



Specialty Care in the Safety Net: Efforts to Expand Timely Access

May 2009

Specialty Care in the Safety Net: Efforts to Expand Timely Access

Prepared for

CALIFORNIA HEALTHCARE FOUNDATION and
KAISER PERMANENTE COMMUNITY BENEFIT PROGRAMS

by

Lisa Canin and Bobbie Wunsch
Pacific Health Consulting Group

About the Authors

Pacific Health Consulting Group specializes in providing management consulting services to public sector health care organizations and foundations. Bobbie Wunsch is a founder and partner. Lisa Canin is a clinical psychologist who does consulting, research, evaluation, and writing in social science and health policy arenas. For more information, visit www.pachealth.org.

About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

About Kaiser Permanente

As a health care provider and nonprofit health plan, **Kaiser Permanente's** mission is to provide high-quality, affordable care services to 8.6 million members and the communities served, through care innovations, clinical research, health education, and community collaboration. Kaiser Permanente provides funding and support for Community Benefit programs and services through research, community-based health partnerships, and direct health coverage for low-income people and families. For more information, go to www.kp.org/newscenter.

Contents

2	I. Introduction Major Activities and Sources of Data
4	II. California’s Safety Net for Specialty Care Areas of Highest Need Efforts to Expand Access Challenges in Referral and Communication Processes Challenges in Data Collection
8	III. Findings and Future Directions Referral and Clinical Care Guidelines Provider Training and Expanded Scope of Practice Expanding Specialist Networks Web-Based Referrals Telemedicine
15	IV. Conclusions
17	Appendices: A: Specialty Care Coalitions and Grants B: Resources to Support Specialty Care Access

I. Introduction

*The work focused on three areas:
the demographics of specialty care
for California's underserved;
the size and scope of access problems;
and the cultivation of innovative
strategies to improve access and
manage demand.*

TIMELY ACCESS TO SPECIALTY CARE IS A SIGNIFICANT AND growing challenge for low-income Californians who depend on safety-net institutions—public hospitals and community clinics and health centers—for their health care.

To better understand the size and causes of the problem, as well as to encourage effective solutions, Kaiser Permanente Northern and Southern California Regions' Community Benefit Programs partnered with the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) in 2006 to examine specialty care access for uninsured and Medi-Cal populations. Project activities included a statewide survey of safety-net providers, discussion papers, roundtable forums, and technical assistance teleconferences. Then, in 2007 Kaiser Permanente Community Benefit and the California HealthCare Foundation (CHCF) came together to fund 28 planning grants and 23 implementation grants to regional provider coalitions across California to identify local barriers to care and develop strategies to improve access. Implementation projects began in early 2009.

The work has focused on three areas: the demographics of specialty care for California's underserved; the size and scope of access problems; and the cultivation of innovative strategies to improve access and manage demand.¹ The purpose of this report is to share findings from these activities with a broad audience.

Major Activities and Sources of Data

This report highlights findings from a series of activities that address specialty care access and the promotion of integrated community care in the safety net. The Specialty Care Access Initiative (SCAI) was established in 2006 by Kaiser Permanente Community Benefit in partnership with the California Association of Public Hospitals and Health Systems/California Health Care Safety Net Institute (CAPH/SNI), and the California Primary Care Association (CPCA). Kaiser

1. The work focused on internal medicine sub-specialty services to adults and did not include mental health or dental care.

Permanente Community Benefit brought CAPH and CPCA together as partners to examine the problem of specialty care access and explore promising approaches to improving access. Building a strong collaborative alliance between these institutions was an important component of the overall project.

To provide benchmark information, the Pacific Health Consulting Group conducted a specialty care survey of the state's community clinics and health centers (CCHCs) and public hospital systems in 2007. Fifty-eight percent of California's clinic corporations responded to the survey, as did 80 percent of the state's public hospital systems.

At the end of 2007, Kaiser Permanente Community Benefit (throughout its Northern and Southern California regions) and CHCF (for rural communities not covered by Kaiser facilities) offered local safety-net coalitions the opportunity to develop community plans to improve specialty care access. In most cases, coalitions were county-based, comprised of community health centers, public hospital systems, and other partners such as county health departments, private providers, and medical societies. In other areas, such as Los Angeles, coalitions were based on specific geographic planning areas within the county. In some rural areas regional coalition members partnered across county lines. Coalitions received planning grants and the opportunity to apply for multi-year implementation grants in 2008. A total of 28 coalitions completed planning grants and 23 coalitions received implementation grants, representing a four-year commitment of more than \$20 million by the funders. A complete list of grants is included in Appendix A.

The funders developed, and will continue to provide, training and technical assistance resources for learning about promising practices across California's safety-net organizations. Included are reports, discussion papers, roundtable forums, and technical assistance teleconferences. These activities are detailed in Appendix B.

