Specialty Care Access Initiative
Roundtable Forum #1 – Innovations in Specialty Care Referral Systems
July 30th 2007; Oakland, CA

ROUNDTABLE AGENDA

I. Overview of Partnership to Improve Specialty Care Access – Kaiser Permanente, California Association of Public Hospitals, California Primary Care Assocation
II. Presentations of Current Innovations in Specialty Care Referral Systems
    a. Valley Express e-Referral System & Guidelines (Jill Evans, MPH; Joe Sexton, RN, MPA; Christine Tyler, RN, MPH)
    b. Camino de Salud Network Streamlined Referral Process & Guidelines (Brian Prestwich, MD; Mike Roybal, MD)
    c. SFGH Specialty Clinic eReferral Project (Alice Huan-mei Chen, MD, MPH; Lisa Pratt, MD, MPH)
III. Small Group Discussions
    a. Expanding Primary Care to Provide Specialty Care
    b. Financial Sustainability
    c. Workflow Issues
    d. Specialty Care Referral Systems in Areas Without Public Hospitals
IV. Large Group Reflections and Meeting Assessment

NOTES FROM SMALL GROUP DISCUSSIONS

TOPIC: EXPANDING PRIMARY CARE TO PROVIDE SPECIALTY CARE

Issues and Opportunities

- NPs trained in specific clinical conditions/chronic care to work with more complex patients (e.g. in DM, CHF, Asthma) as is being started in SF Dept. of Public Health. With FQHC clinics, NPs are billable for this. Make sure the NPs have specialist backup/supervisor, about 0.25 MD/1.0 NP and make sure the backup is a consistent person for the NP to interact with.
- Have house staff as "specialists" e.g. the Camino del Salud model in LA
- In rural counties, the most pressing need is integrated behavioral health training. Fund the services at the clinic. Use Tele-medicine service where possible for this and also be able to bill for this tele-medicine service.
- Have agreement between specialists and primary care providers on clinical guidelines and labs and diagnostics; often what specialists want are too expensive for PCPs to provide at clinic.

New Ideas

- Primary care champion with specialist back-up model from LA
- "Learning by doing"
- NP Model and training as in SF
- FQHC Specialty Care Billing

Interested in pursing further:

- Expanding LA model
- Other models and hybrids of the models
- Cost-benefit analysis of models
- Compensating primary care for providing more advanced care
- Medication costs

TOPIC: WORK FLOW ISSUES

Issues and Opportunities

- Hardware—provides access (computers in exam rooms and hallways; e-referral "lite" used by CHC, interoperability between PMN systems and lab; provider training)
- Focus placed on provider
- Tracking notification challenges: multiple system tracking programs, not all private specialists have access to a tracking system, e-mail f/us to PCP, increased no show rates, assign follow-up roles and responsibilities
- Referrals challenges: time to dictate, communication between provider and MA, difficult to contact patient, real time data entry, restricted roles of the MA, physicians not consistent in reviewing referrals, multiple yet similar forms, no standardized authorization process, include work with IT in staff evaluation, reliance on personal connections with specialists

New Ideas

- Transforming ownership to patients
- Computer training for providers/staff
- Virtual patient decision-making process guide
- Regular brownbag lunches between providers and specialists to increase communication

What to explore in the future

- Who would review referrals?
- Addressing urgent referrals
- Facilitating two-way communication between providers and specialists
- Funding reimbursement

- Advocacy
- E-referral vs. E-consult

TOPIC: FINANCIAL SUSTAINABILITY

Issues and Opportunities

I. **There is no financial incentive for increasing access to specialty care for the uninsured.**
    - Need to incentivize community based providers.
    - Need CMSP dollars to flow to clinics.
    - Need investment – hardware, software, etc., especially in absence of HCAP funding
    - Need to be reimbursed for administrative time
    - Need start up costs, which right now, we have through foundations, grants, etc., but need institutional support and long-term sources of self sustaining funds

