



Redesigning Specialty Care in Community Clinics: A California Case Study

Introduction

California's more than 700 community-based, primary care clinics comprise the backbone of the state's health care safety net, annually serving more than 2.8 million primarily low-income, minority, and immigrant patients.¹ For patients who depend on these safety-net services, however, lack of timely access to specialty care is a significant and growing challenge that can contribute to poorer health outcomes.² Problems with specialty care access for these patients arise from a combination of factors: a dearth of specialists at the clinics themselves; the clinics' lack of specialty diagnostic tools and equipment; primary care providers' (PCP) difficulties in obtaining specialist consultations; absence of clear lines of communication between PCPs and specialists; and extensive wait times for patients to obtain specialty appointments and diagnostic services at other sites.

In 2007, as part an effort to advance the larger goal of integrated community care in the safety net, the California HealthCare Foundation (CHCF) funded COPE Health Solutions (COPE) to initiate local strategies for improving access to specialty services for safety-net clinic patients. Soon thereafter, the *Camino de Salud* (Road to Health) Network (CDSN) of private and public health care providers in downtown and East Los Angeles joined COPE, with additional grant funds and resources from the QueensCare Foundation and the LA Care Health Plan, to develop the Provider Practice Redesign project.³ This project was to shift how CDSN PCPs interacted with public county hospital specialists at the Los Angeles County/University of Southern California

(LAC+USC) Medical Center, with the goal of improving clinic patients' access to specialty care.

CDSN's Provider Practice Redesign had several aspects, which were implemented primarily for care of its rheumatology and cardiology patients:

- **Consensus Care Guidelines**, collaboratively developed by the network's PCPs and the specialists, and implemented throughout the primary care clinics;
- **"Specialty Champions,"** PCPs given specialized training in a particular field by specialists to whom they referred patients;
- **Phone consultations** between Specialty Champions and specialists to determine whether a referral was necessary and to assist with some specialty care at the clinics; and
- **Community Grand Rounds**, monthly meetings at which PCPs, specialists, and administrative and medical leadership discussed respective and common challenges to providing specialty care access.

These redesign efforts were supplemented by grants from other funders to support the establishment of a mobile echocardiogram service, a cardiac stress treadmill at one clinic location, an endoscopy suite at another, and two optometry units at a local community clinic.

Results of the redesign were encouraging. Overall, referrals were more appropriate, and a significant number of rheumatology and cardiology patients were able to be managed at the primary care

sites. These changes were congruent with reports from the clinics' PCPs of their expanded experience, and of increased confidence in diagnosing and managing these patients themselves.

This issue brief reports on the nature and process of the CDSN redesign and on the project's impact on specialty care access for the network's patients. The brief also discusses some of the challenges encountered and lessons learned from implementation of the redesign, and how this experience might benefit other safety-net communities as they grapple with their own specialty care access problems.

The State of Specialty Care in Downtown/ East Los Angeles

CDSN serves the safety-net community within the service area of the LAC+USC Medical Center. This is a densely populated area of downtown and East Los Angeles that is home to over 3 million residents—more than 23 percent of whom are uninsured and lack access to a regular source of care.⁴ Even for patients who are able to access primary care through local safety-net clinics, however, limited and delayed access to specialty consultations, diagnostics, and treatments frequently worsen disease severity and lead to compromised health outcomes.

Specialty Care at Hospitals

LAC+USC Medical Center serves as the anchor hospital system for CDSN. As one of the largest teaching hospitals in the country, and one of the busiest public hospitals west of the Mississippi, LAC+USC Medical Center has significant difficulty meeting the community demand for its specialty care services. Currently, wait times for some specialty areas average six months or more. Safety-net patients who are unable to obtain a timely specialty care appointment are often referred to a hospital emergency department (ED) instead. This pattern leads to ED overcrowding and places patients in the care of emergency physicians who are not equipped to serve as PCPs or to monitor specialty referrals. Additionally, referring patients

to the ED for specialty services results in much higher costs without improved health outcomes.⁵

A shrinking budget and a growing population of uninsured patients combine to overwhelm the medical center's already limited resources. Poor communication and coordination, and the lack of a comfortable overall working relationship, between the hospital and the community clinics have exacerbated the problem, reducing both entities' ability to efficiently and appropriately manage patient care. One element of this dynamic is revealed by specialists at the LAC+USC Medical Center expressing frustration over the volume of cases they believe can and should be handled at the primary care level instead of being referred to them.

