



# RubiconMD eConsult Quality Guidebook



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# Our Vision

At RubiconMD, quality is not just a metric, it's our commitment to democratizing medical expertise. Every eConsult represents an opportunity to elevate patient care, empower primary care providers, and demonstrate the transformative power of specialist collaboration. This serves as your guide to delivering responses that make a meaningful difference in patient outcomes for our clients.

## Our Quality Philosophy

We believe the best patient care emerges when specialists and PCPs work as true partners, each bringing unique expertise to solve clinical challenges together.

### Four Pillars of Quality:

1. **Clinical Excellence:** Providing evidence-based, insightful guidance that goes beyond what PCPs can easily find themselves
2. **Effective Partnership:** Understanding context, setting realistic expectations, and empowering PCPs to provide excellent care
3. **Clear Communication:** Delivering personalized, actionable recommendations that respect both the PCP's time and expertise
4. **Professionalism:** Maintaining a respectful, collaborative tone and professional integrity in every interaction

## Quick Reference Checklist

Before submitting an eConsult response, ask yourself:

### Clinical Standards – Pg. 4

- Have I provided specialty-specific insights beyond general references?
- Did I explain the clinical reasoning behind my recommendations?
- Have I highlighted any safety concerns or red flags prominently?

### Partnership Standards – Pg. 6

- Did I acknowledge the PCP's specific questions and clinical context?
- Are my recommendations feasible given the patient's circumstances?

### Communication Standards – Pg. 8

- Is my response personalized to this specific patient?
- Did I avoid un-personalized snippet usage?
- Are my key recommendations easy to find and implement?

### Professional Standards – Pg. 10

- Is my tone collaborative and respectful?
- Have I maintained appropriate professional boundaries?

# Clinical Standards

## I. Evidence-Based Guidance

Evidence-based practice means grounding your recommendations in current medical literature while adapting them thoughtfully to individual patient circumstances. Excellent responses:

- ✓ Reference specific guidelines or studies when making key recommendations if applicable
- ✓ Explain when standard protocols may not apply to a particular patient
- ✓ Acknowledge areas of clinical uncertainty or evolving practice
- ✓ Provide links or citations for PCPs who want to learn more

### Example of Excellence (Cardiology)

This approach is well supported by hypertension guidelines including the 2017 ACC/AHA joint recommendations. (See: Whelton et al. 2017 ACC/AHA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension. 2018;71:e13–e115).... There are 3 other considerations I have including, sleep apnea, primary aldosteronism, and renal artery stenosis. Hypertension guidelines generally agree sleep apnea is an important contributor and should be excluded in anyone with obesity, loud snoring, or daytime sleepiness...

### Common Pitfalls to Avoid:

- ✗ Making recommendations based solely on personal preference without disclosure
- ✗ Citing outdated protocols
- ✗ Stating "this is how I do it" without explaining why
- ✗ Citing guidelines without considering patient-specific factors

## II. Critical Safety Information

Patient safety is paramount. Excellent responses ensure critical information is never missed or buried:

- ✓ Lead with urgent findings or time-sensitive recommendations
- ✓ Clearly differentiate "urgent" from "routine" next steps
- ✓ Include monitoring requirements and red flags
- ✓ Address any concerning findings from the PCP's submission

### Example of Excellence (Endocrinology)

Wow. That's a huge dose of steroids. We typically give ~10 mg/m<sup>2</sup> BSA hydrocortisone for full replacement, which works out to ~10–15 mg hydrocortisone in the morning and ~5 mg in the afternoon for most people. He's getting the equivalent of 120 mg daily... So whatever is causing his hypotension is not related to his steroid replacement. Is it possible he was over-dialyzed? Is he septic?

### Common Pitfalls to Avoid:

- ✗ Burying critical recommendations in paragraph 3 of a long response
- ✗ Using vague urgency terms ("soon" vs. "within 48 hours")
- ✗ Missing obvious red flags in the clinical presentation
- ✗ Failing to address potentially dangerous current treatments

### III. Clinical Insight & Education

The best eConsults teach while they guide. They provide the "why" behind recommendations and share specialty-specific pearls:

- ✓ Explain pathophysiology relevant to the case
- ✓ Share clinical pearls not found in standard references
- ✓ Anticipate and address likely follow-up questions
- ✓ Provide context about why you're recommending one approach over another
- ✓ Include "teaching moments" that help PCPs manage similar cases

