CIN Partners Share:

Improving Primary Care/Specialty Care Collaboration

The California Improvement Network (CIN) partners — public and private health care organizations actively engaged in improving chronic disease care — meet quarterly to share experiences and to learn from one another. Following are highlights from the partners’ May 2013 meeting, which focused on improving the interface between primary and specialty care. The meeting included presentations from DaVita HealthCare Partners, Los Angeles County Department of Health Services, and San Francisco General Hospital, followed by a discussion among the partner organizations.

DaVita HealthCare Partners  www.healthcarepartners.com

Who: DaVita HealthCare Partners (HCP), one of the largest multispecialty providers in California, uses a group model — with employed clinicians and staff — and an independent practice association (IPA) model. HCP serves approximately 600,000 managed care patients and employs more than 400 clinicians, and its IPA network consists of more than 2,000 primary care providers (PCPs) and 2,000 specialists across Southern California. HealthCare Partners recently merged with DaVita to form DaVita HealthCare Partners, a publicly traded corporation.

What: HCP’s work to improve collaboration between primary and specialty care arose from a recognition that their specialty referral volume was so high that it was limiting access for urgent cases, and feedback from specialists that a large number of these referrals could effectively be handled in primary care. Also, HCP leaders were concerned that specialty referrals were resulting in potentially avoidable inpatient admissions, surgeries, and procedures. To address these issues, HCP implemented a site-based referral review process to optimize use of specialists. A lead physician reviewer was placed at each site to interact with physicians and to decentralize the review process. This program aims to improve communication among referring physicians and specialist use management reviewers, improve patient care coordination, avoid unnecessary referrals and denials, and encourage the discussion of cases among physicians.

For implementation in the first region, all referrals, which were previously automatically approved, were reviewed by a care manager who culled questionable cases and sent them to the site’s physician lead for review. The lead and requesting physician discussed the referral together and formulated a different plan if needed.

All of the leads met weekly to discuss difficult cases and the overall approach. Referral volume and inpatient use decreased in the first region as a result of the program.

In a second region, the program was tailored to address that region’s specific staffing structure, work culture, and concerns among leads about having adequate knowledge to advise other physicians in the referral process. For this region, the lead and specialists attended workshops to learn about conditions that are commonly incorrectly referred. In addition to increasing the lead’s knowledge about referred conditions, these workshops helped generate an acceptance of the new approach.

“This work builds on itself over time. Once a PCP engages in a conversation with a lead or specialist about how to handle one case, the learning impacts all future cases and potential referrals.”
Improving Primary Care/Specialty Care Collaboration JULY 2013

process by all physicians. As a result of the workshops, it was determined that the lead should not handle all referrals, but rather that requests should be sent to trained designees for their input.

In planning the spread of this program to more sites, HCP is considering the following questions: how many specialties to include in the referral review process, how much latitude to give to leads, and how to devise a similar process within the organization’s IPA structure.

Long Beach Region Inpatient Use

![](image)

source: DaVita HealthCare Partners

Los Angeles County Department of Health Services  www.ladhs.org

**Who:** The Los Angeles County Department of Health Services (LAC-DHS) is a publicly supported, integrated health care delivery network governed by the Los Angeles County Board of Supervisors. LAC-DHS operates three acute care hospitals, one rehabilitation hospital, two multi-service ambulatory care clinics, six comprehensive health centers, ten health centers that are owned and operated by Los Angeles County, and more than 100 public-private partnerships (contracts with Federally Qualified Health Centers and stand-alone clinics.) LAC-DHS hospitals and clinics serve approximately 800,000 patients annually, of which almost 50% are new to the system each year.

**What:** As a large, historically fragmented health care system, LAC-DHS faces a number of challenges to providing patient access to specialty care: long wait times, lack of coordination between county-employed and community providers, high no-show rates at specialty clinics, and large variation in care delivery processes. LAC-DHS received more than 350,000 specialty care referrals last year, and uninsured patients waited for as long as nine months to see a specialist after they were referred to the county system. Primary care physicians had no way of knowing how their specialist referrals were being processed.
To address these issues, LA-DHS launched a Specialty Care Improvement initiative in 2012 based on five key principles:

1. Responsiveness: quick answers to requests for assistance
2. Collaboration: the power of dialogue
3. Equity: care irrespective of payer
4. Customer service: a system that patients will choose
5. Effective practice: practical, “real world” improvement

The initiative developed patient-centered medical neighborhoods, where primary care physicians and specialists work collaboratively. Specialty Primary Care Workgroups comprised of providers from the community and from LAC-DHS were tasked with improving collaboration across facilities and developing effective practices and standards of care in support of the triple aim: improving population health, enhancing the patient experience, and reducing costs. Many workgroups focused on defining scope of care to make the best use of limited resources and on training PCPs in high-volume conditions and procedures. For example, there was limited access to podiatrists, so the podiatry workgroup identified annual foot exams for asymptomatic diabetic patients as a task that could fall under the scope of the PCP and trained PCPs accordingly. Currently, 13 workgroups have been established with more than 100 total participants.

“eConsult has been a blessing. Providers are enjoying the opportunity to learn new patient management strategies from specialists. The best part is that our patients aren’t waiting over six months for consultations.”

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**Patient-Centered Medical Neighborhood**

- **PCMH**
- **Specialist**

**BARRIERS**
- Lack of dialogue
- Visit-based care
- Misalignment of incentives

**SOLUTIONS**
- Create dialogue
- Abolish visits as care measure
- Align incentives

**OBJECTIVES**
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

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*source: Los Angeles County Department of Health Services*
In 2012, the initiative implemented eConsult: a secure, web-based portal that facilitates electronic communication and exchange between primary care and specialist physicians. This system has resulted in an increase in collaboration among care providers, an improvement in responsiveness to requests for specialty assistance, a reduction in avoidable specialty visits, and more effective specialty visits. The eConsult system has been implemented in 10 specialties with more than 900 PCP users at 95 PCP sites. The average specialist response time to an initial request is 1.9 days. More than 12,000 eConsults have been submitted to date, and among these, 55% have resulted in a face-to-face specialist visit.