Clinic Response to Specialty Care Patients

PCPs in CDSN identify a number of serious challenges in providing specialty care for their patients. First, they lack standardized guidelines for care and referral processes; such guidelines could provide confidence for both PCPs and specialists that the referrals being made are appropriate. Further, PCPs report difficulty accessing specialist consultations that might confirm or obviate the need for a referral. In addition to poor lines of communication between PCPs and specialists, there is a lack of coordination between them once patients are referred. Finally, PCPs report extremely long wait times in accessing specialty care services for their patients, often preventing patients from receiving the appropriate standard of care. These problems exist in the context of the clinics' difficulties in managing complex disease processes at the primary care level due to poor financial incentives and lack of accessible diagnostic resources.

Many of these challenges stem largely from a structural disconnect between the community clinics and the county medical system. While their patient populations frequently overlap, each system exists in a service silo that fails to properly and efficiently communicate with the other. This environment contributes to an

inefficient overall safety-net health system wherein care is delivered episodically, making it much more difficult for community clinics to focus their energies on preventative care and chronic care management.

Framework for Decentralizing Specialty Care and Diagnostics

Based on the challenges and needs described above, CDSN providers and COPE jointly conceptualized the Provider Practice Redesign project. With LAC+USC Medical Center serving as the anchor hospital system, the project was implemented across CDSN's community clinic organizations under the rubric "the right care, at the right place, at the right time."

The project sought to improve the rate of appropriate referrals from primary care community clinics to specialty care through a combination of jointly (between primary care and specialist physicians) developed specialty care diagnosis guidelines and enhanced training of some of the clinics' PCPs. The project also sought to improve access to and use of diagnostic services through decentralization of these services under the newly developed guidelines. If successful, it was hoped that this project could be used as a model for other providers in under-served communities throughout California and the United States.

Based on CDSN provider input regarding feasibility of implementation and anticipated impact on care, rheumatology, cardiology, and ophthalmology were selected to be the project's central focus. The project used the following four interrelated strategies to systematically enhance access to specialty care for CDSN patients in the chosen specialty areas.

Community Grand Rounds. Monthly Community Grand Rounds meetings provided a forum for hospital specialists and community clinic providers to discuss challenges relating to specialty care access and to build professional relationships. Prior to implementation of these meetings, clinic providers and hospital specialists

had limited opportunities to interact. Community Grand Rounds were also open to and regularly attended by both administrative and medical leadership from LAC+USC Medical Center, enabling medical center leaders to heighten their understanding of community clinics.

During these meetings, primary and specialty care physicians learned about each other's respective challenges and the ways in which they might collaborate to improve specialty care access. For clinic providers, these monthly meetings also served as education opportunities concerning specialty care. At certain meetings, Continuing Medical Education (CME) sessions, approved by the Los Angeles County Department of Health Services, were facilitated by LAC+USC Healthcare Network specialists.

Consensus Care Guidelines. Clinic PCPs and hospital specialty physicians collaborated to develop Consensus Care Guidelines, which not only served as the basis for referral decision-making but also fostered trust between the two physician groups on which to build future clinical collaboration, including consultations and patient co-management. These guidelines were disease-specific, delineating different acuity levels for care in community clinic and hospital settings and defining the referral protocol. Accurately differentiating patients' levels of acuity helped limit specialty referrals to the most severe cases, thereby reducing the number of referrals that wound up being rejected or deferred. All guidelines developed through this project were anchored by national specialty care guidelines, with key adjustments made to reflect the specific specialty care and diagnostic capacities of the project's hospital and clinic partners.

Mini-Fellowships. Following the creation of the Consensus Care Guidelines, participating community clinic providers were given the opportunity to train with hospital specialists in order to gain the clinical experience and confidence needed to properly implement the guidelines. Participating community clinic organizations

were asked to designate one PCP per targeted specialty to be a Specialty Champion. These Champions attended “mini-fellowship” training sessions, which consisted of two half-days at LAC+USC Medical Center during which the PCPs shadowed a designated specialist. These sessions exposed the PCPs to a breadth of cases at a given specialty clinic and showed them how patients were managed there. The sessions focused on expanding the Champions’ scope of practice and improving their ability to manage common conditions at the primary care home, based on the Consensus Care Guidelines.