#### Example of Excellence (Neurology)

Thanks for the consultation and background. A number of things come to mind as considerations: The sleep improving is a very good development and does imply a trajectory of continued improvement –the persistent of symptoms likely warrants additional intervention—at least in the short-term –addressing the low Vitamin D will likely help, at least somewhat, longitudinally –given the history of psychotic sx, even if in the context of a possible delirium, the sx warrant treatment with an antipsychotic since behavior is being affected which tips the risk-benefit in favor of treatment—even if treatment may not be necessary long-term e.g. Seroquel 25mg to 50 mg HS (this may even be in place of Trazodone to minimize polypharmacy)

#### Common Pitfalls to Avoid:

- ✗ Providing "what" without "why"
- ✗ Missing opportunities to clarify common misconceptions
- ✗ Using esoteric jargon without explanation

## Partnership Standards

### IV. Managing Limited Information Responsibly

When PCPs provide limited information, excellent responses balance helpfulness with patient safety.

**NOTE:** there are reasonable limits. Specialists should never feel pressured to guess or provide recommendations without essential clinical data.

- ✓ Engage constructively when core information is present but some details are missing
- ✓ Clearly state what critical information is needed
- ✓ Explain why missing information prevents safe guidance when that's the case
- ✓ Distinguish between "nice to have" and "must have" information

#### Example of Excellence (Hematology):

*When critical information is available (CBC values, duration, basic history):*

Thank you for the consultation. In the evaluation of neutrophilia the first determination to make is whether this is reactive or clonal. Reactive causes include inflammation, infection, smoking, etc. and clonal causes are malignancies such as leukemias and other myeloproliferative neoplasms...

*When critical information is missing:*

I'd be happy to help with this case, but I need some essential information first: What are the actual CBC values? How long has this been present? Without these basics, I cannot provide safe recommendations. Please resubmit with this information and I'll provide detailed guidance.

#### Common Pitfalls to Avoid:

- ✗ Attempting to "mind read" or guess critical clinical details
- ✗ Providing recommendations without minimum necessary information

### V. Managing Expectations

Clear expectation setting prevents frustration and ensures PCPs understand what eConsults can and cannot provide:

- ✓ Acknowledge when questions exceed typical eConsult scope
- ✓ Offer alternatives when unable to fully address a request
- ✓ Set realistic expectations about outcomes

#### Example of Excellence (Bariatric Surgery)

Unfortunately, the question about aspirin is a real tough one because the risk of taking any type of NSAIDs... However, headaches and risk of strokes or other complications from small-vessel cerebrovascular disease is also unpleasant... The patient also needs to have all of the facts and make the choice as to whether to take the aspirin or not.

#### Common Pitfalls to Avoid:

- ✗ Providing recommendations impossible to implement in primary care
- ✗ Creating unrealistic expectations about timeline or outcomes

## VI. Clear Clinical Guidance

PCPs need clear direction on next steps. Excellent responses provide unambiguous guidance:

- ✓ Answer each question asked by the PCP directly
- ✓ Provide clear decision trees or algorithms when appropriate
- ✓ Include specific criteria for different management pathways
- ✓ Clarify the primary clinical goal of recommendations

### Example of Excellence (Rheumatology)

1. My suggestion is to monitor her q 3-4 monthly clinically with labs including CBC, CMP, ESR q 3-4 monthly ( provided numbers are normal/stable)
2. consider trial of reducing dose of Methotrexate to 17.5 -15 mg once weekly over time (if ESR persistently normal and no clinical symptoms/signs suggestive of RA activity) while maintaining her on Folic acid 1 mg once daily.
2. Avoid oral NSAID due to borderline CKD.
3. Make sure to recommend no alcohol use while on Methotrexate and monitor for increased risk of infection, hold Methotrexate for 1-2 weeks if any infection with fever > 101 and continue to reiterate importance of compliance with meds use and with office visits/labs at every visit.

### Common Pitfalls to Avoid:

- ✗ Providing vague or ambiguous recommendations
- ✗ Leaving PCPs uncertain about next steps

# Communication Standards

## VII. Appropriate Personalization

Every response should demonstrate that you've carefully considered the individual patient:

- ✓ Open with patient-specific observations
- ✓ Adapt general recommendations to individual circumstances
- ✓ Reference specific details from the PCP's submission
- ✓ Avoid un-personalized snippets
- ✓ Acknowledge unique aspects of the case

### Example of Excellence (Gastroenterology)

That is a great question. I typically start out with MiraLAX and other laxatives initially, when those become less effective or if they are less effective then I move right on to Linzess; In this case, given the amount of previous laxatives she was needing, I would start with a dose of Linzess, 290 µg daily.