II. California's Safety Net for Specialty Care

Public hospitals are the largest provider of specialty care in California's safety net.

WHILE THE SAFETY NET FOR PRIMARY CARE IS CLEARLY defined, the safety net for specialty care is not well understood. Safety-net primary care providers throughout California rely on three principle sources for specialty care: public hospital systems, community clinics and health centers (CCHCs), and private specialists.

Public hospital systems. These are the largest provider of specialty care for the safety net in California, offering a wide range of onsite services for their own primary care patients and those in the community. The vast majority of public hospital patients' specialty care needs are met in-house. Where there are no public hospital systems, patients receive specialty care from an array of sources, including private providers, CCHCs, out-of-area specialty centers, and private hospitals. Further findings:

- Most referrals to public hospitals for specialty care come from providers within the public hospital systems: In-house primary care providers account for 52 percent of the total referrals, and in-house specialists provide another 12 percent. One-fifth of the referrals come from CCHCs, and 11 percent from private providers.
- Public hospital systems are the largest referral destination for outside specialty care for CCHCs, receiving 39 percent of their total outside referrals.
- All of the public hospital systems refer at least some patients to sources outside of their systems for specialty care.

Community clinics and health centers. Though the level of specialty care provided by CCHCs is often limited, 61 percent of CCHCs indicated that their organizations provide at least one specialty service onsite, and more than a third offer three or more different specialties. Despite the generally limited role that CCHCs play in providing specialty care services, a few serve as major safety-net specialty care providers in their communities; this is particularly true in rural Northern California.

Specialty care services offered by CCHCs tend to be targeted to their own primary care patients. Of the specialty care referrals that CCHCs receive, 82 percent come from in-house primary care providers. Ten percent come from primary care providers at other CCHCs, and 4 percent come from private providers. Only 16 percent of the CCHCs that provide onsite specialty care do so with special funding. Almost half of those with special funding for specialty care are located in the Los Angeles area; this indicates that most CCHCs absorbed these services into their annual operating budget.

Private providers. These deliver a significant amount of specialty services for safety-net patients. Survey respondents reported that 33 percent of all CCHC referrals for outside specialty care were made to private providers. The lowest percentage of referrals from CCHCs to private providers was reported in communities with public hospital systems, such as Los Angeles County (16 percent); the highest percentage was in rural Northern California (61 percent) and other communities without access to public or University of California hospital systems.

Areas of Highest Need

The 2007 survey findings reaffirm a 2004 Mathematica survey commissioned by CHCF that found significant barriers to timely access for specialty care by Medi-Cal and uninsured patients. In

One-third of safety-net primary care providers “frequently” limit referrals to high-need specialty services because of perceived lack of access.

the 2004 study, 85 percent of clinic medical directors in California’s federally funded health clinics said their patients “often” or “almost always” had trouble accessing specialty care. Half of the surveyed medical directors described the situation as having worsened over the prior two years.

As reflected in both the 2007 statewide survey and the regional coalition needs assessments, orthopedics, gastroenterology, neurology, and dermatology were perceived as the services most difficult for safety-net patients to access. These specialty areas were also among the top ten most needed services identified in the 2004 Mathematica study. Not surprisingly, the 2007 survey showed that the longest mean wait time for CCHC patients referred out were ones identified by survey respondents as being among the most needed and most difficult to access: neurology, orthopedic surgery, and dermatology. For two-thirds of the types of specialty services referred out, CCHC patients typically waited between one and three months to see specialists. Public hospital patient referrals to neurology care outside of the public hospital system also had long waits (three to six months). The longest wait time of all was for dermatology services referred out of public hospital systems for patients with complex needs; the typical wait was more than six months.

The survey inquired about the extent to which primary care providers limit patient referrals due to anticipated access difficulties. Respondents estimated that approximately one-third of their primary care providers “frequently” limit referrals to high-need specialty services because of perceived access difficulties. This type of referral suppression was more pronounced among CCHC providers than those in public hospital systems, possibly because these hospitals provide a range of specialty services in-house.

Furthermore, primary care providers in CCHCs had difficulty accessing consultation with specialists when they needed it. The clinics reported that their primary care providers were able to consult with a specialist less than half of the time that consultation was needed. Some regional differences were notable, with primary care providers in Los Angeles County reporting particularly high levels of difficulty obtaining consultation. Primary care providers in the public hospital systems were somewhat less impacted; survey respondents reported that these providers were able to access consultation 50 percent to 75 percent of the time.

Efforts to Expand Access

Prior to new funding there were already efforts underway to increase access to specialty care, according to survey respondents. These strategies included providing onsite specialty care, expanding the scope of practice for primary care providers, building a specialty referral network, and acquiring the capacity to get access via telemedicine.