Feedback from PCPs who participated in mini-fellowship sessions revealed a wide range of experiences. The majority of providers indicated that the most valuable aspect of the sessions was the opportunity for relationship-building with specialty care providers. Some PCPs, however, reported an incomplete level of engagement by the specialists during the sessions. Based on this feedback, COPE is continuing to work with LAC+USC Medical Center specialists and the PCPs to refine the mini-fellowship sessions. This process will include the creation of a formalized curriculum for each rotation and will offer up to ten CME credits per session.

Phone Consultations. Upon completion of the mini-fellowship sessions, each Specialty Champion began phone consultations with the session specialist. On average, phone consultations took place bi-weekly. Phone consultations decreased over time for rheumatology Champions but remained constant for cardiology Champions. Participating providers were originally assigned a specific phone consultation time-slot. However, many PCPs reported challenges in reaching the specialists at the designated time or finding another mutually agreeable time to discuss cases. As a result, the project is currently evaluating secure electronic consult (“e-consult”) and other health information exchange systems that might supplement and facilitate these phone consultations and other information-sharing (e.g., laboratory and diagnostic results) between specialists and PCPs.

Project Impact and Challenges Regarding Specialty Access

The Provider Practice Redesign project produced immediate, positive qualitative and quantitative results among almost all of its community clinic participants. The project also revealed a number of challenges in implementing such a collaborative effort across system and practice boundaries, the lessons of which can be useful to those seeking to establish analogous projects in other safety-net provider environments.

Impact on Specialty Care

During the course of the two-year implementation period for the Provider Practice Redesign project, participating PCPs reported a decided increase in their clinical confidence in managing patients at the primary care home, in part due to telephone consultation support from the specialists. In the case of rheumatoid arthritis, for example, CDSN providers noted an increased ability to treat patients in their clinics through the use of inexpensive medications which previously had not been available in their formularies but which were added as a result of their consultations with the hospital-based specialists. The project’s clinic providers also reported significant increases in diagnostic capacities for cardiology and ophthalmology.

Based on self-reported information provided on a monthly basis (from mid-2007 to September 2009), Specialty Champions across the participating clinics were able to manage 78 percent of all patients screened at the clinics for cardiology (with the other 22 percent referred for specialty care), and 60 percent of patients screened for rheumatology. Without training and telephone consultations with the specialists, Champions might have instead referred many of those patients to specialty care. Additionally, it is likely due to the increased frequency and quality of communications with the specialists that Champions made a higher proportion of appropriate specialty care referrals, in part based on agreements reached during consultations. Preliminary results from

an independent project evaluation indicate that data on this issue are underreported, with time constraints having prevented participating PCPs from regularly and accurately reporting on the work they dedicated to the project.⁶ This suggests that the Provider Practice Redesign may have resulted in an even higher percentage of specialty care patients being cared for within the clinics or being appropriately referred to specialty care.

Providers Determine Guidelines and Community Grand Rounds

During the early months of the Provider Practice Redesign implementation, COPE set the agenda for the monthly Community Grand Rounds meetings, selecting the specialties to focus on and the lecture topics to be discussed. During these early months, however, it turned out that providers did not become engaged in the process to the extent necessary to drive adoption of new methods and guidelines and for other related changes in behavior. To remedy this lack of engagement, in subsequent months providers were given the responsibility of setting priorities for the group meetings, including selecting the specialties of focus, while COPE changed its role in the meetings to that of facilitator. As an added incentive, Community Grand Rounds were restructured to allow providers to receive CME credits for participation.

Stakeholder Understanding and Engagement Is Key

The defining characteristic of the Provider Practice Redesign project was its collaborative nature, requiring joint participation and cooperation by hospital specialists and community clinic PCPs. Each provider group entered the project with preconceived notions about the other's challenges, competency, and scope of care. For the initiative to succeed, each "side" had to develop a better understanding of and comfort level with the other's work. One way to accomplish this was to have providers and administrators from both groups jointly engage in the planning and delivery of care efforts. For the redefining of specialty care protocols in particular, it was determined that efforts to engage leadership should extend to the clerical and line staff levels. Indeed, engagement of the referral coordinators at CDSN proved critical in the Provider Practice Redesign project's diagnostic expansion efforts.