### Common Pitfalls to Avoid:

- ✗ Repeat use of identical blurbs for similar cases
- ✗ Starting with generic information before addressing specifics
- ✗ Copy-pasting without customization
- ✗ Missing patient-specific factors that affect management

## VIII. The Goldilocks Principle

Balance is key. Provide enough detail to be helpful without overwhelming:

- ✓ Lead with most important recommendations
- ✓ Use structure (e.g. numbered lists) for longer responses
- ✓ Provide complete answers to all questions asked
- ✓ Know when brevity serves the PCP better

### Example of Excellence (Obstetrics/Gynecology)

Thanks for this consult. An endometrial biopsy can be appropriately deferred for now. Postmenopausal bleeding is not uncommon among patients starting combined (ie estrogen-progestin) hormone therapy. It is particularly common if taking cyclic progesterone and in the early months of therapy. If PMB continues beyond 6 months in patients using a continuous progesterone regimen, endometrial evaluation is warranted. This can be with TVUS or endometrial biopsy. An endometrial stripe measuring <5mm has 98-99% sensitivity in excluding endometrial cancer. In other words if the endometrial stripe is homogeneous and less than or equal to 4mm you can be reassured that there is < 1% risk that the cause of the bleeding is endometrial cancer and endometrial sampling is not required. So to summarize since the patient is early in her initiation of HRT and her EE is <5mm EMB can be deferred. You can continue HRT at this dose for now and if bleeding persists after 6mo reevaluate with either TVUS or biopsy.

### Common Pitfalls to Avoid:

- ✗ Short responses that lack substance
- ✗ Lengthy responses without clear organization
- ✗ Including irrelevant educational content

## IX. Strategic Information Placement

Where you place information matters as much as what you include:

- ✓ Lead with direct answers to PCP questions
- ✓ Place critical safety information prominently
- ✓ Put patient-specific recommendations before general education
- ✓ End with clear next steps or follow-up guidance

### Example of Excellence (Pulmonology)

1. If a patient like this presented to me, these would be my general thoughts. Thank you for reaching out to me.
2. The vast majority of COPD patients do not benefit from chronic prednisone and therefore only suffer from side effects without benefit...

### Common Pitfalls to Avoid:

- ✗ Burying the answer multiple paragraphs in
- ✗ Leading with lengthy background before addressing the question
- ✗ Hiding critical recommendations in dense text
- ✗ Placing personalized guidance after generic information

## Professional Standards

### X. Professional Tone & Respectfulness

Your tone sets the stage for effective collaboration:

- ✓ Acknowledge PCP expertise and clinical judgment
- ✓ Express appreciation for interesting or challenging cases
- ✓ Maintain warmth while being professional
- ✓ Show respect for the PCP's time and effort

#### Example of Excellence (Various)

Thank you for this consult and for involving me in your patient's care..." "That is a great question..." "Thanks for the consultation and background..." "I hope you find this helpful and again sorry for a tough case with limited medication options..."

#### Common Pitfalls to Avoid:

- ✗ Condescending language or lecturing tone
- ✗ Using phrases like "obviously" or "as you should know"
- ✗ Using ALL-CAPS, as it comes across as aggressive in an eConsult
- ✗ Questioning PCP competence or decision-making
- ✗ Cold, impersonal responses that feel transactional

### XI. Professional Integrity

Maintaining the highest standards of professional conduct:

- ✓ Focus solely on clinical guidance
- ✓ Avoid any self-promotion or advertising
- ✓ Maintain objectivity in recommendations
- ✓ Respect professional boundaries

#### Example of Excellence (Rheumatology)

Note if he has inflammatory back pain, worse in the morning, better with activity, this young gentleman may actually have a seronegative spondyloarthropathy such as ankylosing spondylitis. If you don't have documentation of his RF and CCP autoantibodies I would check these as well.

#### Common Pitfalls to Avoid:

- ✗ Promoting your practice
- ✗ Criticizing other providers' management
- ✗ Overstepping eConsult boundaries
- ✗ Making definitive diagnoses without examination

## Excellence in Action (Quality Comparison/Examples)

### Medication Concerns Post-Bariatric Surgery

#### Poor Response:

Aspirin is contraindicated after gastric bypass due to ulcer risk. Use alternatives.

#### Excellent Response:

Thank you for recognizing the importance of this question and asking about it. Unfortunately, the question about aspirin is a real tough one because the risk of taking any type of NSAIDs or steroids (coffee, smoking and ETOH) all increase the risk of patients who have had gastric bypass to form a marginal ulcer. Marginal ulcers (a mucosal ulcer that forms at the anastomosis of the stomach and jejunum), once they form, are very hard to treat and tend to be recalcitrant to conservative management. However, headaches and risk of strokes or other complications from small vessel cerebrovascular disease is also unpleasant and a risk without taking aspirin. In these cases, surgeons tend to go back to the specialists prescribing the ASA and ask to consider the risks vs benefits of taking the ASA vs. marginal ulcer risk in the individual patient... In my experience, I shy away from all NSAIDs in patients that have had bariatric surgery because I have seen terrible complications of marginal ulcerations... Are they on a PPI? If so this can help protect the patient if they take the ASA. If the patient is not on a PPI then I imagine that this might be a good reason to start one while taking the ASA. Here is a PUBMED article that retrospectively looked at those on ASA vs. not and it showed no difference in ulceration. (cautioning that this is one study and retrospective).