- Onsite specialty care, provided to some degree by 61 percent of responding CCHCs and all the public hospital systems, reduced patient wait time, improved primary care providers' ability to expedite service delivery, and enhanced the frequency and ease with which primary providers could access consultation. For example, while the typical wait time for a majority of outside referrals was between three and six months, CCHC patients typically waited less than four weeks for onsite care. In addition, primary care providers were much more likely to receive consultation reports back from onsite specialists.
- Only 14 percent of CCHC respondents indicated that some of their primary care providers incorporated specialty dermatology, infectious

disease (including HIV/AIDS), or orthopedic care into their scope of practice. There was little evidence of expanded scope activities in other specialties.

- Personal relationships were critically important in engaging specialists and obtaining care for patients and consultations with providers. Safety-net institutions overwhelmingly depended on providers' personal relationships to recruit specialists. Concern was expressed about the risk of overburdening a limited number of specialists personally known to safety-net providers.
- Although nearly one-third of the responding CCHCs had telemedicine equipment available, it was not widely used to expand access to specialist providers in the safety net, except in isolated rural areas.

Challenges in Referral and Communication Processes

Referral processes generally were not standardized and did not incorporate referral guidelines and treatment protocols. The resulting inefficiencies were particularly problematic in an environment of limited resources. They included:

- Inappropriate or ambiguous referrals (those without sufficient information);
- Incomplete or insufficient work-ups better addressed with more complete primary care attention, resources, or training to manage routine specialty needs in-house;
- Difficulty allocating specialty appointments rationally for the sickest or most complex patients; and
- Over-reliance on one-to-one personal relationships and informal processes that are

inefficient and do not build a reliable and sustainable institutionalized network of specialty providers.

Few CCHCs and public hospital systems had or used written guidelines for referring patients for outside specialty care. Most of the public hospital systems had written referral guidelines for at least some onsite specialty areas.

Furthermore, strategies for improving coordination of specialty care referrals had not been widely adopted in safety-net practice. These strategies include technology enhancements, such as tracking, electronic health records (EHRs), email, and Web-based referral, as well as offering patient support to insure that appointments are kept and that records are in order and present at appointments. A significant survey finding was that 68 percent of the CCHCs and 53 percent of public hospitals used a manual log to track referrals, and 30 percent of safety-net institutions did not track specialty referrals in any formal way. Only 4 percent of the CCHCs and 20 percent of the public hospitals reported using electronic medical records, and less than 15 percent of all respondents used email to communicate with specialists.

Most safety-net primary care providers used manual logs to track specialty referrals; 30 percent did not track referrals at all.

Challenges in Data Collection

In order to establish a baseline understanding of specialty care access, the authors used the survey and the needs assessment component of the implementation planning grants to assess the access problems in a range of ways. For example, the survey included queries regarding numbers of patients seen, specialty visits provided, and number of patients referred.

There were significant difficulties in capturing consistent, reliable, and valid information about the level of care provided by CCHCs and public hospital systems and the amount of care needed by their patients. Often, the data were incomplete, inaccurate, or missing. Only a minority of the organizations consistently tracked referrals in searchable and quantifiable ways. The safety-net organizations had very different processes for tracking referrals and accessing data about them. Some only kept information in patient charts or handwritten logs; some that had computer systems did not use them; and others used computer referrals, but with systems that were not searchable. Even clinics that maintained computerized referrals often captured information that was inconsistent across standard fields. This meant that observations regarding need were likely to reflect qualitative impressions.

The lack of a common understanding of metrics created other problems. For example, “wait time” for specialty care could be defined as beginning when a provider identifies the need for specialty care, or when a referral clerk records and enters the need.

Another measurement challenge was the difficulty of accounting for demand *suppression*—which occurs when providers do not refer patients to specialty care because they have not been successful in accessing it in the past. A related problem was measuring the impact of referral lists being closed because they were too long or full to accept referrals.

III. Findings and Future Directions

Three broad approaches emerged:

Reduce the demand for specialty care; expand the supply of available services; and strengthen the coordination of care.

IN LATE 2008, KAISER PERMANENTE COMMUNITY BENEFIT and CHCF Specialty Care Initiative grantee coalitions submitted implementation proposals describing local strategies to improve access to specialty services. Twenty-three coalitions received funding to implement the strategies. Three broad approaches emerged: Reduce the demand for specialty care; expand the supply of available services; and strengthen the coordination of care. The plans reflected the unique needs and capabilities of individual coalitions, as well as knowledge and opportunities that emerged through the statewide survey, discussion papers, technical briefs, roundtable forums, and regional planning processes. The goal of coalition activities is to enable systemwide change and advance the larger goal of integrated community care in the safety net. It is anticipated that future work will extend far beyond the life of the grants.