Formal Process for Information Dissemination

The collaborative nature of the Provider Practice Redesign project required that a large amount of information be distributed to providers in different organizations. In most cases, medical directors were tasked with informing their staff about the new Consensus Care Guidelines and referral protocols, but without a structured process for this dissemination. As a result, adoption of Consensus Care Guidelines varied among PCPs who were not directly involved in the Provider Practice Redesign process. One lesson learned from this experience was that in order to ensure consistent understanding, sense of

Added Clinic Technical Capacity Also Reduced Referrals

As part of the implementation of the Provider Practice Redesign, COPE and CDSN launched a mobile echocardiogram service in December 2007, with funding from the Larry King Cardiac Foundation and the Ahmanson Foundation. To date, the mobile echocardiogram service has provided over 900 diagnostic tests to uninsured patients.⁷ Additional funds from LA Care Health Plan helped provide two optometry units at a CDSN partner clinic. A cardiac stress treadmill and an endoscopy suite were added at two other clinics. All of these services were designed to provide local access to specialty care for uninsured patients at CDSN community clinic sites. The availability of these resources helped to relieve pressure on the overwhelmed outpatient diagnostic resources at LAC+USC Medical Center. For example, an analysis of results from the echocardiogram service found that only 22 percent of all patients tested had abnormal results. Consequently, a large majority of patients were managed by the cardiology Champion in the primary care setting rather than being referred for specialist care.

ownership, and adherence to new protocols and processes, it is crucial to establish mechanisms through which all PCPs at participating clinics are drawn into the project. Such techniques might include: discussing the new model at clinic provider meetings; incorporating project guidelines into intranet Web pages or electronic medical record systems; and creating monthly provider newsletters that update providers on the practice redesign process.

Responding to Added PCP Time Commitments

The Provider Practice Redesign changes in referral practices resulted in more PCP visits and the need for additional related administrative time. The most active Specialty Champions consistently reported the need for as many as four hours a week in added administrative time, including phone consults, chart reviews for other providers, clinical documentation, and data tracking. The lack of financial reimbursement for such added time creates a disincentive for providers to fully participate in the project.

In order to encourage Specialty Champions to continue being active participants, the Provider Practice Redesign project secured new funds through Kaiser Permanente's Specialty Care Initiative to reimburse CDSN clinics for time their Specialty Champions spend caring for patients under the project.⁸ Also, CDSN partner clinics incorporated "Champion codes" into the encounter forms their providers use daily. These forms track patient visits, chart reviews, phone consults, and referrals made by PCPs in their capacity as Champion. The partner clinics submit a monthly report of these activities to COPE, which then allocates grant funds according to the number of patients seen by each Champion. This added funding has helped enable Champions to apply the specialty knowledge acquired through mini-fellowship training, while the tracking system has eased the administrative burden of data collection.

The hospital specialists, too, have been required to put in extra time under the project. To provide further support for participating specialists, changes were made to the Management Services Operational Agreement between Los Angeles County and the USC Keck School of Medicine (Keck). Under this new agreement, time is specifically budgeted for specialist phone consultations and chart reviews with PCPs. Additionally, CDSN is currently in discussions with Keck's Specialty Division chairs of rheumatology, cardiology, and gastroenterology about engaging specialty fellows in the Provider Practice Redesign project. Participation by specialty fellows would not only increase the clinics' capacities for phone and electronic consults, but would also provide a valuable learning opportunity for the specialists by giving them the chance to interact with PCPs in the community and thereby to gain a better understanding of the challenges they face.

Financial Incentives Must Support Clinic Specialty Care

In order to substantially improve providers' ability and willingness to manage patients at a primary care level, a realignment of financial incentives is needed. Such a realignment would allocate funds to offset and reward the additional time providers would spend with each patient managing specialty care needs, as well as time allocated to collaborative network and quality improvement efforts, such as Community Grand Rounds. Realigning incentives in this way could also help ensure that primary care-level providers comply with guidelines and meet performance standards relating to patient specialty care processes.

Streamlining Data Collection Methods and Tools

Data tracking posed a technical challenge in implementing the Provider Practice Redesign project. With limited administrative time, participating providers found it difficult to self-report on the clinical time and work they devoted to the project. As

discussed above, providers were not compensated for the additional administrative efforts that resulted from their participation, which in turn contributed to an underreporting of data. To address this issue, the project has developed a data tracking system that can increase data collection efficiency through the special Champion encounter codes described above. By incorporating data tracking into the clinics' existing processes, and by regularly auditing records, this system provides an efficient and reliable method of receiving and analyzing outcomes data, while reducing the administrative work required of providers in the project.