II. **At what point does improving efficiency translate to a decrease in specialty care utilization? What is the unmet need?**
    - Must take into account the high cost of these patients in terms of psychosocial needs.
    - Can we really decrease demand by increasing the scope of practice of PCP's?
    - Is there a metric of specialty care utilization?
    - Need to improve service line management – what specialties are truly needed? Look at the "slack" in the system – are some clinics under-utilized? 25-30% referrals could be pulled out if you could do this, how do you convert that to a dollar? At least part of it is savings
    - From the presentation, LA had a driver – they were reducing the number of beds at the new LAC+USC Medical Center. What's our driver?
    - And San Francisco had an outstanding physician champion – how do we get someone like Hal Yee to implement changes? Requires leadership at the CEO level
    - How did SF pay for e-referral system? From the SF Health Plan – not because of an ROI for them, just from their good will.

III. **How can KP become more involved in providing specialty care services more directly?** Right now, KP focused more on providing technical assistance. Looking into the idea of providing direct specialty care services however. In terms of TA, what's needed is training for NP's and RN's to do routine, less costly specialty procedures

IV. **Where else can we look to demonstrate savings through, or identify metrics of, improved specialty care access?**
   - Models of cost savings within Medical
   - Performance standards for Medi-Medi's
   - Changes in payor mix

V. **Before taking on any specialty care improvements, have to be assured that there is capacity at the primary care level to take on these patients.**

New Ideas

- Define metrics that are common in safety net
- Model for tracking savings (return on investment)
- Standardizing metrics/definition/benchmarks
- Does their have to be ROI? (improve quality, increase pt./staff satisfaction, decreasing health disparities)
- Aligning incentives throughout safety net (for community clinics)
- Look throughout specialties (procedure/non-procedure)
- Specialty care extenders (MD, NP/PA)
- Operational efficiencies
- Research where medical students are going

Continue to work on:

- Look at referral software from KP
- MD Champions - Kaiser training
- ROI – savings in other institutions
- Leverage opportunities to share resources
   - Guidelines
   - Subspecialty resources across counties
   - Community volunteer networks

TOPIC: SPECIALTY CARE REFERRALS IN AREAS WITHOUT PUBLIC HOSPITALS

Issues and Opportunities

- Billing and reimbursement issues
- HRSA Ban (on specialty scope change)
- Telemedicine, catalogue of capability from the specialists (e.g. UC system) and community
- Secure portal statewide
- Local barriers, tax incentives

Short term ideas:

- Meeting with medical societies, private, county MIA HP to allow for relationship building and organized systems among and between the participants
- Mini-fellowships via Med schools, associations, UC system, etc.
- Explore access to care e.g. Operation Access
- Specialty Triage
- Non Public Hospital CHCs refer to private specialists

New Ideas

- Public/Private collaborations
- Medical Society
- County MIA
- Incentives for Specialist
- Legal Issues
- CPCA to identify barriers
- Telemedicine reimbursement
- Liaison between UC and CPCA
- Statewide solution (rural)
- Optometry

LARGE GROUP REFLECTIONS AND MEETING ASSESSMENT

Possible Future Roundtable Topics and/or Activities

- KP Resources Demo/Availability
- Strategies on Payment
- Recruiting MDs
- Community Volunteer Networks (how can/should they be used)
- Locum Tenens
- Opportunities to share sub-specialty resources
- Malpractice issues
- Where are Med students going?
- Citizenship
- Opportunities to share guidelines
- Rural Issues

Meeting Assessment

Valuable	Δ
Presentations (would like it if groups were further along with their processes)	Earlier start time and end time
Get together with colleagues	Think about expanding the conversation and audience (e.g. policy)
Open Space-everyone together from different perspectives, better than expected	Focus on practical at wrap-up
Discovered not alone on issues	Q & A too short, let discussion flow from presentations
	Have presenters stay for discussion afterwards