More than half of the regional coalitions plan to implement one or more of five types of improvement activities, including:

- Development and implementation of referral and/or clinical care guidelines;
- Training for primary care providers, including fuller scope to incorporate specialty care activities;
- Expanded specialist networks;
- Web-based referral or consult systems; and
- Referral coordination improvements.

In addition, a wide range of other approaches are being planned or expanded by the coalitions, including:

- Shared specialist or hub models to expand specialist networks;
- Use of mid-level providers;
- Internal specialty clinic redesign;
- Chronic disease registries;

- Clinical care screening programs;
- Community collaborations and regional partnerships;
- Public health campaigns; and
- Transportation services to specialty care appointments.

The planned improvement activities tend to be multi-dimensional. Adoption of one approach typically involves a range of inter-connected activities. For instance:

- Primary care provider training to incorporate some degree of specialty care or diagnostic activity into the primary care setting is almost always planned alongside clinical guideline adoption;
- Expanded specialty care networks designed to encourage broader participation by private specialists are generally accompanied by complementary strategies to simplify the referral process, ensure appropriate referrals, and improve provider communication (i.e., referral coordinators, Web-based referral systems, referral guidelines);
- Web-based referral projects are frequently implemented with the use of referral guidelines; and
- Telemedicine, Web-based consulting technologies, shared specialists, and circuit riders are all strategies that require recruitment of specialists or expansion of specialist networks; some of the plans articulate recruitment strategies.

The specialty areas most frequently focused on in implementation plans include:

- Orthopedics (addressed in 50 percent of the coalition plans)
- Gastroenterology (38 percent)
- Neurology (31 percent)
- Dermatology (23 percent)
- Cardiology (19 percent)
- Endocrinology (19 percent)
- Ophthalmology (15 percent)
- Rheumatology (15 percent)

The implementation plans are not necessarily directed toward highest-need specialties. In a number of situations, coalitions selected specialties perceived as having the greatest opportunity for success. For example, while cardiology and ophthalmology were identified by CCHC survey respondents as two of the easiest specialty services for their patients to access, they are included as focus areas in a number of the coalition plans. Feasibility and ease of implementation, regardless of relative assessment of need, was a significant factor for some coalitions. In fact, one plan characterized a component of their activities as a “low-hanging fruit” approach, in which it was determined that a large impact on access and quality could be realized with minimal added cost.

Referral and Clinical Care Guidelines

Safety-net providers see guidelines as a way to standardize and streamline specialty referral, improve provider relations, and triage specialty resources by preserving them for higher-need cases. Rather than designing guidelines from scratch, a number of coalitions and safety-net providers intend to use guidelines that have already been implemented in other settings. Significant concern was expressed about the extent to which guidelines incur additional diagnostic services and care management resources

Safety-net providers see guidelines as a way to standardize and streamline specialty referral, improve provider relations, and triage specialty resources by preserving them for higher-need cases.

for which there is generally no compensation. In addition, internal resources need to be allocated for provider education and training to use guidelines effectively. The coalitions that plan to develop guidelines through specialist/primary care collaborative processes, sometimes referred to as “consensus guidelines,” see this as an opportunity to create the trust needed to build future clinical collaboration—including patient co-management, consultation, and mentoring.

Provider Training and Expanded Scope of Practice

Training for primary care providers, included in 61 percent of the coalition plans, focused on general specialty training and skill development in specific diagnostic and treatment procedures. A range of purposes were given, including:

- Increasing comfort and familiarity in expanded clinical areas in order to implement care guidelines effectively in specialty areas and pre-referral work-ups;
- Enabling primary care providers to expand their scope of practice in order to directly provide specialty care and diagnostics;
- Allowing primary care providers to adopt the role of specialist champion at their sites, providing internal training for and consultation with other primary care providers; and
- Enhancing the possibilities for co-management between specialists and primary care providers for patients with complex specialty care needs.

The plans identified a range of delivery approaches to expanded training, including:

- Mini-fellowships, in which specialists provide intensive clinical training opportunities (often alongside themselves) as well as mentoring, patient co-management, and access to future consultation;
- Monthly or quarterly CME workshops, typically onsite in the primary care provider environment, focused on effective triage and delivery of specialty care;
- Access to Webinar classes or telemedicine consults for training purposes; and

- Procedure-intensive training opportunities, including short courses and focused procedural mini-fellowships.

These approaches often focus on the most common procedures and conditions with high unmet need, such as flexible sigmoidoscopy, colposcopy, breast cyst aspirations, facial lesions, cryotherapy, splinting, casting, joint injections, diabetic foot care, nail/callous removal, stress testing, and office ultrasound.

