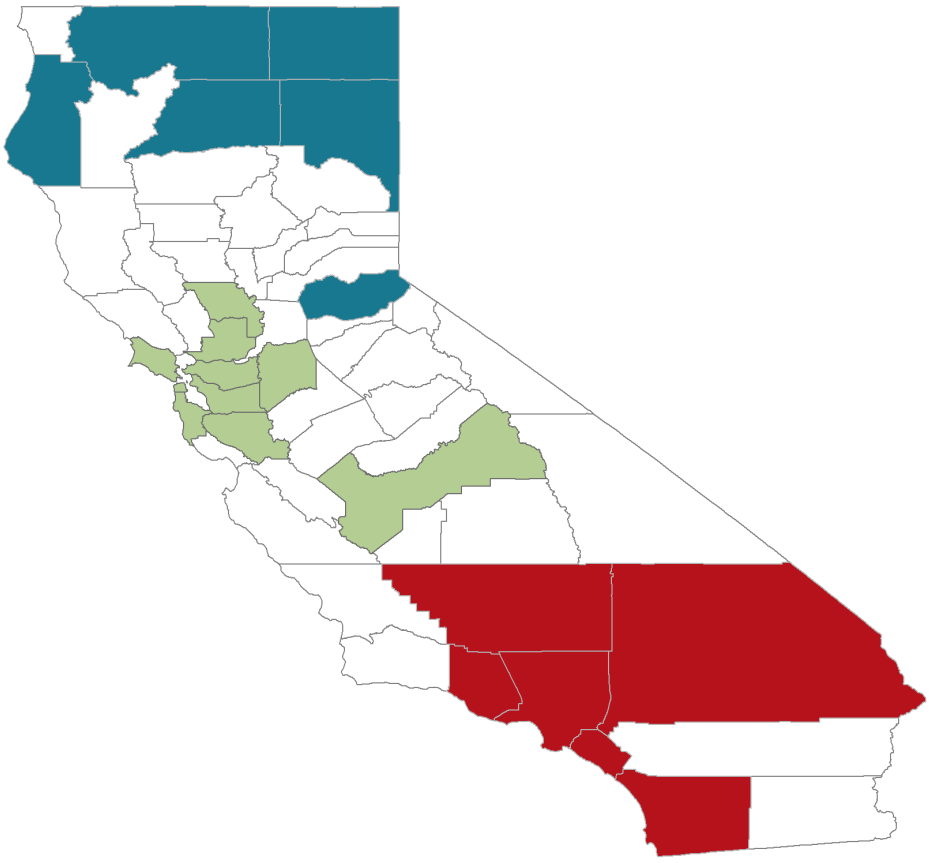
Kaiser Permanente and California HealthCare Foundation Specialty Care Initiative

Evaluation Report

October 2011

Prepared by the
Center for Community Health and Evaluation



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I. Background

More than 20% of Californians lack health insurance and this proportion has increased in recent years, placing a growing demand on the health care safety net for both primary care and specialty care services.[1] The current safety net specialty care system is challenges in many communities, with an inadequate number of specialists available and lack of coordination between primary and specialty care providers. [2]

The California HealthCare Foundation (CHCF) and Kaiser Permanente are committed to supporting interventions that ensure patients' and providers' specialty care needs are met in timely, cost effective, and appropriate ways. Because this is an issue that impacts the entire health system, community-based solutions are needed for a coordinated response. In late 2007, Kaiser Permanente's Northern and Southern California Regions' Community Benefit Programs and CHCF launched a jointly funded Specialty Care Initiative (SCI). The aim of the initiative was to support community coalitions in implementing comprehensive, long-term strategies that increase the capacity of local safety net organizations to effectively address the specialty care needs of the uninsured/underinsured populations in their communities.[2]

In 2007, twenty-eight coalitions received funding for a one-year planning phase (21 funded by Kaiser Permanente and seven by CHCF). Kaiser Permanente's grants focused on addressing specialty care needs in those communities where Kaiser Permanente is part of the health care delivery system and CHCF grants focused on rural areas not included in the Kaiser Permanente initiative. During the planning year, coalitions were required to conduct a needs assessment to determine specialty care priority areas. The deliverable of the planning phase was an implementation plan detailing the strategies and activities the coalition would employ to increase access to priority specialty care areas identified in their needs assessment (e.g., dermatology, neurology). In 2008, twenty-four grantees were funded for implementation (21 funded by Kaiser Permanente and three by CHCF) (Table 1). In October 2008, Kaiser Permanente and CHCF contracted with the Center for Community Health and Evaluation (CCHE) to evaluate SCI. This report summarizes findings from the SCI implementation period (January 2009-September 2011).

Table 1. SCI Implementation Grant Awards (2009-2012)

	# of implementation grants awarded	Total grant award for each coalition	Duration of grant
California HealthCare Foundation	3	$250,000	2 years
Kaiser Permanente Northern California Region's Community Benefit Program	10	$600,000	2 years
Kaiser Permanente Southern California Region's Community Benefit Program	11	$900,000	3 years

[1] California HealthCare Foundation. California Health Care Almanac California's Uninsured, 2010. Available at http://www.chcf.org/publications/2010/12/californias-uninsured.

