

A DISCUSSION PAPER

**Weaving Webs in the Safety Net:
Public Hospital Systems and Community Health Centers
Collaborating to Improve Specialty Care**

Prepared for the Specialty Care Access Initiative

**A Partnership of Kaiser Permanente Community Benefit, California Association of
Public Hospitals and Health Systems and California Primary Care Association**

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Introduction

California's safety net institutions – both public hospital systems and community clinics and health centers (CCHCs) – are experiencing increased demand for primary care services and a corresponding increased demand for specialty care services. Lack of access to specialty care for the uninsured and Medi-Cal populations is a widespread problem in California.

One set of strategies to improve specialty access involves efforts to enhance collaboration *within* the safety net in order to make better use of scarce resources, improve communication and coordination between primary and specialty care, reduce systemic barriers, and expand options for receiving care. This paper is intended as a springboard to stimulate discussion about specialty care collaborations in California's safety net, by presenting examples of different collaborations between public hospital systems and CCHCs from around the state.

Background

To address the complex issue of access to specialty care in the safety net, Kaiser Permanente Community Benefit, the California Association of Public Hospitals and Health Systems (CAPH) and the California Primary Care Association (CPCA) formed a Specialty Care Access Initiative (SCAI) Partnership. Goals of this Partnership include: identification of barriers to specialty care access and demand; elucidation of solutions to increase access and reduce demand; dissemination of knowledge about barriers and solutions; and advocacy for needed changes.

In order to formulate a baseline understanding of the issues, SCAI engaged Pacific Health Consulting Group to conduct a survey in 2007 of the CCHCs and public hospital systems in California. The survey addressed three primary research areas: the demographics of specialty care for California's underserved; the extent of the problem of specialty care access; and current and emerging practices presently used to improve access and manage demand.

Building on knowledge gleaned from the statewide survey, SCAI also began collecting qualitative data, hosting a series of statewide roundtable discussions and developing several discussion papers designed to spread knowledge, sharing promising practices, and increasing networking across safety net institutions. This paper, on collaborations, is the second of three papers in a series. The first discussion paper explored fuller scope practice for primary care providers, one of the approaches identified in the survey that has been used by some safety net institutions to increase access to specialty care; the third, and final, discussion paper will address means of sustaining specialty care access initiatives.

The Power of Collaboration

Although the term “safety net” is often used with regards to community health care for the underserved and uninsured, the system of care – and particularly, the relationships between different parts of the system -- is far from a well-woven web. Efforts to close gaps and to improve the safety net typically require effective communication, collaboration, and coordination between parts of the system.

In a recent monograph, “Real Collaboration: A Guide for Grantmakers,” David La Piana describes dimensions that characterize authentic collaborative activities. “Real” collaborations are seen as being those that¹:

- Involve leaders working closely together on substantial, content-laden issues
- Require strong motivation to partner
- May entail conflict, but must involve engagement
- Are relationship-based and require getting to know one another enough to develop trust
- Are voluntary
- Are based in the perception of potential synergies and benefits to partners’ constituencies
- Take time
- Are painful and difficult to achieve and may well engender conflict and stress which are signs of a healthy collaborative process
- Are not dependent on grant money.

Many of the projects described in this paper reflect healthy and effective collaborations, with significant improvements identified for individual groups of patients, providers and organizations. They all reflect significant investment in relationship-building, and commitment to keeping partners engaged with one another, not only in building on their successes, but in facing ongoing challenges.

Public Hospital Systems and CCHC Collaborations in California

A request for examples of effective collaborations between public hospital systems and CCHCs aimed at specialty access improvement was disseminated through CPCA and CAPH and at a SCAI Roundtable. Written descriptions of collaborative projects were collected and were followed by interviews with recommended key informants from public hospital systems and CCHCs. (See Appendix A).

Specialty Access Problems Addressed by Collaborations

A range of specialty care access problems were addressed by the sample of collaborations submitted. Not surprisingly, a number of projects in different counties noted similar conditions as the impetus for collaboration. They include:

¹ La Piana, David. (2001). Real Collaboration: A Guide for Grantmakers
<http://www.lapiana.org/consulting/pubs/reports/collaboration.html>

- A significant need to increase availability of, access to, and appropriate utilization of specialty services in county facilities and to provide more coordinated care and communication between referring and specialist providers; a desire for more rational allocation of scarce specialty appointments, reduction in wait time for appointments for most needed visits, and a reduction in the number of inappropriate, incomplete or ambiguous referrals.
- Significant inefficiencies in the referral system for patients waiting to see specialists in the public hospital system, with community health centers using outdated referral systems (handwritten referrals, faxes, phone calls, and paper) or systems that do not provide efficient determination of eligibility or track referral status.
- Poor continuity of care with little or no communication between public hospital and community health center providers.
- Lack of geographic access to obstetrical care for community health center patients and, specifically, to early pre-natal care and deliveries due to a range of systemic barriers, including cancellation of hospital Medi-Cal contracts with the state, provider availability, cultural barriers, and insufficient resources to address eligibility.
- Concern that training for primary care providers needed to emphasize broader scope and more extensive procedural training in order to ensure that safety net patients had greater access to needed services.