Because the scope of practice for primary care providers has narrowed over the past decades, there is vigorous debate within national family and internal medicine societies regarding the need to train and certify primary care providers in a fuller range of procedural and diagnostic skills. The potential benefits include better access for patients, greater continuity of care, and professional growth and competence-building opportunities for providers. A discussion paper about an expanded scope of primary care practice described eight examples in safety-net institutions throughout California. Major discussion points included the following:

- Activities most frequently identified as appropriate for primary care provider fuller scope include: colonoscopy, esophagogastroduodenoscopy, diagnostic ob/gyn ultrasound, colposcopy, outpatient radiography, office orthopedics (including joint exams, injections, simple castings, and fracture care), fine-needle aspiration, skin cancer screening and biopsy, EKG interpretation, diabetes care, and infectious disease management.
- Expanded scope activities that specialists do not want to do tend to happen naturally and with relatively little “turf” conflict. The same is true for locations, settings, and populations (e.g., rural

areas and safety-net patients) that specialists are less interested in. Geography plays an important role.

- Providing primary care providers with training in procedures is resource intensive in terms of time, cost, and personnel. A growing number of fellowships as well as successful commercial ventures offer hands-on CME specialty procedures training for primary care providers. In making decisions, safety-net providers must weigh need, capacity, and access to cost-effective training.
- Consideration must be given to managing time and resource demands as well as financial disincentives such as reimbursement obstacles and productivity pay arrangements. One viewpoint is that primary care providers can most easily train to provide procedures and diagnostics that are more objectively assessed and amenable to practice guidelines (e.g., ENT, diabetes, fractures, and sigmoidoscopies). Further, it is argued by some experts that the more “cognitively complex” and time-consuming areas (e.g., neurology, psychiatry, and pain) pose too great a potential drain on basic primary care to recommend as a strategy.

Ongoing consulting relationships with specialists are an important support for expanded scope of practice. Collaborative training experiences, including mini-fellowships and formal and informal mentoring relationships, all provide opportunities for the growth of consultative relationships and patient co-management.

The benefits of an expanded scope of practice must be balanced against potential negative impacts on primary care time and overburdening primary care providers. Concerns include increased marginal

costs (diagnostics, medications, and provider time dedicated to specialty care), the need for expanded liability coverage, and increased demand for specialty services. In addition, fear was expressed about increased demands of more complex, medically difficult patients.

Strategies for retention of primary care providers included opportunities for professional growth such as teaching, leadership, clinical care, and procedural training activities. However, it was noted that such experiences make primary care providers more eligible for recruitment to specialty practices. Additionally, the role and training of mid-level clinicians such as nurse practitioners and physician assistants was discussed as a strategy to further reduce the burden on primary care physicians.

Expanding Specialist Networks

About one-third of coalitions proposed developing “specialist networks” that formally engage a larger network of volunteer and paid specialists to serve safety-net patients. This differs markedly from the historically informal personal relationships that characterize specialty care in many safety-net settings. In order to make participation more attractive to specialists and efficient for safety-net primary care providers, coalition strategies typically include system improvements such as strengthened utilization tracking, clear contractual agreements, Web-based referral systems, and implementation of consensus care guidelines. Benefits of developing more formalized referral processes include simplifying participation for specialty providers, ensuring that there are clear terms of participation for them, and reducing the burden on primary care providers caused by having to manage multiple individual relationships. Some providers plan to use physician champions or specialty care coordinators for their

recruitment efforts to develop and publicize system improvements.

Expanded efforts are expected to help support professional norms and expectations regarding participation in safety-net care, which, in turn, helps create sufficient “critical mass.” When more specialists are engaged to help, those who do can be assured that the burden will be spread so they are not overwhelmed with unmet need.

Not all of the plans intend to use newly recruited specialists in the same way. Some are committed to having decentralized onsite services, although only four programs plan to recruit for the purpose of scheduling specialists onsite. To attain malpractice coverage and enhanced Medi-Cal reimbursement, some plans are moving toward shared specialist care through a specialty care “hub” at sites with federally qualified health center (FQHC) approval.

A discussion paper and technical brief commissioned for this project address some of the financial, legal, and regulatory challenges safety-net institutions face as they offer more specialty care within primary care settings. Providing onsite care requires considerable administrative time and attention to manage. Safety-net providers must attend to a complex set of federal and state policies and regulations that govern accepted scope of practice and licensing. Additionally, there are financial implications of onsite care, including:

- Risk of increased levels of uncompensated care;
- Increased auxiliary staffing and other resources, including space, equipment, pharmaceutical and diagnostic needs; and
- Need to provide malpractice “gap” coverage for specialists who otherwise would not be covered (e.g., retired specialists).

A January 2009 Policy Information Notice (PIN) regarding “Specialty Services and Health Centers’ Scope of Project” describes the criteria federal agencies will use to evaluate requests from health centers seeking to add specialty services. Important implications for staffing arrangements, malpractice coverage, data requirements, and compliance reporting are outlined in these new criteria.

