so we have access to all of the transcripts on a centralized database. So our medical director overseas, you know,

reviewing them for accuracy, the provider satisfaction score gives us an indication as well, like if there was a satisfactory response, and then PicassoMD also has a QA, QI process for evaluating the transcript. So we're sort of doing it on both sides of the relationship.

Reid Plimpton

That's great. So there's this next one's kind of a multi parter, and I'll pause in the middle of it, but I do want to, I want to read a verbatim because I think the perspective on it is important. So coming from the patient kind of perspective, but obviously a healthcare professional that's interested enough to join us to Saccone, based on my recent experience with specialist care, I the impression that they they don't talk to each other all that often, and they're not usually treating me as much as they're treating my you know, insert thing here, right? Like joint joint pain or degenerative joint disease or something like that. Do you think bringing the specialist into a consult with the primary care clinician who already has an established relationship with the patient has the potential to move the needle there, right? And to be done in a in have this specialist concept be done more in that manner of like, I understand you as a person in a less of us, absolutely.

Mary Butler Fleming

Yeah, I love, I like, I like that comment, and I think that's a benefit we haven't like overtly captured. But I think that's huge, because it brings to life the details of the patients' experience, and it centers the patient in the interaction between the PCP and the specialist. So yeah, I think that's I think that's certainly true.

Reid Plimpton

So the second half of that is kind of like flipping the script on it right. There are a number of Americans who do right, especially in rural areas, who do not have a PCP and really only show up to health systems with either an emergent issue or are already in there because of some sort of long term chronic condition. And so there are think pieces and articles about the possibility of using this specialist as a conduit to more continuous care, right as a conduit to the primary care model. Do you have any thoughts on that?

Mary Butler Fleming

Hmm, I don't know that. I've thought about it all that much that way. To be completely honest with you. I know that some of our sites have walk in care, so they've used the tool to do a consultation for patients that are not established primary care patients like their walk in care patients. But yeah, I think any opportunity to engage a patient that for, you know, any number of reasons they're not intimately connected to primary care, any opportunity to get that that feedback and to engage them is is wonderful. So, yeah, I like that. Sure.

Reid Plimpton

No, that's great. And so this next question kind of spawned out of the conversation we were just having the consult itself, is that, truly, is it provider to provider only, or is the patient kind of involved in the conversation with the PCP being like the, you know, The medium,

Mary Butler Fleming

it is, strictly speaking, PCP to specialists. There is no direct patient interaction with the specialist. I know that many PCPs will be transparent and forthcoming with their patient, right? So I've seen it demonstrated like you know, it would be about nine months for you read to see a dermatologist, but I actually have access to one on this platform. Would you mind? And they'll get verbal permission. Would you mind if I, you know, took a picture of the rash, or whatever it is, and sent it to one of my dermatologists colleagues, and so they'll be able to send the PCP. They'll be able to see the PCPs and

the photo and type and so they can have to see the interaction going on, especially within the office, but they're not like explicitly invited into the actual interaction between the PCP and the specialist. That makes sense, but they are consenting to it and aware that it's going on. If it's happening at the point of care,

Reid Plimpton

sure, but they Yeah, no, that makes sense, right? They know it's happening. They understand the reason for it, but they can't necessarily, be ACO. Can you also ask this following question? Okay, no, that's great. I appreciate you working through all those with me. I'm looking just make sure I think we made it through. Oh, I missed one that went into the chat. Are you using any monitoring devices within the within this workflow, in the system that you've developed, and if so, how does that data interact with the specialist, right? Like, if it's a blood pressure monitoring kit, and you have all this information, is there? Is there any integration? There? Are you doing any of that?

Mary Butler Fleming

That's a great question, because the consultation is, by definition, like, kind of episodic, right? And as needed, I could see the consult interacting with like RPM data. And so far as the provider see something unusual or concern in the RPM data, and that sparks them to request consultation about what they're seeing. But it's not integrated in the sense that, like it's, there's an automatic outreach. If something flags on right, if there's a

Reid Plimpton

red flag, all of a sudden, ACO, MDS like, let me and that's, yeah, okay, sure. Again, yeah. I mean, thank you. It's a great presentation. I really enjoyed this kind of Q A back and forth. Kind of feel like we did a little podcast here. I know seated questions, yeah, and, I mean, we do have a few minutes before I want to turn it back over to ARIA to give the spiel about the upcoming NCTRC events. So if anybody else has anything else, feel free to pop it in monitoring both here. But otherwise, yeah, Mary, really can't. Thank you enough that was so informative. And always appreciate you being so willing to share the data that you have as well.

Mary Butler Fleming

Yeah, of course, thanks for having me. Appreciate it. You.

Reid Plimpton

I think I'm not good at this new eight second ACO, pause. I'm still trying to get my five seconds underneath me, but I think we are all set here. Aria, if you want to sort of do the wrap up spiel and close this out. And yeah, thank you all. That's the last thing I'll say. Thank you all for taking time. Taking time out of your day to to join us in providing these questions so that we can get this back and forth and we can all go through this period of learning. And thank you again, Mary.

Aria Javidan

Thank you Mary. And thank you Reed. Just a reminder that our next webinar will be held on Thursday, April 16. That webinar will be hosted by the Northwest Regional telehealthresourcecenter, and it will focus on data interoperability, what's changing, what it means and how to prepare registration information is available on the NCTRC events page. And then lastly, we do ask that you take a few short minutes to complete the survey that will pop up at the conclusion of this webinar. We also have another survey, as I mentioned, where you can share your tele success story for a chance to have it in your organization featured in our monthly newsletter that is distributed to our national audience. Your feedback is very valuable to us. Thank you again to the northeast telehealthress Center for hosting

today's webinar, and thank you to Mary for her presentation today. Have a great day. Everyone.
Goodbye. CIN.