There were some similarities in the collaborative projects submissions. A number of the projects focus on improvements to referral systems, including shifts to reduce inefficiencies through technology and development of electronic referral systems, creation of nurse or physician pre-consultation referral review, and the implementation of guidelines to improve the quality of referrals. A few of the projects utilize additional training in specialty care for primary care providers for multiple purposes: to expand primary care scope, to enable community health centers to provide more in-house specialty care, and to create the structure for improved communication and collaboration between specialists and primary care providers. Other projects focus on increasing the number of specialists, or expanding contracted specialty services for patients. A few of the projects include either public health information campaigns, improved marketing of available services, or informational materials to help patients navigate complicated safety net services.

Specifically, the collaborations submitted were:

- 1) The Contra Costa Pre-Natal Partnership Project, created to provide appropriate, more cost-effective labor and delivery services at the county public hospital through better coordination with a community health center;
- 2) The Contra Costa Specialty Services Accessibility Guide for Community Clinics, a pamphlet for safety net patients and training for community health center staff to better understand the county referral process, system and resources;
- 3) Los Angeles Camino de Salud Network Specialty Care Initiative, a project in which community health center primary care physicians receive advanced specialty training from public hospital specialists and develop consultative relationships and opportunities to co-manage patients with specialists;
- 4) Monterey County Specialty Care Services, created to facilitate patient access to public hospital specialists and to strengthen the relationship between the community health center and public hospital;

- 5) San Francisco General Hospital eReferral, a referral system and technology interface designed to ensure more efficient and rational allocation of scarce specialty appointments through specialist review of referral requests and improved communication with referring primary care providers;
- 6) San Joaquin Community-Based Obstetrical Services, intended to increase local access to obstetrical services and earlier pre-natal care by placing public hospital obstetricians in community health centers in multiple locations throughout the county;
- 7) Santa Clara Valley Express, designed to improve coordination and information-sharing between primary and specialty care providers and to streamline the referral process through use of an e-referral system, technology interface between community health centers and the public hospital, ambulatory care guidelines, and staff training;
- 8) T.E.A.C.H., a residency training rotation through Planned Parenthood clinics to expose Family Medicine residents to a fuller range of reproductive services in order to expand their scope of practice;
- 9) Ventura County Collaboration, intended to improve safety net patient access to specialty care through primary care provider advanced specialty training, development of a referral center with dedicated staff to review incoming referrals and schedule appointments, dissemination of referral guidelines, and future plans to implement e-referral.

More detailed descriptions of each project are provided in Appendix B.

Impacts on Specialty Access

There is a range of positive impacts demonstrated by the collaboration examples. The highlights include:

- Significant decrease in wait times for targeted specialty services has been realized in public hospital systems, including neurology, rheumatology, endocrinology, pulmonary, gastroenterology; greater access to early pre-natal care and deliveries.
- Hospital-based referral reviewers and community health center primary care providers do more aggressive utilization management and specialty referral triage: a much higher percentage of more routine specialty needs of patients are managed in-house, saving specialist referrals for more unusual conditions, and allowing the sickest patients to access care more quickly.
- There is improved coordination and communication and increased opportunity to co-manage patients between specialists and primary care providers.
- Safety net organizations can more easily discuss issues or opportunities for improvement because collaborating allows their administrators, providers, and staff to build more familiar and trusting relationships.
- There are expanded training opportunities: primary care residents rotate through community health centers; residents obtain fuller scope procedural training; and primary care providers are offered the opportunity for advanced specialty training.

- Community health center staff develop more personal contacts with staff in county facilities and public hospitals, making it easier to call and get a response regarding appointment access issues or other concerns (from referral clerks to CEOs).
- Greater transparency and efficiency in referral tracking saves valuable staff time; specialty care coordinators and medical assistants have been trained and have a better understanding of more effective referral processes.
- A number of counties have realized significant strides in getting their community health centers connected electronically; many outdated referrals systems have been eliminated.
- Improvements have been made in efficiency of eligibility determination and in referral to counselors to help identify coverage options.
- Referral and ambulatory care guidelines have been developed both to help triage specialty referrals and to support primary care management of more specialty needs.
- Primary care providers with advanced specialty training provide in-house consultation to other primary care providers.
- Additional revenues were achieved: community health centers manage obstetrical patients longer into their pregnancies, allowing for more revenue and greater continuity of care; access to community grants to help pay for otherwise unrecoverable collaboration expenses (e.g., public health information materials).
- There are fewer complaints from safety net patients about the way they are treated and reports of better experiences in county hospital facilities.

Challenges to Collaboration

The challenges faced by collaboration partners are valuable to note as well. Several represent difficulties that have been addressed; others are anticipated in the future, with uncertain resolution. Some of the challenges of note include:

- The ever present threat of financing care in the safety net: a lack of sustainable funding, state budget cuts, and proposed Medi-Cal cuts;
- Increasing need for specialty care;
- Difficulty attracting and maintaining specialty and primary care providers for safety net patients;
- Technology glitches, including connectivity problems, down time due to acquisitions and upgrades, staff resistance, and the cost of hardware, software and training;
- Identifying or attracting effective future champions in other specialties, in community health centers, and in specialty departments who will provide on-going leadership for innovations and collaborations;
- Unfunded expenses associated with collaboration projects;
- Staff adjustment to more standardized procedures (e.g., no workarounds for getting patients into specialty clinics, particularly with referral guidelines and e-referral systems);

- Slow-moving bureaucracies that impede more efficient implementation of changes;
- It takes a long time to build trusting relationships between agencies and staff turnover makes them more difficult to achieve;
- Unclear how models could accommodate significantly higher volume specialty needs or additional community health centers' participation; and
- Primary care providers can experience ambulatory care and referral guidelines as frustrating, if implemented without flexibility or their input, and as unfairly shifting too much burden to them.