Web-Based Referrals

Over 60 percent of the coalitions plan improvements to their referral and consulting systems. Some encompass full integration with EHRs and interoperability with other systems management tools, while others focus on specific specialty areas or on standardizing email protocols. A range of goals were identified for these initiatives, including:

- Automation of appointment reminders;
- Integration of guidelines;
- Convenient review and triage of requests;
- Increase in legibility and completeness of referral and scheduling;
- Ability to expedite urgent referrals;
- Ability to track referral progress;
- Capacity to store and forward diagnostic information and images; and
- Standardization and improvement of consultation reports back.

Even implementation plans that lack guideline and decision-support or provider communication mechanisms can enable the tracking of access and utilization data (e.g., referral or consult request and utilization by specialty, reason for referral, provider, specialist, time from initiation to appointment,

number of patients referred, seen, closed, remaining open, and directly booked).

There are financial implications of referral technologies and Web-based programs. Advantages range from improved allocation of scarce resources, reduced waste and inefficiency, improved communication between primary care providers and specialists, and enhanced capacity to track and report on referral metrics. The costs are also significant: intensive commitment of staff resources; hardware; software licensing, subscription, and maintenance; implementation support; training; and maintenance. An additional obstacle is that some private specialist offices may be unequipped to handle referrals or connect electronically to the referral system.

Some implementation plans proposed new or modified staff roles to help oversee improved specialty referral and case management. These varied by institution with respect to terminology and functions of personnel. Specific activities described for these staff roles include:

- Recruiting and maintaining relationships with specialty providers;
- Overseeing care coordination and planning (work-ups, patient education, tertiary care, follow-up);
- Referral coordinating and tracking;
- Standardizing, streamlining, and coordinating communication between specialists and primary care providers and between patients and providers;
- Developing and/or implementing referral guidelines and treatment protocols;
- Managing chronic disease registry activities;
- Internal quality improvement and referral review;

- Patient navigation and advocacy;
- Matching patient requests with volunteer specialists;
- Staff training;
- Appointment reminders and scheduling; and
- IT support and review of alternative vendors for new systems acquisition.

Telemedicine

Telemedicine is gaining attention as a way to address the gap in specialty care access for both urban and rural patients. In the statewide survey, nearly one-third of the CCHCs indicated they had some availability of onsite telemedicine equipment; however, only rural sites reported using telemedicine with any frequency. Half of the coalition implementation plans included some telemedicine-

Primary care sites have significant difficulty finding specialists who are equipped and willing to see their patients via telemedicine, particularly if patients are uninsured or on Medi-Cal.

related activity, often targeting ophthalmology (for retinal screenings) and dermatology. Other plans included provider continuing education and consultation for specialty care.

California has been a pioneer in telemedicine policy, enacting one of the first state telemedicine laws in 1996 and expanding it in 2005. Nevertheless, reimbursement policies lag behind current practice.

Though a “site fee” designed to cover the costs of telecommunication, setup, and administration of the program for some referring provider sites is provided by some payers, there is still significant confusion among providers about whether and how to bill for telemedicine consultations. In addition, primary care sites have significant difficulty finding specialists who are equipped and willing to see their patients via telemedicine, particularly if patients are uninsured or on Medi-Cal. To date, most telemedicine providers have had difficulty developing a viable business model, and safety-net providers have relied heavily on grant funding to support telemedicine activities.

Infrastructure and broadband connectivity have also been barriers to more widespread use of telemedicine. The California Telehealth Network, established in 2008 under a federal grant from the FCC, will provide access to subsidized, high-speed broadband for hundreds of safety-net providers throughout the state. This will allow them to connect to one another more easily and with the security and service-level guarantees necessary for telemedicine. Funds available through the American Recovery and Reinvestment Act (ARRA) will also offer funding opportunities for the advancement of broadband and telehealth programs.

IV. Conclusions

These findings and the integrated project activities engaged safety-net participants across the state in learning from one another and developing a common understanding of the challenges they face.

THE PROJECT SURVEY ESTABLISHED A FOUNDATION FOR conversations about specialty care access for California's underserved. These findings and the integrated project activities engaged safety-net participants across the state in learning from one another and developing a common understanding of the challenges they face. A number of overarching themes emerged from this multi-phase project:

- While initiatives are locally designed and implemented, they share common goals and strategies across the state in their efforts to impact the demand for care, the supply of providers, and coordination of patient care;
- To the extent possible, the one-on-one relationships need to be transformed into institutional relationships, so they can be sustained over time and are not solely dependent on specific individuals and situations;
- The ability to capture accurate information about the status of specialty care and of the need for specialty care in the safety net are critical to progress;
- Improvement activities and systemwide changes aimed at providing more integrated and comprehensive care require multi-dimensional approaches;
- Planning and implementing improvement activities are resource-intensive in terms of time, funding, and individual and organizational motivation;
- Relationships, effective communication, and recognition of individual and partner contributions build the trust and create the foundation upon which collaborations depend; and
- Coalition-building—among regional safety-net partners and between professional institutions like CAPH and CPCA—is necessary for systemwide change as well as for implementation of specific strategies.