[2] Adapted from "Request for Proposals: Joint Evaluation of the California HealthCare Foundation's Improving Appropriate Access to Specialty Care in Rural California Project and Kaiser Permanente's Specialty Care Initiative," 2008

II. Evaluation Design

The SCI evaluation used a logic model design that was developed collaboratively with Kaiser Permanente's Northern and Southern California Regions' Community Benefit Programs and CHCF. The SCI logic model described the relationship between SCI activities, grantee strategies, short-term outcomes (e.g., successful implementation of strategies), intermediate outcomes (e.g., more appropriate referrals, increased availability of specialty appointments), and long-term outcomes (e.g., more efficient, integrated delivery system). The logic model was reviewed annually to ensure that it was reflective of any changes in SCI; although no major changes have been made to date. The most recent logic model is attached (**Attachment A**).

Based on the logic model, evaluation questions were developed for the initiative-level evaluation. These questions included:

1. How successful has the overall initiative been in:
    - Stimulating the implementation of new strategies/models by grantees?
    - Improving access to specialty care?
2. Which strategies/models appear to be the most successful and have the greatest potential for replication?
3. How successful has the initiative been in spurring new, stronger and more sustainable coalitions?

From these questions, a series of evaluation sub-questions and more specific indicators were developed. The full evaluation plan is included as **Attachment B**. To further refine and operationalize these questions and indicators, coalitions were grouped by similar strategies and a discrete set of quantitative measures was identified on which the coalitions were required to report. CCHE conducted a survey and a small number of grantee interviews to better understand strategy activities and current data collection capacities. Based on the results of the survey and interviews, conversations with funders, and a series of webinar discussions with the coalitions, four strategy clusters were identified:

- Embedding Guidelines into the Referral Process
- Building/Expanding Specialty Care Networks
- Increasing Primary Care Provider (PCP) Capacity/Scope of Practice
- Integrating Care Coordination

These strategy clusters, discussed in detail later in this report, were used to guide peer learning opportunities as well as evaluation activities.

Additionally, through webinar discussions, four quantitative measures were selected—wait time to specialty appointments, referral volume, disposition of referral (i.e., referrals denied), and no-show rates—to facilitate the collection of quantitative data across coalitions.

Once this framework was established, an evaluation work plan and more detailed data collection plan were created for three years of evaluation. These were reviewed and agreed upon by the funding partners.

III. Data Collection

Data collection activities were designed to answer the SCI evaluation questions. Routine data collection activities included:

- **Grantee oral progress reports**: One-hour telephone interviews were conducted every six months with each coalition (n=24) to understand grantees' progress toward goals, accomplishments, challenges, plans for sustainability, functioning of their coalition, data collection plans, technical assistance needs, and feedback for the funders. Five rounds of interviews have been completed to date.
- **Web-based coalition survey:** CCHE created and administered a web-based survey of all coalition members to assess coalition engagement and functioning. The survey was administered in November 2009, and again in April 2011.
- **Quarterly reporting by coalitions on the four quantitative measures:** Using a template created by CCHE, coalitions submitted quarterly reports on the four quantitative measures: wait time, referral volume, disposition of referral, and no-show rates. CCHE tracked these data over time and provided feedback on how to improve data quality.
- **Document review:** Grantees' proposals and reports to CHCF and Kaiser Permanente were reviewed to supplement the information provided during the oral progress reports.
- **Funder/technical assistance provider interviews:** Interviews with the funders and technical assistance provider were conducted annually to ensure their perspectives were incorporated into the evaluation and learn their perspectives on grantee progress and challenges, promising models, and successes and challenges of the coalition process.

In addition, CCHE developed four case studies to highlight progress within each strategy cluster. Six sites were identified through preliminary data analysis and discussions with the three funders and technical assistance provider. Selected sites had demonstrated success in implementing promising models. Additional data collection with the case study sites included:

- **Provider interviews:** Interviews with 5-6 specialty and primary care providers to better understand the impact of SCI activities on access. These 30-minute telephone interviews were conducted from May to July 2011.
- **Site visits:** CCHE staff conducted site visits to better understand the details of how strategies were implemented in practice. Site visits included interviews with key project staff, tours of facilities, and demonstrations of electronic systems. Site visits lasted 3-6 hours and occurred in June and July 2011.

IV. Evaluation Findings

A. Participating Coalitions

Twenty-four coalitions were granted implementation funds through SCI. Within the first year, three coalitions withdrew from SCI due to staff turnover and shifts in organizational agendas. SCI coalitions were located throughout the state of California—13 in the northern half of the state (Fresno County being the furthest south) and 11 in the southern half. The majority of coalitions targeted one county; however, one of the CHCF grantees worked in four counties in northern California and six separate coalitions targeted different parts of Los Angeles County (**Table 2**).

Each coalition was coordinated by a lead agency, who was the grant recipient. Of the 24 lead agencies, seven were county-funded entities (i.e., public hospitals (6) and a health department (1)). The other lead agencies included: health-related coalitions/collaboratives (6), community clinics (5), regional clinic consortia (4), and IPA/health plans (2) (**Table 2**).

The eight coalitions that included public hospitals (either as the lead agency or as a key member in the coalition)[3] worked within a centralized system for specialty care built around the public hospital. That is, since the vast majority of specialty care for the uninsured/underinsured population is provided by the public hospital, the strategies to address access focused mostly on improvements at the hospital. The remaining 16 coalitions operated within more decentralized systems, requiring that changes be implemented at multiple institutions.