Lessons Learned

Cross-cutting themes regarding “lessons learned” by safety net collaborators are revealing. Key informants emphasized similar aspects of the collaboration experience in reflecting on advice they would offer others interested in developing and implementing collaborative projects. The collective wisdom of those interviewed highlight critical aspects in the collaborative process:

- Early steps need to be carefully crafted, with strong vision, leadership, and achievable goals.
- The role of adequate time for planning is crucial.
- The role of effective internal champions of the process cannot be underestimated.
- Relationships and effective communication build trust, upon which collaborations depend.
- Collaborations are developmental and evolving.
- Recognition of individual and partner contributions is important.
- Technology initiatives are planning and resource intensive.

More specific suggestions regarding each of these general themes are outlined below.

Early Steps

- It is critical that the highest level leaders in all partner agencies have bought in to the collaboration goals: CEOs, CMOs, department chiefs, health plan administrators.
- Effective, strong leadership at the beginning of the collaborative process generates good will that allows difficulties to be addressed later on.
- Emphasize common vision and the value of creating a team approach which has as its goal improvements in overall patient care; help create an increased sense that the partners are all part of a system, despite how fractured and fragmented it can seem.
- Start with modest goals that all partners can agree on.

Planning

- Anticipate that there will be a great deal of work in advance of any change initiative to understand different perspectives and to map out future; incorporate lots of advance time to work through new protocols and processes; try to avoid setting up a process “under the gun,” in a constricted time frame.
- Because the partners typically lack the resources (time, attention or skill) necessary to develop and nurture the process, consider finding and working with an effective third party agent who acts at “relationship broker,” bringing the right people together and working and organizing behind the scenes between meetings to keep things on track. Maintain awareness that all partners are working on narrow financial margins; financial planning needs to ensure that no individual constituency is disadvantaged. After initial successes with smaller projects, incremental expansion can be planned.

Role of Champions

- Key champions internal to each collaborative partners' organizations are critical in modeling willingness to re-evaluate the status quo, openness to change, and commitment to shared mission and articulating a clear vision.
- The role of energetic visionaries with strong implementation abilities cannot be underestimated.

Communication and Relationships

- Success depends on ability to develop and sustain trust between partners; need to make tremendous investment in relationship-building, hand-holding, communication, and trust.
- When things get really difficult, remember that the goal, at times, is simply to keep people at the table.
- Lines of communication must be actively kept clear and open: build in opportunities for regular feedback to be voiced and heard; encourage participants to express concerns, fears about institutional and clinical changes; ensure that there is someone who reviews feedback, is empathetic, is willing to listen to a lot of complaining with tact and gets back to people about their concerns.
- Misunderstandings can crop up easily, especially if key people are not in regular attendance at meetings; develop plan for communicating with people who are not at the table.
- Good communication supports the collaborative process and effective collaboration reinforces communication.

Process

- Each step of the way builds on what has happened before; success builds on success.
- Recognize that some ideas and plans proposed early on might not work during the development phase, but might succeed elsewhere or later.
- It is critically important to include as many constituents as possible, to get all stakeholders on board from the beginning to stay involved in planning for change: primary care, specialists, IT, administration, payors, clerical.
- Recognize diversity and the need for different strategies to engage different individuals and organizations: one style does not fit all organizations within a collaboration.
- Do not underestimate the need for on-going training to address changes in personnel and the emergence of new issues, problems and concerns.

Recognition

- Give credit where credit is due to individual agencies and staff.
- Highlight the collaboration in the community; it is beneficial to partners to be seen as working together.
- Consider small recognition and thank you gifts for partners and trainees at kick-off or training events.
- Make sure that staff requests for help, training, and feedback in partner organizations are responded to.

Issues specific to technology initiatives

- IT projects are timely and time-consuming.
- Success of large IT projects depends on ability to develop and sustain trust between the partners, particularly because frustrations are inevitable; help staff anticipate the inevitable frustrations, work changes, and ongoing need for training.

- Current status of internet connectivity, agency technology capabilities, and the capacity of the platform to handle multiple users and remote access is critically important.
- Plan for adequate IT support staff to address network infrastructure changes; important that IT staff are tactful, pleasant, and responsive.
- Sometimes you just have to make the old way not work anymore (e.g., turn off fax machine for incoming referrals).

Conclusion

Collaboration in the safety net has increasingly gained attention as a strategy to expand impact, improve services, reduce duplication of effort, and realize untapped benefits of the synergies of working cooperatively. The projects highlighted here demonstrate why collaborations can work: a small group of champions, with a clear vision, and a solid understanding of how parts of the system contribute to the whole, can accomplish significant improvements in specialty access.

Collaboration requires a commitment to viewing the safety net as a system, even where torn and sometimes unraveling, with parts that can be woven together more tightly. Collaborations create synergy as partners understand how they impact one another and recognize that their interdependence can strengthen effective connections.