The funding for planning and implementation projects enabled most of the coalitions to move forward with a variety of projects. The participants offered general guidelines for others pursuing similar goals:

- Carefully craft the early steps, with strong vision, leadership, and achievable goals;
- Begin with smaller projects or pilots to build competence and confidence;
- Establish adequate time for planning that includes detailed business and feasibility assessments and addresses strategies for sustainability;
- Recruit internal champions and identify, support, and develop capable and visionary leaders;
- Attain “buy-in” from impacted staff—from administrators to line staff; and
- Be committed to adaptation and change, which are not universally embraced within systems.

Both the statewide survey and the planning grant needs assessments revealed the need to establish standardized and reliable methods for specialty care related data collection—a challenge common among safety-net institutions in many areas of patient care. Systemwide use of some common metrics and comparable data fields to capture and report on a range of variables is critical to creating an accurate clinic, regional, and statewide picture of access to care. Without valid and reliable data, it is not possible to capture and report on the status of safety-net care, establish benchmarks, assess progress, and demonstrate return-on-investment.

Numbers will not, on their own, tell the whole story. As one participant stated: “High care utilization rates do not necessarily imply waste; low

utilization rates do not necessarily imply prudence.” To give the data meaning, it is important to set benchmarks for judging progress, whether it be Medi-Cal or other cost savings, reduced wait times, increased patient and staff satisfaction, or improved performance standards.

The findings from this project so far provide a snapshot in time, but the implementation of local access strategies will continue to reflect a dynamic process and changing environmental conditions. In addition, the experiences of participating coalitions will further highlight statewide policy opportunities to address systemic barriers to specialty care access.

Future publications will address new lessons that emerge as local specialty care access strategies are implemented and evaluated. The stage is now set for supported implementation of projects around the state that are designed to reduce obstacles and to increase access to specialty care for California’s safety-net patients.

Appendix A: Specialty Care Coalitions and Grants

COALITION	LEAD AGENCY	PLANNING GRANT	IMPLEMENTATION GRANT
California HealthCare Foundation			
ACCEL Specialty Access Project	El Dorado County Department of Public Health	✓	✓
Gold Country Access to Care Coalition	Northern Sierra Rural Health Network	✓	
Improving Appropriate Access to Specialty Care in Rural California	Del Norte Clinics, Inc.	✓	
Improving Specialty Care Access on the North Coast	Humboldt Del Norte IPA / North Coast Clinics Network	✓	✓
Lassen Modoc Shasta Siskiyou Coalition	Shasta Consortium of Community Health Centers	✓	✓
MCHCC Specialty Care Planning Project	Merced County Health Care Consortium	✓	
Mendocino County Specialty Care Access Project	Alliance for Rural Community Health	✓	
Kaiser Permanente Community Benefit Programs			
NORTHERN CALIFORNIA REGION			
Ad-hoc Specialty Care Access Committee	Santa Clara Community Health Partnership	✓	✓
Alameda County Access to Care Collaborative	Alameda County Medical Center	✓	✓
Community Clinic Consortium	Community Clinic Consortium of Contra Costa	✓	✓
Fresno Healthy Communities Access Partners	Fresno Healthy Communities Access Partners	✓	✓
Marin Specialty Access Coalition	Marin County HHS	✓	✓
San Francisco Safety-Net Coalition	San Francisco General Hospital/UCSF	✓	✓
San Joaquin County Specialty Access Coalition	Health Plan of San Joaquin	✓	✓
San Mateo County SCAI	San Mateo Medical Center	✓	✓
Solano Coalition for Better Health	Solano Coalition for Better Health	✓	✓
Yolo County Future of the Safety Net	Communicare Health Centers	✓	✓