#### Why the second response excels:

- ✓ Addresses both immediate interventions and long-term management strategies
- ✓ Acknowledges complexity and presents balanced risk/benefit considerations

### Addressing Abnormal Lab Values

#### Poor Response:

TSH is elevated at 7.2. Start levothyroxine 25mcg daily. Recheck levels in 6-8 weeks.

#### Excellent Response:

If I saw a case like this, I would consider the following. This TSH level is appropriate for a patient of this age. Several studies have shown that TSH levels naturally rise with age while FT4 levels remain steady. Levels often rise to 7.5-8 mIU/L and the elevations are more pronounced and present in patients over 90 years of age, like this one. This does not reflect abnormal pathology and these patients are therefore unlikely to benefit from treatment.

Please note additional resources regarding this topic here:

<https://pubmed.ncbi.nlm.nih.gov/34766382/>  
<https://www.thyroid.org/thyroidguidelines/file/thy.2012.0205.pdf>

I would continue to monitor the levels once/year and target a TSH under 8 mIU/L. Should her FT4 become abnormal as well, treatment may be considered, but please re-consult if this occurs so that all the details of this patient's medical history can be taken into account before making a recommendation at that time. I hope this helps. Please let me know if you have further questions.

#### Why the second response excels:

- ✓ Explains the clinical reasoning - why elevated TSH doesn't require treatment in this context
- ✓ Cites evidence (studies showing TSH naturally rises with age)
- ✓ Provides specific, actionable monitoring guidance (yearly, target TSH under 8)
- ✓ Personalizes to the patient's specific age
- ✓ Sets clear criteria for when to reconsider treatment (if FT4 becomes abnormal)
- ✓ Invites follow-up, maintaining the collaborative relationship

## Anatomy of a High-Quality eConsult

### Example: Cardiology – Refractory Hypertension

PCP Question: 54-year-old incarcerated patient with HTN claims adverse reactions to multiple BP medications. Blood pressure remains high on metoprolol 200mg BID. Creatinine 1.52, eGFR 52. Any other medication recommendations?

### Specialist Response (condensed):

Hi there, thanks so much for your question.

Personalizes advice to the patient's specific symptoms and medical history.

This sounds like a difficult situation but I'm sure we can find a therapy that works for him. I think it's a great idea to trial the metoprolol and start low-dose diuretic or, if he is open to trying another beta blocker, labetalol works very well with refractory hypertension as it has both alpha and beta blockade. I usually start with 100 mg TID and increase as needed.

Stays concise enough to be actionable, but thorough enough to cover all relevant points.

As a first step, I confirm the accuracy of blood pressure readings. I find home readings to be best.

On days they check their blood pressure, I instruct them to do so in the morning before taking medications and in the late afternoon before dinner.

Helps the PCP understand why a recommendation is made, making the response educational.

Secondly, I confirm that the patient does not have excess sodium intake in their diet from processed food, that they are not drinking excessive alcohol or coffee, and that they are not taking NSAIDs frequently.

Draws on evidence-based guidelines or recent clinical studies when making recommendations.

There is good data in guidelines that screening for these contributors improves outcomes (see: Carey et al., Hypertension 2018;72:e53-90).

Identifies potential red flags or urgent warning signs and explains how to address them.

There are three other considerations I have: sleep apnea, primary aldosteronism, and renal artery stenosis. Hypertension guidelines generally agree sleep apnea is an important contributor and should be excluded in anyone with obesity, loud snoring, or daytime sleepiness.

If sleep apnea is not present, I obtain a morning plasma aldosterone concentration (PAC) and plasma renin activity (PRA) to evaluate the PAC/PRA ratio, which is usually  $> 20$  in primary hyperaldosteronism.

This approach is well supported by the 2017 ACC/AHA guidelines (Whelton et al., Hypertension 2018;71:e13-115).

Maintains a professional, respectful tone, even if suggestions differ from the PCP's initial plan.

I hope you find this helpful and again sorry for a tough case with limited medication options but I agree with considering secondary hypertension workup (including echo) as you have already suggested. Let me know if you have further concerns and thanks again for your great question!