APPENDIX A: KEY INFORMATION SOURCES

Contra Costa Pre-Natal Partnership Project

- Cheryl Johnson, CEO, Brookside Community Health Center
- Jeff Smith, MD, CEO, Contra Costa Regional Medical Center

Contra Costa Specialty Services Accessibility Guide for Community Clinics

- Diane Dunn-Bowie, Director, Ambulatory Care Services, Contra Costa Health Services
- Stephanie McDowell-Haley, Contra Costa Health Services
- Maeve Sullivan, Contra Costa Community Clinic Consortium Liaison

Los Angeles Camino de Salud Health Network/COPE Health Solutions

- Paul Giboney, MD, Clinica Msr Oscar A Romero
- Brian Prestwich, MD, L.A. Free Clinic
- Nicole Ramos, COPE Health Solutions

Monterey County Specialty Care Services

- Maximiliano Cuevas, MD, CEO, Clinica de Salud del Valle de Salinas

San Francisco General Hospital e-Referral Project

- Alice Chen, MD, MPH, UCSF/San Francisco General Hospital
- Lisa Johnson, MD, Community Oriented Primary Care, San Francisco Department of Public Health
- Maria Powers, Vice President, Finance & Operations, San Francisco Community Clinic Consortium
- Hal Yee, MD, PhD, UCSF/San Francisco General Hospital

San Joaquin Community Based Obstetrical Services

- Dale Bishop, MD, CMO, Health Plan of San Joaquin
- John Hackworth, CEO, Health Plan of San Joaquin
- David Jomaoas, COO, Community Medical Centers
- Becky Knodt, Community Benefit Manager, Kaiser Permanente
- Bill Mitchell, Director, San Joaquin County Public Health Services
- Jerry Royer, MD, CMO, San Joaquin General Hospital
- Jeff Slater, Grants Manager, Health Plan of San Joaquin

Santa Clara Valley Express

- Norma Avalos, Nursing Director, Gardner Family Health Network
- Jeff Collins, IT Director, Community Health Partnership of Santa Clara County
- Jill Evans, Acting Executive Director, Community Health Partnership of Santa Clara County
- Heather Frederickson, Santa Clara Valley Medical Center
- Ricardo Lopez, MD, Medical Director, Gardner Family Health Network
- Ignacio Perez, CFO, Gardner Family Health Network
- Caroline Yip, Santa Clara Valley Medical Center

T.E.A.C.H.

- Suzanne Goodman, MD, MPH, Family and Community Medicine, UCSF

Ventura County Ambulatory Care System and Medical Center

- Diana Casey, RN, Clinical Nurse Manager, Ambulatory Care, Ventura County
- Albert Reeves, MD, Medical Director, Ventura County Community Clinics

APPENDIX B:

EXAMPLES FROM THE SAFETY NET: PUBLIC HOSPITAL SYSTEM AND CCHC COLLABORATIONS

Contra Costa Pre-Natal Partnership Project (PNPP)

PNPP was created to provide appropriate, more cost-effective labor and delivery services at the county public hospital with better coordination of care. Partners included Brookside Community Health Center and Contra Costa Regional Medical Center (CCRMC). Approximately 20 additional obstetrical deliveries per month are now provided by the public hospital (CCRMC) in Contra Costa County for Brookside patients. Brookside midwives and CCRMC leaders worked to develop a plan to provide for high quality obstetrical care. Patient resistance to traveling to and using county facility needed to be addressed and a plan was implemented to market services and educate patients about using county facilities for deliveries.

Most patient care is reimbursed to the hospital through Medi-Cal. Brookside providers follow obstetrics patients longer into their pregnancies and are able to be reimbursed for more services. The clinic has experienced an increase in transportation costs, in the form of cab vouchers, because patients must travel from far parts of the county to reach the public hospital.

There have been significant successes and significant challenges. As a result of the PNPP, coordination between pre-natal and post-partum planning has been significantly improved: clinics manage obstetrical patients longer into their pregnancies, patients are discharged from CCRMC with post-partum and new baby visits scheduled at the clinic; and mid-wives have more post-delivery treatment planning contact with OB/GYNs. There are fewer complaints from Spanish-speaking patients about the quality of their care and how they were treated. Word of mouth, in addition to formal marketing and tours, has spread throughout the county and patients have been reassured that they will receive excellent obstetrical care in nice facilities by using CCRMC for labor and delivery.

Blue Cross payor patients have had to be excluded because of contractual issues with the county hospital. CCRMC has more obstetrical patients than it was designed for. Some clinic patients live far away from CCRMC; as such, the added travel time is a barrier for them and transportation, provided when necessary by the clinic through cab vouchers, is costly. Brookside advice nurses need some technological workaround to that enable them direct access to the hospital appointment system; they currently experience long wait times on the telephone to reach appointment services in the hospital. Mid-wives who want to continue to provide deliveries in their scope of practice currently can not do so until malpractice, scheduling and medical staffing issues at CCRMC are addressed.

For additional information, please contact: Cheryl Johnson, Brookside Community Health Center, cjohnson@onebox.com.