COALITION	LEAD AGENCY	PLANNING GRANT	IMPLEMENTATION GRANT
Kaiser Permanente Community Benefit Programs, <i>continued</i>			
SOUTHERN CALIFORNIA REGION			
Access OC Specialty Care Work Group	Access OC (Orange County)	✓	
Coalition of Safety-Net Access Providers	Valley Care Community Consortium (Los Angeles)	✓	✓
Kern Medical Center Specialty Care Coalition	Kern Medical Center	✓	✓
LAC+USC Camino de Salud Network Specialty Care Access Project	LAC+USC Healthcare Network	✓	✓
Long Beach Community Increased Access Specialty Care Coalition	The Children’s Clinic	✓	✓
San Bernardino Specialty Care Coalition	Latino Health Collaborative	✓	✓
San Diego Specialty Care Access Initiative	Council of Community Clinic Health Care Network	✓	✓
Service Planning Area (SPA) 3 Specialty Care Planning Coalition	East Valley Community Health Centers (Los Angeles)	✓	✓
South Los Angeles Collaborative for Specialty Care Access	Southside Coalition of Community Health Centers	✓	✓
Ventura County Safety-Net Specialty Care Access Coalition	Ventura County Medical Center Health Care Agency	✓	✓
Westside Specialty Care Access Project	Venice Family Clinic (Los Angeles)	✓	✓

Appendix B: Resources to Support Specialty Care Access

	DATE/ LOCATION	FUNDER/ ORGANIZER
California HealthCare Foundation Publications		
<i>Examining Access to Specialty Care for California's Uninsured</i> www.chcf.org/specialtycare or www.chcf.org/topics/healthinsurance/index.cfm?itemID=102587	May 2004	CHCF
<i>Transforming the Specialty Referral Process</i> www.chcf.org/specialtycare or www.chcf.org/topics/view.cfm?itemID=133607	March 2008	CHCF
<i>Bridging the Care Gap: Using Technology for Patient Referrals</i> www.chcf.org/specialtycare or www.chcf.org/topics/view.cfm?itemID=133761	September 2008	CHCF
<i>Understanding Common Reasons for Patient Referrals in Difficult-to-Access Specialties</i> www.chcf.org/specialtycare	May 2009	CHCF
Telehealth Reports and Initiatives (multiple reports) www.chcf.org/telehealth	Ongoing	CHCF
Pending specialty reports on these topics will become available in June 2009:	June 2009	CHCF
<ul style="list-style-type: none"> • Nurse practitioner and physician assistant specialty practice models • Federally qualified health centers as specialty care providers—business planning tool • Regulatory issues related to federally qualified health centers as specialty care providers • Improving specialty access through enhanced primary care scope—mini-fellowship models www.chcf.org/specialtycare		
Discussion Papers		
<i>Fuller Scope of Practice for Primary Care Providers: A Strategy to Improve Access to Specialty Care in the Safety Net</i> by Pacific Health Consulting Group 208.176.52.104/content/Upload/AssetMgmt/Site/programs/specialtycarematerials/roundtable3/ScopeofPracticeDiscussionPaper.pdf	February 2008	KPSC CB
<i>Weaving Webs in the Safety Net: Public Hospital Systems and Community Health Centers Collaborating to Improve Specialty Care</i> by Pacific Health Consulting Group 208.176.52.104/content/Upload/AssetMgmt/Site/programs/specialtycarematerials/SCAIDiscPaper2Collaboration.pdf	July 2008	KPSC CB
<i>A Slippery Slope: Financing Specialty Services in California's Safety Net</i> by Pacific Health Consulting Group www.safetynetinstitute.org/content/upload/AssetMgmt/Site/DiscussionPap3SpecialtyCareFinancing.pdf	January 2009	KPSC CB

	DATE/ LOCATION	FUNDER/ ORGANIZER
Roundtable Forums		
www.safetynetinstitute.org/content/SpecialtyCareResources.htm		
Developing and Managing Effective Referral Systems (65 attendees)	July 30, 2007 Oakland	KPSC CB
E-Health (70 attendees)	November 5, 2007 Burbank	KPSC CB
Scope of Practice (70 attendees)	March 6, 2008 Burlingame	KPSC CB
Protocols and Guidelines (90 attendees)	June 17, 2008 Sacramento	KPSC CB
Workforce Strategies (45 attendees)	September 22, 2008 San Diego	KPSC CB
Financing (60 attendees)	November 3, 2008 Burbank	KPSC CB
Technical Assistance Teleconference Calls		
www.communityclinicvoice.org/webx/.eeaf98 (register to enter)		
Needs Assessment (participant numbers unavailable)	March 8, 2008	KPCB
Coalition Building (28 participants/17 coalitions)	April 4, 2008	KPCB
Building a Case for Sustainable Strategies (35 participants/24 coalitions)	May 21, 2008	KPCB
Business Case Statements (7 participants/6 coalitions)	June 25, 2008	KPCB
Promising Practices: Telemedicine (20 participants/14 coalitions)	July 15, 2008	KPCB
Promising Practices: Volunteer Model (21 participants/14 coalitions)	July 22, 2008	KPCB
Promising Practices: Hub Model (21 participants/14 coalitions)	July 22, 2008	KPCB
E-Referral Approaches (38 participants/20 coalitions)	October 8, 2008	KPCB



**CALIFORNIA
HEALTHCARE
FOUNDATION**

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org