Of the 24 coalitions, half (n=12) were in existence prior to SCI. These coalitions typically had formed around broader health care access issues and SCI created a focus on specialty care access. Some existing coalitions formed a sub-committee to work on this initiative, while others incorporated SCI work into existing coalition structures. The remaining 12 coalitions formed in response to this initiative; although in most cases there were existing relationships in place and key partners had previously worked together (**Table 2**).

Table 2. Description of Participating Coalitions

Funder	Coalition	Grantee (Lead Agency)	Lead Agency Type	Existing Coalition	Grant Status
CHCF	ACCEL (Access El Dorado)	El Dorado Department of Public Health	Health Department	Yes	Grant ended June 2011
CHCF	LMSS (Lassen, Modoc Siskiyou, Shasta) Specialty Care Coalition	Health Alliance of Northern California	Clinic Consortium	No	Grant ended June 2011
CHCF	IRIS Steering Committee	Humboldt-Del Norte IPA	IPA/Health Plan	Yes	Grant ended June 2011
Kaiser Permanente NCAL	Alameda County Specialty Care Task Force	Alameda County Medical Center	Public Hospital	Yes	Received subsequent SCI grant
Kaiser Permanente NCAL	Santa Clara County Specialty Care Access Collaborative	Community Health Partnership	Clinic Consortium	No	Received subsequent SCI grant

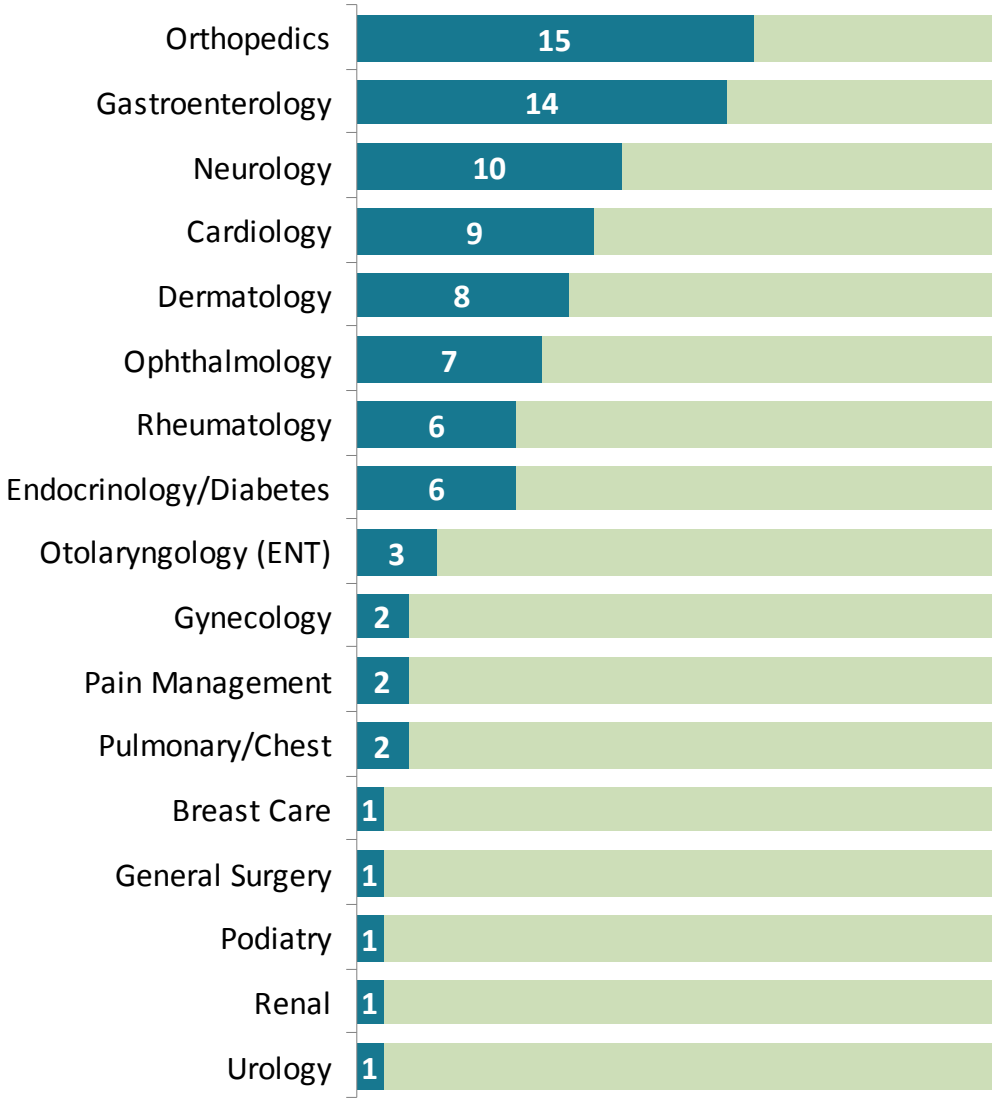
[3] This includes the six coalitions that have public hospitals as the lead agency and Santa Clara County Specialty Care Access Collaborative and San Joaquin County Specialty Care Access Coalition.