Other Systems Adopt a Similar Model

Drawing on the experience of the CDSN Provider Practice Redesign project, and funded by a specialty care grant through the Kaiser Community Benefit program, Harbor UCLA Medical Center and a number of community clinics in Long Beach and in West Los Angeles and the South Bay have adapted the Provider Practice Redesign framework. This project includes implementation of a more rigorous referral screening process through Specialty Champions, which could result in a decrease in avoidable specialty referrals. To date, the project has begun to be implemented in cardiology, with rheumatology to follow soon.

In Central California, the Kern Medical Center Health Plan (KMC plan), funded by the California 1115 State Medicaid Waiver and the Kaiser Specialty Care Initiative, has also adapted the Provider Practice Redesign model to improve specialty care access. Because Kern County's PCP capacity differs significantly from urban Los Angeles County's, the KMC plan has tailored the model to better reflect the region's resources, including a heavier reliance on the participation of physician assistants and nurse practitioners, using specialty care protocols. Participation by these providers is structured by guidelines and practice protocols and supported by training sessions designed specifically for these practitioners.

Conclusion

Access to specialty care, especially for the poor and underserved, is an issue of critical importance. As the population ages and demand for specialty resources continues to climb, it is important to expand primary care resources and to reserve specialty resources for patients with complex or rare disorders. Coupling payment reform with improvements in and expansion of the scope of primary care, as well as in the efficiency of the specialty referral process, represents an effective model for improving patient access to specialty care.

ABOUT THE AUTHORS

COPE Health Solutions (COPE), based in Los Angeles, California, works with hospitals, clinics, and health care organizations across the country to develop integrated health care delivery networks and to train and grow the health care workforce needed to support these networks. COPE provides services through three major service lines: Clinical Integration Solutions, Health Workforce Solutions, and Business Solutions.

Sarita A. Mohanty, M.D., M.P.H., is medical director for COPE. Her work for COPE involves helping to improve access to quality care for safety-net populations by developing and implementing comprehensive and sustainable programs. Dr. Mohanty is also a clinical assistant professor of medicine at the University of Southern California's Keck School of Medicine.

Ana Alvarez is a senior project manager for COPE. In this capacity, Ms. Alvarez is responsible for operations at the *Camino de Salud* (Healthy Road) Network, an integrated delivery system composed of hospital and community clinic organizations.

Jodie Pham is a project manager for COPE. Ms. Pham primarily supports COPE's work around policy analysis, grant development, and strategic planning.

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.

ENDNOTES

1. The California Endowment. December 2004. "The Health Care Safety Net: Challenged Like Never Before, Needed More than Ever." *Health in Brief* 3 (3).
2. In a 2004 survey of Federally Qualified Health Centers, 85 percent of respondents reported that their patients "often" or "always" had difficulty obtaining needed specialty care. Felt-Lisk, S. and M. McHugh. *The Uninsured: Examining Access to Specialty Care for California's Uninsured*. California HealthCare Foundation, May 2004, www.chcf.org. See also Patrick, G. and J. Hickner. *Four Models Bring Specialty Services to the Safety Net: Enhancing Scope of Practice and Referral Efficiency*. California HealthCare Foundation, July 2009, www.chcf.org.
3. Formerly known as the Specialty Care Access Project.
4. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. *Key Indicators of Health by Service Planning Area*, 2007.
5. Forrest, C.B. and B. Starfield. 1996. "The Effect of First-Contact Care with Primary Care Clinicians on Ambulatory Health Expenditures." *Journal of Family Practice* 43 (1); 40–8.
6. Cousineau, M.R., and K. R. Partlow. *Impact of the Specialty Care Access Project on Serving Uninsured Patients*. Center for Community Health Studies, University of Southern California, 2010.
7. To ensure long-term financial sustainability of the mobile echocardiogram service, COPE entered into a contract with Healthcare LA IPA, the major independent physician association for CDSN clinics. This has permitted billing for these diagnostic services when provided to managed Medi-Cal and managed Medicare CDSN patients. Revenue thus generated is used to help offset service costs for the uninsured.
8. The Kaiser Permanente-CHCF Specialty Care Initiative is a multi-year effort funded by the Kaiser Permanente Community Benefit Programs and the California HealthCare Foundation. It focuses on expanding access to specialty care in the safety net. The initiative has funded 21 provider coalitions throughout California. Additional funding from the Kaiser Permanente Southern Region Community Benefit Program went to support the LAC+USC Medical Center-CDSN coalition.