In addition, LA-DHS implemented a patient-centered specialty scheduling process to reduce process variation, lower no-show rates, and improve the patient experience. Under the prior system, appointment cards were mailed to the patient’s home. With many addresses no longer current, the network experienced high no-show rates. Under the new system, LAC-DHS calls patients to schedule appointments or asks the PCP to contact patients they are unable to reach. This new system also allows scheduling across sites, and has helped reduced the no-show rate from 30-40% to 10%.

San Francisco General Hospital  www.sfdph.org

**Who:** San Francisco General Hospital and Trauma Center (SFGH) is a public hospital owned and operated by the City and County of San Francisco. It is part of a city-wide integrated health system, which provides primary, specialty, and hospital care for vulnerable populations. SFGH provides 20% of the city’s inpatient care, and has more than 500,000 ambulatory visits a year. It receives referrals from SFGH-based clinics, the Department of Public Health’s community-oriented primary care clinics, and the San Francisco Community Clinic Consortium’s primary care clinic network.

**What:** Two SFGH initiatives were designed to increase patient access to specialty care, reduce costs, and enhance the quality of specialty care: eReferral (an electronic referral system) and specialty workgroups.

Implementation of eReferral at SFGH has helped reduce wait times for specialty care, improve patient access to specialists, and improve documentation of dialogue between primary care and specialty care providers in electronic health records (EHRs). PCPs have benefited from case-based learning opportunities, and patients have received a broader scope of care in their patient-centered medical home. Of all the primary care physicians participating in the eReferral system, 71% reported that the system has resulted in better clinical care for their patients. Even those PCPs with the highest percentage of referrals that never result in a specialist visit still report high rates of satisfaction with the system, possibly due to opportunities for co-management and education. SFGH specialists reported the following results: fewer unnecessary referrals, being better able to appropriately triage urgent patients, clearer consultation questions, more efficient in-person visits with pre-consultative guidance, and an increase in acuity of patients seen in clinic. Specialists appreciated the opportunities for education and the ability to engage in virtual co-management through eReferral.

SFGH specialty workgroups were designed to foster mutual understanding, communication, and collaboration between primary care and specialty care providers. The workgroups sought to improve communication among providers after specialty clinic visits by making specialty notes more readily available in the EHR and by standardizing note content. The workgroups also developed and implemented consensus guidelines for discharge from specialty care, improved the quality of the eReferral exchange, and developed registries and panel management for specialty clinics, all efforts to enhance patient access to specialty care.

As a result of these initiatives, SFGH saw an increase in orthopedic surgery clinical note dictation from 43% in July 2012 to 81% in April 2013. SFGH also saw a reduction of wait times (measured by third next available appointment) by 53.3% from December 2012 to April 2013.
Improving the interface between primary and specialty care requires a new perspective on care delivery by providers. In-person referrals have developed as the mechanism for primary care providers to get assistance from specialists, but there are other ways to access this expertise and co-management support. LAC-DHS is eliminating the language of “denials” and “approvals” and instead is focusing on collaborating to find the best venue for a patient to receive care.

Providers are concerned that patients will perceive innovations such as eReferral or eConsult as barriers to care if they don’t result in a face-to-face visit. To address this concern, PCPs should discuss the positive attributes of electronic referral and consultation systems, which include closer collaboration between PCPs and specialists in co-management of patients and the convenience to the patient associated with avoiding additional specialty clinic visits.

Respecting the patient’s desire to see a specialist in person is important. HCP has a “patient request” check box in their EHR to designate a specialty referral of this type.

Collaboration between primary care and specialty care providers offers an opportunity for informal training and for providers to practice to their full scope. With the advent of EHRs, the old-fashioned curbside consult has been lost, but eReferral and eConsults bring back this opportunity for dialogue.

EHRs are not necessarily developed to encourage dialogue and interaction, both of which come from the people using the tool.

Selecting the right specialists is critical, as is providing constructive feedback to both PCPs and specialists about the quality of their communication with one another.
**Asked and Answered!**

*How have organizations reimbursed and offered incentives for better communication and collaboration among primary care and specialty care providers?*

- Most organizations agree that global payment systems are the most effective tool for encouraging collaboration. Moving from traditional fee-for-service payment systems to alternative payment structures requires a shift from valuing volume to prioritizing performance.

- Organizations may consider setting a high-level goal with money attached to it and let the providers and leaders figure out how to implement the details. This may be easier to achieve in an integrated system.

- Effective incentives require transparency, actionable data, and the tools needed to capture that data.

- It is important to align payments such that primary and specialty care physicians have similar incentives. One organization offers collective bonuses to primary care and specialty care providers based on how care is provided to patient pods.

- One organization found that about 10% of overall compensation is the threshold that starts to impact behavior. Since primary care and specialty care often vary considerably in compensation, flat incentive amounts may not be as effective.

- Organizations compensate providers who review referrals for their time, and they also compensate providers for using the electronic referral systems. PCP and specialist surveys measuring satisfaction with the referral process are a nonfinancial incentive, although organizations concede that physicians are often reluctant to give other physicians low scores.

**Online Resources**

Improving the Primary Care–Specialty Care Interface: Getting From Here to There

A Typology of Specialists' Clinical Roles

Improving the Primary-Specialty Care Interface: A Conference to Promote Interdisciplinary Collaborative Projects — Conference Proceedings