Funder	Coalition	Grantee (Lead Agency)	Lead Agency Type	Existing Coalition	Grant Status
Kaiser Permanente NCAL	Contra Costa's Specialty Care Stakeholder Committee	Community Clinic Consortium of Contra Costa	Clinic Consortium	No	Grant ended June 2011
Kaiser Permanente NCAL	Fresno Access to Care Task Force	Fresno HCAP	Health-related Coalition/ Collaborative	Yes	Received subsequent SCI grant
Kaiser Permanente NCAL	Marin Specialty Access Coalition	Marin Community Clinic	Community Clinic	No	Grant ended December 2010
Kaiser Permanente NCAL	San Francisco Specialty Care Steering Committee	San Francisco General Hospital	Public Hospital	No	Received subsequent SCI grant
Kaiser Permanente NCAL	San Joaquin County Specialty Care Access Coalition	San Joaquin Health Plan	IPA/Health Plan	No	Grant extended through December 2011
Kaiser Permanente NCAL	San Mateo County Specialty Healthcare Improvement Project (S.S.H.I.P.)	San Mateo Medical Center	Public Hospital	No	Grant extended through December 2011
Kaiser Permanente NCAL	Solano County Specialty Care Committee	Solano Coalition for Better Health	Health-related Coalition/ Collaborative	Yes	Withdrew in Spring 2010
Kaiser Permanente NCAL	Yolo County Future of the Safety Net	CommuniCare Health Centers	Community Clinic	Yes	Received subsequent SCI grant
Kaiser Permanente SCAL	AccessOC Coalition	AccessOC	Health-related Coalition/ Collaborative	Yes	Withdrew in Spring 2010
Kaiser Permanente SCAL	San Bernardino Specialty Care Coalition	Latino Health Collaborative	Health-related Coalition/ Collaborative	No	Withdrew in Fall 2009
Kaiser Permanente SCAL	Coalition of Safety Net Access Providers (C-SNAP)*	Valley Care Community Consortium	Health-related Coalition/ Collaborative	Yes	Grant scheduled to end March 2012
Kaiser Permanente SCAL	Kern Medical Center Specialty Care Coalition	Kern Medical Center	Public Hospital	No	Grant scheduled to end March 2012
Kaiser Permanente SCAL	LAC+USC Camino del Salud Network Specialty Care Access Project*	LAC+USC Healthcare Network	Public Hospital	Yes	Grant scheduled to end December 2011
Kaiser Permanente SCAL	Long Beach Community Increased Access Specialty Care Coalition*	The Children's Clinic	Community Clinic	No	Grant scheduled to end December 2011
Kaiser Permanente SCAL	San Diego Countywide Specialty Care Initiative Coalition	Council of Community Clinics	Clinic Consortium	Yes	Grant scheduled to end December 2011
Kaiser Permanente SCAL	South Los Angeles Collaborative for Specialty Care Access*	Southside Coalition of Community Health Centers	Health-related Coalition/ Collaborative	Yes	Grant scheduled to end December 2011
Kaiser Permanente SCAL	SPA 3 Specialty Care Planning Coalition*	East Valley Community Health Center	Community Clinic	Yes	Grant scheduled to end March 2012
Kaiser Permanente SCAL	Ventura County Safety-Net Specialty Care Access Coalition	Health Care Agency of Ventura County	Public Hospital	No	Grant scheduled to end December 2011
Kaiser Permanente SCAL	Westside/South Bay Specialty Care Coalition*	Venice Family Clinic	Community Clinic	No	Grant scheduled to end March 2012

*Coalition located in Los Angeles County

As part of the planning process, coalitions were required to identify the 3-5 most impacted specialty care areas to inform their implementation strategies (i.e., the largest gap between demand and capacity). For the most part, coalitions focused strategies on areas identified areas during the planning period. Some coalitions were more opportunistic (i.e. focusing on areas where they could make progress) and others took a "phase-in" approach, focusing on piloting strategies in one or two areas initially and expanding to other areas in subsequent years. Over the course of the initiative, orthopedics and gastroenterology were the most frequently identified specialty care areas being targeted (**Figure 1**). Six coalitions implemented strategies that extended to all of their specialty clinics/referrals. Within these specialty care areas, most coalitions focused on improving access for the entire safety net population (both underinsured and uninsured patients); but a few focused on either only MediCal patients or only the uninsured.

Figure 1. Specialty Care Areas of Focus (% of coalitions)



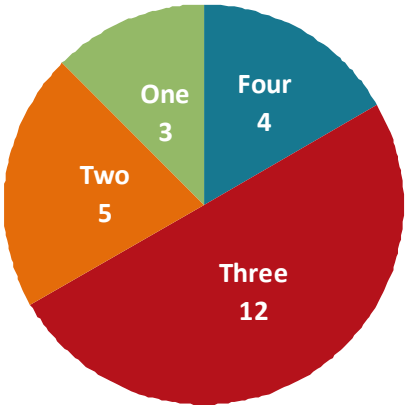
B. Strategy Clusters

As noted, four strategy clusters were identified to group coalitions that were pursuing similar strategies. Clusters included:

- Embedding Guidelines into the Referral Process
- Building/Expanding Specialty Care Networks
- Increasing PCP Capacity/Scope of Practice, and
- Integrating Care Coordination.

Peer learning opportunities and the evaluation were organized around these strategy clusters. Most of the coalitions pursued work targeting more than one cluster (**Figure 2**).

Figure 2. Number of Coalitions Participating in Multiple Clusters



Coalitions identified several factors that contributed to their success, regardless of the specific strategies implemented.

Participation in SCI. Coalitions stated much progress was due to participating in SCI:

- SCI funding provided the opportunity to devote attention and resources to addressing specialty care access in an intentional, strategic and collaborative way;
- SCI funder support, technical assistance and participation in a peer learning community provided coalitions with new ideas, best practices and an opportunity to problem solve.