Contra Costa Specialty Services Accessibility Guide for Community Clinics

The Accessibility Guide was developed in response to community health centers' expressed concerns about general access difficulties their patients were having with Contra Costa Regional Medical Center (CCRMC) facilities. Collaboration partners were La Clinica de la Raza, Brookside Community Health Center, Shasta Diablo Planned Parenthood, the Safety Net Council, Contra Costa Department of Health Services, and CCRMC.

County and community health center staff worked together to understand clinic staff and patient concerns, conducting site visits, attending Safety Net Council meetings, and fielding patient and staff complaints. An informational pamphlet was developed and disseminated in English and Spanish for patients and staff to better understand how to negotiate the county system, explaining hours, transportation, and financial counseling resources. The county referral coordination manager now conducts annual in-service trainings at clinic sites to train staff on the referral process and provides answers to frequently asked staff questions. New referral forms were developed to improve communication. Safety Net Council is a network of safety net providers; it is used as a forum to continue to collaborate, build relationships and improve communication. Kaiser Permanente initially funded the \$4000 cost to print forms and produce informational pamphlet. County absorbs personnel time for site visits.

Through a clearer understanding of the needs and demands of multiple systems, community health centers now have a responsive contact person who they personally know and can call with access or other concerns. Specialty care coordinators and medical assistants have a better understanding of the process. Referral system allows priority ranking, so sickest patients are able to be promoted through the system faster.

There are significant challenges as well. Bureaucracies move slowly: there were long delays to obtain approvals for changes to referral form. Trusting relationships take time to build: not only will it continue to be a challenge to maintain the county's commitment to setting aside personnel time for site visits, there is significant turnover in community health center staff. As such, it is necessary to constantly renew introductions and nurture new relationships. Without additional funds, the pamphlets will not get printed.

Access continues to be a problem. From county perspective, it is unclear if the pamphlet has significant impact or is being disseminated; community health center patients make up a very small percentage of the total patients waiting for limited resources at the public hospital.

For additional information, please contact: Dianne Dunn-Bowie, Contra Costa Health Services, ddunnbow@hsd.cccounty.us.

Los Angeles Camino de Salud Health Network- Specialty Care Initiative

The Camino de Salud Network is an integration of community clinics with the LAC + USC Healthcare Network. The goal of the Network is to develop a sustainable healthcare system with neighborhood access to primary care; enhanced access to specialty and diagnostic care; and the coordination of primary care with inpatient and outpatient specialty and diagnostic services.

Building on a prior pilot project focused on management of frequent users, COPE Health Solutions facilitated dialogue and partnership around specialty care access between LAC+USC and community health centers through the Specialty Care Initiative. Through the Initiative, the Camino de Salud Network expands the scope of practice of the primary care providers and builds true collegial relationships between specialists and community clinic primary care providers. These relationships improve clinical confidence between specialty and primary care providers and serve to address problems or issues that may arise in coordinating patient care.

Monthly Community Grand Round meetings provide a forum for hospital specialists and community clinic providers to build professional relationships. During these meetings providers will gain information on the challenges faced by each entity and the ways in which they may collaborate with one another to improve access to care. During the monthly Community Grand Rounds, consensus care guidelines are created for each specific specialty and delineate different acuity levels for care provided in a community clinic or hospital setting depending on acuity.

Participating community clinic providers undergo training under a specialist working at the hospital in order to gain the clinical confidence necessary to properly implement and follow the guidelines. Upon completion of a fellowship, providers have access to phone consultations and chart reviews in order to obtain medical advice from the specialist whenever necessary.

The Specialty Care Initiative implemented models for rheumatology, a specialty need with a manageable level of volume, and cardiology; work is currently expanding to gastroenterology and ophthalmology.

The Camino de Salud Network Specialty Care Initiative has enabled the clinics to do more aggressive utilization management to ensure that referrals are requested only for conditions and patients most critically in need of specialist visits. In one year's time, more than 300 hours of rheumatology and cardiology Medical Center specialist's time has been saved. For rheumatology, at Clinica Msr Oscar Romero, over 90% of patients are managed in the clinic, with only unusual conditions like Lupus being referred to specialists. Clinic specialty champions who gain specialty skills are able to offer curbside consultation in-house to other primary care providers. Better communication between primary and specialist care providers are apparent, with primary care providers no longer describing the sense that their referrals in impacted areas go into "black holes" at LAC/USC Hospital.

With any emerging systemic change, there has been number of significant challenges to address with this project. The first phase of project has involved a small number of clinics and lower volume specialties; it is unclear how sustainable this model will be when as it attempts expansion to other, higher demand specialty areas and to other clinics. Primary care physicians serving as clinic specialist champions need to have training and administrative time carved out of their schedules; in addition, management of specialty patients generally involves greater appointment time and more costly diagnostics and medications. Some clinics may not be able to afford this impact on primary care time and resources. Without attention to the need for flexibility, ambulatory care guidelines designed to reduce inappropriate referrals to specialists can unduly tax and disadvantage primary care resources; merely shifting the burden of and demand for potentially expensive diagnostics and medications to patients' primary care home is not a sustainable mechanism.

For additional information, please contact: Nicole Ramos, COPE Health Solutions, nramos@copehealthsolutions.org.

Monterey County Specialty Care Services

This project was developed to meet the specialty needs of the safety net patient population in Monterey County. Partners are Clinica de Salud del Valle de Salinas, the Monterey County Health Department, Monterey County Board of Supervisors, the Natividad Medical Center (NMC) and NMC Family Medicine Residency Program.