Dedicated project manager. Many grantees indicated that having a dedicated project manager helped to facilitate progress and drive efforts forward. This role was particularly important to: convene the coalition, serve as a liaison across various health care organizations, manage the work plan, and hold people accountable.

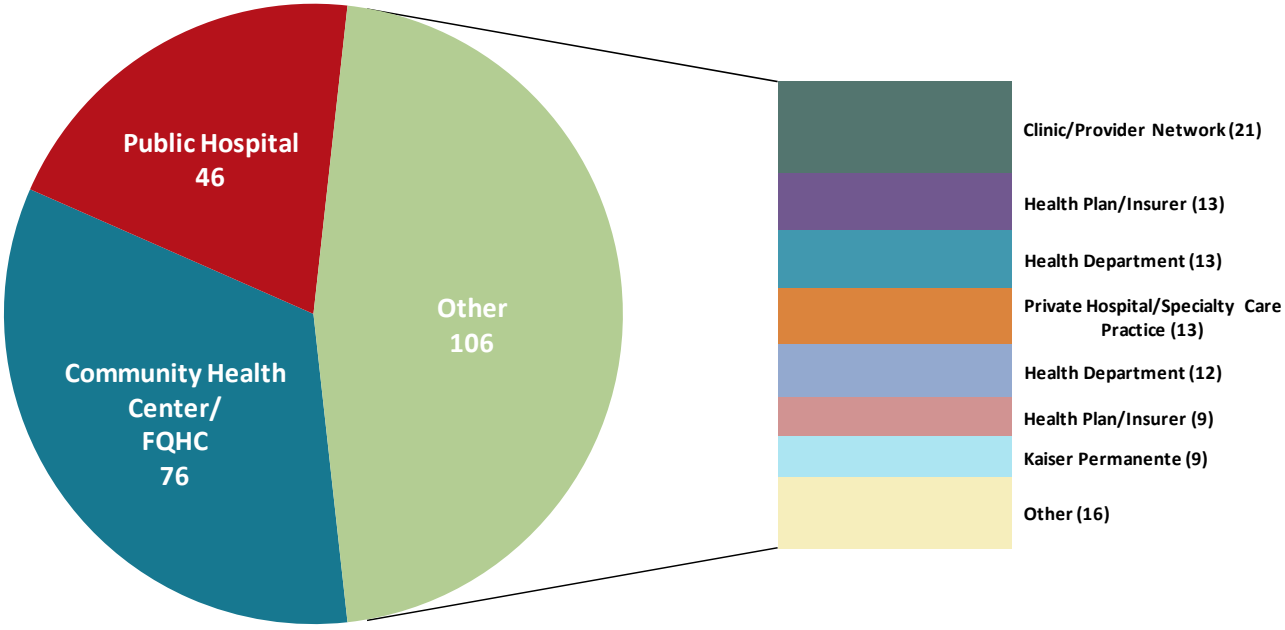
Adequate involvement and buy-in from key stakeholders. Coalitions benefitted from identifying and seeking input from key stakeholders in their safety net system throughout the planning and implementation processes. In addition to getting buy-in from leadership and decision-makers, involving groups that were affected by or responsible for implementing the proposed changes was also important. Engaging physicians, especially specialists, was essential for implementing and sustaining most coalitions' efforts.

Leverage existing relationships, resources and infrastructure. Coalitions that were able to build on existing relationships and work—either internally or externally—were able to build momentum and make more rapid progress than those that had to develop relationships or systems from scratch. Building on existing resources also allowed coalitions to apply lessons learned from previous efforts, and avoid common pitfalls.

Establish a broad and representative coalition. The coalition initially was an effective mechanism for grantees to plan and get buy-in for their efforts. During implementation, the coalition played an important role problem solving and providing feedback. Having a coalition with representation from all of the key organizations in the safety net helped to develop community-based solutions that were appropriate for the local health care system, rather than just a few organizations (**Figure 3**).

The following sections describe each strategy cluster, discuss the strategies pursued, and summarize the lessons learned.

Figure 3. Number of Coalition Members by Organization Type (n=228)



1. Embedding Guidelines into the Referral Process

> *"What works is relationships and then systems…and then the systems have to work to build relationships."*
>
> - Humboldt County IRIS Steering Committee

The Embedding Guidelines into the Referral Process cluster ("Embedding Guidelines") included strategies focused on implementing referral process protocols, clinical referral guidelines, and clinical decision support protocols and integrating these into new or existing referral systems (often electronic referral (eReferral) systems). The aim of these strategies was to better manage demand for existing appointments by ensuring more appropriate referrals.

Description of Strategies

During SCI, 20 of the 24 coalitions pursued work relevant to the Embedding Guidelines cluster. Coalitions approached their work on referral guidelines differently; however, most tried to identify existing referral guidelines and worked with their coalition to prioritize which guidelines to develop or customize to their environment. Once created, the guidelines were implemented in various ways, some posting the guidelines on a website for reference and others building them into an eReferral system as "rules" for referral (i.e., a primary care provider would need to follow the guidelines in order to get a referral processed). While the work of creating guidelines was often tied closely to the development or improvement of eReferral systems, not all coalitions pursuing these strategies had an electronic system in place.

Many coalitions made significant progress developing guidelines early in SCI. The development of guidelines was often a successful mechanism to engage and build relationships between specialists and PCPs. After successfully creating the guidelines, many coalitions shifted their focus into other areas, including improvements to referral processes and systems. To achieve this, most coalitions engaged in ongoing relationship building efforts to increase trust and improve communication between specialty and primary care providers. Many coalitions coordinated opportunities for face-to-face dialog between specialty and primary care peer groups (e.g., providers, referral coordinators); these conversations resulted in increased understanding of the realities and challenges on both sides of the referral.

Attachment C provides a high-level summary of the coalitions' work to date.

Success Factors

There are several common success factors that have been identified by coalitions that have been effective in creating and implementing referral guidelines. Coalitions were more effective creating guidelines when the effort was tied to overall improvements in the referral process, rather than something being done in isolation. As discussed above, this work was often integrated into the development of a new eReferral system or improvements to an existing eReferral system; a few coalitions successfully embedded guidelines into a non-electronic referral process. Because many coalitions used guidelines to bolster overall improvements in the referral process, the success factors discussed below include considerations for both creating guidelines and making improvements to the referral process.

Build on existing relationships and infrastructure. Communication and trust are essential in creating successful referral guidelines and processes. Coalitions benefitted from a history of collaboration among key stakeholders and established processes for communication and information exchange. Through the initiative, some coalition members with referral systems in place opened up their systems to their coalition partners, which strengthened the relationship and the referral process.

In lieu of existing resources, coalitions benefited when they were able to identify and adapt external tools and systems for use in their local context. This helped move work forward more quickly. For example, coalitions implementing guidelines were able to save time when they brought existing guidelines to physicians to start the discussion. Coalitions creating new referral systems benefited from using existing systems that could be customized for their needs.

Identify how the local safety net operates and then develop the tools and infrastructure to support practice. Referral guidelines, eReferral systems and electronic health records (EHRs) are tools to facilitate information exchange and patient care. Coalitions spoke about the need to map out current referral practices and identify needs prior to selecting and developing a referral tool. After initial assessment, some coalitions invested in new eReferral systems while others determined that adjustments to existing systems would be adequate. Regardless of the tool selected, coalitions were most successful when they solicited feedback from stakeholders—primarily users of the tools—during the development of both referral tools and guidelines.

Employ a strategic approach to engaging stakeholders. Regardless of whether relationships were in place at the beginning of SCI, grantees were able to make more progress when they were strategic in identifying and engaging stakeholders at different points during implementation. Many coalitions found that they needed participation and buy-in from various levels of participating safety net organizations to successfully implement guidelines and referral system improvements. For example, coalitions that only had leadership or provider involvement struggled with getting guidelines implemented appropriately; coalitions with only referral staff engaged suffered from a lack of decision makers at the table, which often delayed progress because of additional steps needed to ensure leadership buy-in for proposed strategies and make high level decisions. Two groups of stakeholders particularly important for coalitions to engage were:

- Physicians (primary and specialty care): In the beginning of the initiative, guidelines were often developed by specialists for PCPs. While this was an efficient way to create guidelines, several coalitions encountered difficulties with implementation. Challenges arose when guidelines required things that PCPs felt were unreasonable because of lack of expertise or available resources. Referral guidelines were well received when they were presented as training tools and opportunities for discussion about appropriate referrals, rather than mandates of what had to be done before a patient could be referred.

- Referral coordinators/staff: Reimbursement and workflow challenges often prevented physicians from utilizing referral guidelines and referral systems. As a result, referral coordinators were often key participants in the referral process and the primary users of guidelines. A number of coalitions discovered benefit to engaging referral coordinators in guideline development and referral system improvements.

Address issues of privacy and malpractice early in a health information technology effort. To move forward with implementing new health information technology, coalitions had to resolve any outstanding issues about protecting personal health information and determining liability (i.e., who's responsible if there is an adverse event). This was important to assure participating providers that the tools comply with legal requirements (e.g., HIPAA) and that they will be appropriately protected.

Challenges

The key challenges identified in the Embedding Guidelines cluster were associated with ensuring referral tools, guidelines and processes met the needs of the various users. When implementating guidelines, coalitions struggled with:

- Changing clinic workflow and existing practice. Mitigating this effectively required identifying current workflow, determining where changes needed to occur, and providing the appropriate training and support to make the necessary modifications.
- Variable comfort and capacity with technology among staff (when using eReferral systems).
- A lack of a minimum amount of clinical expertise to use effectively. There were challenges and inefficiencies related to clinical guidelines being used by non-clinical staff.

Implementing new or updating existing eReferral systems had additional challenges related to developing and implementing the tool. In many cases, these were large and complex systems that required the involvement of multiple entities. A number of coalitions encountered delays due to the capacity of key organizations' information technology (IT) departments. An additional challenge was the ability of an eReferral system to interface with other clinic systems (e.g., EHRs); most eReferral systems were not able to interface with all of the coalition clinics' EHRs, which made it more difficult to establish support for the new system.

In many communities, the demand for specialty services was greater than the safety net's ability to meet the need. While guidelines helped to eliminate some unnecessary referrals, several coalitions noted that the demand for appropriate specialty services continued to outweigh capacity. This imbalance was anticipated to continue to grow given the current economic environment.