NMC provides specialty consultation in hospital clinics using its full-time staff and visiting faculty from UCSF. Community health center physicians belong to the medical staff of the hospital and work closely with the hospital and community health center to make sure patients have access to needed care. NMC has functioning specialty clinics that also support its Family Medicine residency Program. The community health center medical director and CEO met with hospital administrators to facilitate safety net patient referrals to clinics; when that is not possible, temporary access to community specialists is used.

Specialty care is accessed when needed. Organizations can more easily discuss issues or opportunities for improvement because most of the individuals know one another. The community health center administration has more access to hospital administrators now. An additional positive impact is that arrangements have been made to have Family Medicine residents rotate through the community health centers, because medical staff members also have academic appointments at University of California-San Francisco.

For additional information, please contact: Maximiliano Cuevas, MD, Clinicas de Salud del Valle de Salinas, mcuevas@csvslink.org.

San Francisco General Hospital e-Referral Project

This eReferral project was designed to reduce wait times for specialty care through more rational allocation of scarce appointments. It sought to improve the quality and appropriateness of referrals (assuring sufficient indication and primary care evaluation, and enhancing specificity in consultation requests) through improved communication and education between referring and specialty providers. The collaborative partners were San Francisco General Hospital (SFGH); the University of California, San Francisco; San Francisco Department of Public Health (SFDPH) Information Systems; 15 clinics in the SFDPH Community Oriented Primary Care (COPC); 10 clinics in the San Francisco Community Clinic Consortium (SFCCC); and the San Francisco Health Plan.

SFCCC and SFDPH clinics have access to SFGH's Lifetime Clinical Record, an electronic health record. eReferral is a program developed by Dr. Hal Yee in conjunction with the SFDPH IS group which provides a HIPAA-compliant, web-based, secure platform for primary care providers to submit referral requests to SFGH-based, UCSF specialists. Specialty referrals are submitted electronically and reviewed by a designated specialty clinician who assesses whether patients should be scheduled or if additional information or clarification is needed from the referring provider. The project was developed by and piloted for gastroenterology and liver clinic referrals. It has subsequently been expanded to six additional medical subspecialty clinics and six surgical clinics, with the plan to target all other specialties, including medical, surgical, and radiological services in the future. The significant cost to build and maintain a connection to the LCR for the SFCCC Clinics has been paid for through SFCCC investments of over \$4 million, creating the virtual provider network and infrastructure with monies obtained through federal sources (e.g., H-CAP, ISDI), Tides Foundation Community Clinic Initiative, Kaiser Permanente and other funders. Funds available to help create and maintain the system have decreased over time. The San Francisco Health Plan provided approximately \$1.5 million to support the initial expansion and evaluation of eReferral project. Ongoing support for reviewer time is being supported by SFDPH.

Wait times for gastroenterology, endocrinology, rheumatology, orthopedics, neurosurgery, podiatry, and pulmonary appointments at SFGH have decreased significantly. More effective medical triage is occurring with a reduction in the numbers of inappropriate specialty referrals. A triage system allows for the opportunity to be more realistic about cost-effective systems and resource allocation, and to take a hard look at the patient as part of a system with physicians as one of the resources that need allocation. eReferral is now integrated with SFGH databases, minimizing need for repetitive data entry of demographic and clinical diagnostic information. Centralized electronic submission process allows transparency in referral tracking, saving valuable staff time. Two thirds of primary care providers report that patient care has improved with eReferral, with somewhat less enthusiastic assessments by community clinic primary care providers than their counterparts at Public Health or SFGH-based clinics. The less enthusiastic, although still favorable, review of the program by SFCCC providers is thought to reflect greater difficulties with IT connectivity.

Remote access to the centralized referrals system has many glitches, particularly for referral clerks: having to log-in multiple times, getting timed out on log-ins and, generally, having connectivity problems related to bandwidth. The out-of-network, SFCCC clinics have been more heavily impacted by these problems. The eReferral system was initially built as a home-grown system for a single-specialty and for hospital-based providers; it has been challenging to maintain its functionality and capacity as additional specialties and outside clinics have been added. Clinics have needed costly additional hardware, upgrades, and training to increase utilization. Clinic staff are accustomed to work-arounds to advocate for their individual patients and are not accustomed to more standardized processes. An additional challenge is the need to expand the base of internal advocates beyond the formative partners, and to cultivate leaders within each specialty area willing to champion the cause, sustain investment in change, and manage the difficulties of implementation.

For additional information, please contact: Hal Yee, MD, San Francisco General Hospital, hyee@medsfgh.ucsf.edu or Alice Chen, MD, SF General Hospital, Achen@medsfgh.ucsf.edu.

San Joaquin Community Based Obstetrical Services

The goal of this San Joaquin county project was to increase access to local obstetrical services and to earlier pre-natal care. Collaboration partners were the San Joaquin General Hospital (SJGH), San Joaquin County Department of Public Health, Community Medical Centers (CMC), and Health Plan of San Joaquin.