Sustainability and Replication

While a large initial investment, referral process and system improvements generally do not require a lot of financial investment to sustain; however, referral systems and guidelines do require updating and maintenance to stay relevant. In SCI, sustainable efforts resulted in one organization taking responsibility for ongoing updates, maintenance, monitoring and technical support. Overall, coalitions' efforts in this cluster created systemic changes that are likely to continue beyond the grant period. In addition, establishing communication mechanisms and formalizing partnerships through referral process improvements better positioned coalitions to respond to additional needs related to specialty care access for the safety net.

Replication and spread of best practices in this cluster may be possible. Many referral guidelines have been created across a large number of specialty areas, and most coalitions have been willing to share their guidelines to help others get started. However, guidelines must be customized to

the local health system and individual providers to be effective, so there needs to be an investment in creating appropriate guidelines for each community. Replicating the work with eReferral systems without grant funding would be difficult, because of the large initial investment needed to build or customize a new eReferral system. However, many coalitions were able to make improvements to existing systems—both electronic and manual—by engaging key stakeholders in discussion about current practice, making appropriate changes to workflow, and then developing tools to support those changes. The strategies pursued in this cluster did change current referral practice, so taking on these strategies requires a willingness to make and sustain institutional changes in how referrals are made and processed.

Impact

Coalitions that pursued strategies in this cluster discussed progress in many of the outcomes associated with success in the SCI logic model. These included:

- More appropriate referrals to targeted specialties
- Increased access to timely care for targeted specialties
- Improved demand management for available specialist appointments
- Improved referral coordination
- Improved ability to track and report data on specialty referrals (discussed more in **Section D**)

Because of the interactivity between strategy clusters, the impact of the SCI work on these outcomes will be discussed in more detail in Section E of this report.

In addition, coalitions reported that the strategies pursued—developing guidelines and improving referral systems—increased the transparency of the referral process and improved communication between primary and specialty care providers.

"From a practice standpoint, there are so many inefficiencies if patients aren't ready [for a specialty care visit], repeat lab tests and radiology procedures. The system improves efficiencies. Previously we would hand out paper packets [with all of the guidelines]. Now it is a living document and the community clinics always have access….The information is always there. Referral is no longer the black hole where the data goes in and nothing ever comes out."

– Ventura County Safety-Net Specialty Care Access Coalition (describing the impact of its Referral Center)

For more information on Embedding Guidelines into the Referral Process:
CCHE developed a comparative case study focusing on the work of two coalitions in improving the referral process, in part by embedding guidelines—Humboldt County IRIS Steering Committee and San Francisco Specialty Care Steering Committee. Both coalitions' work demonstrates progress and illustrates many of the common themes discussed in this section.

2. Building/Expanding Specialty Care Networks

> *"I now have a relationship with these people…I can call them. It didn't start out that way. It was a real challenge in the beginning to figure out who would do what…it took a long time to be able to stand together in partnership, really linked."*
>
> – Contra Costa's Specialty Care Stakeholder Committee

The Building/Expanding Specialty Care Networks cluster ("Building Networks") included strategies focused on increasing the participation and/or availability of specialty care providers, such as volunteer models, recruitment of paid specialists, use of mid-level providers, and telemedicine. These strategies often relied on work in other cluster areas—development of referral systems and care coordination—to facilitate referrals within the network. The aim of these strategies was to decrease wait time by increasing the number of available appointments for the safety net.

Description of Strategies

During the initiative, 21 of the 24 coalitions pursued work relevant to the Building Networks cluster. Coalitions have approached expanding appointment availability in different ways depending on the existing resources within their county. The most common approach for coalitions led by community clinics or collaboratives was to recruit specialists to see publicly insured and/or uninsured patients at reduced or no cost. Several public hospital-led coalitions explored the use mid-levels and recruited additional paid specialists to meet demand. Telemedicine was also a very common strategy for coalitions, regardless of the type of lead agency. Specific strategies included:

- ***Recruiting specialists to see safety net patients:*** The majority of coalitions (12/21) addressed appointment availability by recruiting specialists to see underinsured and uninsured patients. Coalitions piloted different approaches including:

    - Volunteer models that have specialists provide discounted or uncompensated care either in a community clinic setting or in their own office. Referrals to volunteer specialists were typically sent to a centralized location for review and scheduling. The specialist then agreed to see a certain number of patients during a set time period. Often the specialist defined what services they were willing to provide (e.g., only diagnostics, certain procedures, surgery) and what should be completed in primary care (e.g., lab work, follow up).

    - The "Fair Share" model was an example of a volunteer model where key specialty care service providers (in this case, hospitals) agreed to see their "fair share" of safety net patients in an effort to equitably distribute the financial burden of underinsured and uninsured patients across the county health system. This required a centralized program office to track how much uncompensated care each hospital provided and make referrals accordingly.

    - Kaiser Permanente Surgery Days is a focused volunteer model where local coalitions partnered with their local Kaiser Permanente facility to coordinate

Surgery Days. The events were coordinated by the local coalition, which handled administration, screening and selection of patients, recruiting Kaiser Permanente personnel and surgeons, and patient care coordination. Designated surgeries (primarily hernia and gall bladder procedures) were provided by Kaiser Permanente surgeons and support staff at the Kaiser Permanente facility.

- ***Implementing telemedicine:*** About half of the coalitions participating in this cluster (10/21) pursued telemedicine as a way to increase the availability of appointments for targeted specialty areas. Of those, eight implemented teledermatology programs and three used telemedicine for digital retinal screening. Most coalitions used store-and-forward systems (where images are sent to specialists and reviewed), but some linked patients to specialists for a live consult.