SJGH provides obstetricians to work in CMC locations, enabling them to offer pre-natal care and obstetrical services on-site and to provide continuity of care for hospital-based procedures. Over time, the program has grown from 1 FTE OB/GYN in one site to a total of almost 6 FTE providers in multiple locations throughout the county. An additional community pre-natal collaboration was developed as well: "Go Before You Show" is a public health information campaign that provides and promotes early pre-natal care with educational materials and information regarding eligibility, directs patients to the providers who give presumptive eligibility for care, and helps patients negotiate the range of community resources. The clinics maximize program funding, billing Medi-Cal using FQHC rates, Comprehensive Perinatal Services Program (CPSP), Sweet Success (to help pay for registered dietician for nutritional counseling component); CPSP reimburses hospital for patients seen. Coverage for some of the unrecoverable costs (e.g., outreach) has been subsidized through a range of sources, including Health Plan of San Joaquin's community grants program; First 5 San Joaquin and Health Plan of San Joaquin funding of outreach, enrollment, and utilization activities; and First 5, Health Plan of San Joaquin, and private foundation support of the Healthy Kids program. Kaiser Permanente has provided financial support as well.

Significant positive impact has been demonstrated with an increase in the number of women being seen in community health centers for earlier pre-natal care, and then staying for delivery. The rate of pre-natal care at CMC is higher than that for the county generally. Currently, CMC is seeing 64% of its patients for early pre-natal care and has, as a future goal, reaching 90% of its target population. Pregnant patients are identified earlier and fast-tracked for appointments. The collaboration has provided good opportunity to network, identified available community resources, and support integration of resources for safety net patients.

There are significant challenges as well. There are generally too few obstetrical providers for the safety net population; and access to care, overall, will be further impacted by the recently approved Medi-Cal provider rate cut. The strategy of using primary care providers impacts their availability for other services. Space constraints at some locations limit the extent of services that can be made available. Increasing capacity and public education means that clinics are seeing higher acuity in diabetic complications which are more resource intensive. Sustainability funding is unclear to adequately support outreach, enrollment, and partner interest.

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Santa Clara Valley Express

The goals of this Santa Clara county project were to improve coordination and information-sharing between primary and specialty care providers, streamline referral process from community clinics into specialty care at the public hospital, enhance scheduling processes, and increase use of improved clinical practice referral guidelines to enable better triage of limited specialist resources.

Collaboration partners were the Community Health Partnership (CHP) of Santa Clara County, nine CCHCs, Santa Clara Valley Health and Hospital System (SCVHHS), Valley Medical Center (VMC), and key staff members from Information Systems and Provider Relations at Valley Health Plan, the county health plan.

Technology was developed to enable electronic, web-based referral into the public hospital system specialty clinics; community health center primary care providers were trained to use new guidelines in completing referrals; and referral clerks were trained to use new technology. On-line questions and ambulatory guidelines provide resources and suggestions intended to help referring providers triage patients for services. CHP has taken the lead in coordinating all the partners to ensure constant communications and ongoing project planning. Communication is facilitated by regular quarterly meetings to support the collaboration, and at least three other meetings every two months that involve IT, claims managers, medical directors, quality managers from different parts of the system. H-CAP funds, a federal program to expand access to care for the uninsured, funded a considerable amount of clinic cost; some costs were not covered. SCVHHS paid for the bulk of the referral system, while CHP obtained funding for hardware (scanners, printers, computers for clinics). Preliminary round of funding paid for a classroom with necessary equipment; VMC is bearing cost of trainers.

Implementation of the Valley Express is showing promise. Kick-off of the e-referral system took place approximately two years after inception of project. All clinics except one have achieved technology interface. Fax referrals have been eliminated and all specialty referrals to VMC are done electronically, with sections for referring providers and referral clerks to complete. 80% of patients needing specialist appointments are able to be authorized within 3 days and the remainder within 6 days. There is an on-line mechanism to identify patients whose eligibility is not yet determined and links them to a hospital counselor more efficiently to work on eligibility qualifications. Confirmation reports regarding receipt of referral are available. Referring physicians can electronically access ambulatory care and preventive care guidelines as referral resources.

There have been a number of challenges along the way. Many community health centers did not have sufficient capacity for connectivity (i.e., hardware or bandwidth) and there were significant delays in implementation, both on the community health center and the public hospital system side, as hardware and software were integrated. The VMC website is slow, which exacerbates other connectivity problems. The current system does not have capacity to provide feedback about the status of scheduled appointments which is a source of concern, but it is anticipated that this capacity will be available to clinics within the next six months. There are significant clinic impacts, including some challenges getting all staff to embrace the process, changes in some job functions and work processes, and an ongoing need for training for referral clerks and providers. While there have been funding cuts and a loss of staff guidance due to the ending of H-CAP programs, the Community Health Partnership and SCVHHS provide significant guidance and support. Despite the challenges, the project has proven to be both a success and a true collaboration between the Community Health Centers, the Community Health Partnership, and Santa Clara Valley Health and Hospital Systems.

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Training Early Abortion for Comprehensive Healthcare (T.E.A.C.H.) Program

The goal of this project was to provide residency training through Planned Parenthood clinics to expose residents in Family Medicine to a fuller range of evidence-based and patient-centered reproductive services, including pregnancy options counseling, early ultrasound dating, contraception, pre- and post-abortion care, and outpatient miscarriage management in order to expand the future scope of family medicine provider practice. Provision of comprehensive reproductive health care services has been found to be well-suited to the strengths of family physicians, as they are widely distributed in medically underserved areas, have procedural training, and routinely provide women's primary care and early pregnancy care.

The TEACH Program's collaboration partners include four Family Practice Residency Programs at UCSF, Sutter Santa Rosa, Contra Costa Regional Medical Center (CCRMC), and Natividad Medical Center, three Planned Parenthood affiliates including Golden Gate, Mar Monte, and Shasta Diablo, and Reproductive Health Education in Family Medicine (the national coordination center at Montefiore Medical Center in New York). The program has been partially grant funded.

Residents in the 2nd or 3rd year of their Family Medicine Residency Program rotate through the Planned Parenthood clinics for training in comprehensive women's reproductive health. This initiative incorporates didactics on public health aspects of abortion, contraceptive and pregnancy options counseling, pregnancy dating, procedural training in abortion and miscarriage management, and interactive conferences, including values clarification sessions. Residents spend 4-8 days at Planned Parenthood clinics, where both problem based review and procedural training occurs. Residents become skilled in counseling women about their pregnancy options, first trimester ultrasound, pelvic exams in early pregnancy, IUD placements, and, to the extent that they wish, first trimester aspiration and medication abortion.

The great majority of graduates receive training and exposure to fuller range of reproductive services and procedures which are reflected in their training satisfaction (even among those who opt out of training in abortion procedures) and feelings of preparedness to integrate many of the skills learned upon graduation. There is a growing network of family physicians who are experts in reproductive health care which provides greater opportunities for academic networking, career development, and normalization of reproductive health care in general practice. Proactive means of exposing new generation of primary care providers to the benefits of Planned Parenthood as a valued training institution and center of excellence for patient care.

The critical challenge is overcoming concerns that the provision of abortion services is controversial and polarizing. It is important to provide opportunities to talk and work through areas of anticipation and fears in a safe environment. Enlisting champions from the outset is critical, from within the different parts of the hospital (obstetrics, radiology, anesthesia, nursing department, residency program, and staff) to build support.

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Ventura County Collaboration

The goals of the Ventura County collaboration included improved tracking system to monitor impact on access, creation of a Referral Center that coordinates and reviews referrals, development of clinical protocols and referral guidelines, and specialty training for primary care providers. Collaboration partners were the Ventura County Ambulatory Care System (VCAC), Ventura County Medical Center (VCMC), and Ventura County Health Care Agency, 11 privately owned primary care clinics.

The program includes several components: primary care provider specialty training, review and coordination of incoming referrals by Referral Center staff, and development of referral guidelines; in addition, an e-referral system is currently being developed.

Initially, a pre-consultation screening process was developed and targeted to most impacted specialties and an intervention piloted to provide advanced specialty training for primary care providers, first in Hepatitis C, dermatology and rheumatology, and then expanded to neurology, oncology and nephrology. The Ambulatory Care Department recruited family medicine and internal medicine physicians from clinics who were interested in advanced specialty training; they were provided the opportunity to work one half day/week alongside selected specialists. PowerPoint training was developed and distributed via CD format on how to do Endoscopy consultations. In addition, Medical Center staff and contract specialists see patients both in the hospital system and at clinic sites. In 2007, a Referral Center opened which coordinates outside referrals, centralizing the processing, providing for nurse/physician referral review, and appointment scheduling using experienced nurse reviewers. This intervention reduces inappropriate or incomplete referrals, frees up more time for patient care at specialty clinics, and enables referral tracking through use of a database and electronically booked appointments. E-referral, with built-in referral guidelines, clinical and research information, as well as a much-needed opportunity for providers to check status of referrals, is currently being developed. The Medical Center and Ambulatory Care covered funding for an additional RN, specialists, training and support staff, with clinics picking up the cost of lost productivity for primary care provider specialty training time. Health Care Agency administration is probing different avenues for funding, including talking with private IPAs about sending referral business through our specialists to increase payor mix. Kaiser Specialty Care Initiative funding will support ongoing community collaboration work to continue to address impacted specialties.

Positive changes have been documented after one year with Referral Center. Referral tracking is in place and the following impacts documented: Neurology experienced a 32% reduction in appointment wait time; rheumatology, 10% reduction; endocrinology, 14%; and nephrology, 30% ENT services continue to be most impacted specialty with long wait times and waiting lists for appointments. The wait for gastroenterology appointments is less than two weeks, with urgent slots available in four days. Referral centers are fulcrum for communication and coordination and nurses are in contact on a daily basis with primary care providers and specialists to facilitate referrals. Lots of enthusiasm about a newly initiated community coalition which will address impacted specialties and continue to help think in creative ways about funding and improving health care delivery for safety net patients.

There have been significant challenges as well. The volume of need for specialty care continues to increase, threatening to overwhelm the Referral Center, and requiring evolving strategies. Specialty training and practice for primary care providers means reducing their primary care productivity and availability. Staff turnover and challenges recruiting primary care providers is an ongoing problem as are constant funding constraints. All the primary care clinics are privately operated and are diverse both geographically and organizationally, and often have different needs and cultures. If left out of the development process, primary care providers can feel that referral guidelines create more "hoops to jump through," unfairly shifting responsibility to them while limiting access to specialists. Referrals are still done on paper; system needs to move to an electronic platform to reduce inefficiencies.

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