- ***Recruiting specialists at local hospitals:*** A few coalitions used data gathered by the coalition to inform recruitment efforts at local hospitals. When data showed excess demand in certain specialty areas, the hospitals were able to make the case for hiring additional specialists. In three counties, this resulted in new specialists being hired at teaching and/or public hospitals to serve the safety net population.

- ***Using Mid-Levels:*** Two coalitions trained mid-level providers (e.g., physicians assistants and nurse practitioners) to provide support to specialists in orthopedics. The mid-levels were employed by the public hospital and trained to provide consults, triage patients, and complete basic diagnostics and procedures. This opened up appointments with the specialists for more complex diagnostics and procedures.

Attachment D provides a high-level summary of the coalitions' work to date.

Success Factors

Coalitions working on building networks made varying degrees of progress. Like in the other strategy cluster areas, coalitions emphasized the importance of getting leadership buy-in, having a dedicated project manager to coordinate efforts, and building on existing infrastructure and ongoing work. They also identified several success factors that were specific to their work in this area. These success factors focus on the two most commonly pursued strategies—recruiting volunteer specialists and telemedicine.

Focus on building relationships with physicians. In the words of one coalition, "it's all about the relationships." Successful efforts emphasized developing relationships with specialists rather than just securing appointment slots. Initially, some specialists may not be willing to see patients, but are open to providing training to PCPs or working on referral guidelines. By accepting these offers and focusing on relationship development, several coalitions found that specialists were more open to seeing patients after working with the coalition in other areas.

Identify physician champions to help access resources and opportunities. Coalitions benefitted from engaging a physician champion in recruitment efforts. These efforts were even more successful when coalitions were able to engage a specialist to recruit other specialists in their field. The recruiting specialist was able to more accurately and concretely discuss the opportunity, what was being requested, and what the specialist could expect to receive.

Integrate effective internal and external care coordination. Care coordination within and among organizations was an important component of successfully building specialty care networks. When specialists were volunteering their time, it was important to ensure that their time was well utilized. Care coordination ensured that referrals were appropriate, that patients showed up to the appointment, and that patients and physicians had the necessary information. Typically, effective care coordination entailed dedicated staff to manage the referrals and information transfer to:

- Schedule patients with off-site specialists and follow up to get consult reports
- Provide patients with the information they needed for the appointment
- Ensure patients know of the appointment and have what they need to get there (e.g., transportation arrangements)
- Manage logistics and details for specific events, like Surgery Days.

Develop standardized systems for information exchange. Successful specialty care networks had processes and systems that allowed for easy exchange of patient health information on both sides of the referral.

Develop processes to recruit and retain individual volunteer specialists. Coalitions that were most successful in this cluster had infrastructure established to provide the volunteer specialists with the resources and support they need. This included having a concrete plan in place to address issues such as: space, legal and contractual requirements, referral process, billing, and liability. These coalitions were able to be very clear early in negotiations about what the specialist would be required to provide and what would be provided for them. (See tips for recruiting, to the right.)

Formalize and institutionalize individual relationships for spread and sustainability. Processes relying on one individual clinician or administrator for access to an organization or system were challenged by limited capacity, organizational changes and turnover. Formalizing relationships by integrating the process or program into the operations of the organization can help spread a successful model to other specialty areas and increase the likelihood of sustainability.

Tips for recruiting & retaining volunteer specialists

- √ **Diversify ongoing recruiting efforts.** Reach out to specialists through multiple venues (i.e., hospitals, existing volunteers, board members, professional association).
- √ **Personalize the approach.** Know what motivates individual specialists to provide uncompensated care and tailor recruitment efforts accordingly.
- √ **Make signing up to volunteer as easy as possible.** Establish volunteer-friendly application processes and quickly be in touch with applicants. Be clear about what you are asking them to provide and what you are offering.
- √ **Be flexible.** Accommodate providers in terms of the level of their commitment, where they see patients, and the types of patients they are willing to see (e.g., diagnoses, procedures).
- √ **Make it seamless for volunteers to provide services.** Provide trained support staff, standardized treatment rooms and the necessary equipment for providers to accomplish what they committed to doing. Have the logistical, contractual, and legal requirements predetermined.
- √ **Establish efficient systems to connect patients with volunteer specialists.** Manage the schedules and coordination in a standardized way.
- √ **Cultivate a culture of appreciation within your organization.** Make efforts to help volunteers feel like part of the team. Tell/show volunteers often that you appreciate their efforts. Even small gestures of "thanks" make volunteers feel valued and important.

Challenges

Coalitions found that recruiting specialists to provide care (often uncompensated) to safety net patients was very difficult. Challenges occurred throughout this process and included:

Recruiting/engaging specialists at different stages:

Initially:	Establishing the necessary infrastructure Identifying interested/willing specialists
After they express interest:	Finding time/excess capacity for specialists to participate Negotiating which services they would provide
After they are engaged:	Not overburdening specialists

"[The coalition clinics] feel they ask the most they could from them…and don't want to jeopardize the services that they do get [by asking more]."

Coordinating referrals: Coalitions had difficultly establishing clear and standardized processes for coordinating referrals. The first step was ensuring clear expectations for the PCP, specialists and patients; then determining the process for scheduling, sharing clinical information, ensuring the patient can get to the specialist appointment, and getting consult reports back from the specialists.

Ensuring continuity of care for patients: Coalitions often cited specialists' concerns with duty of care. For example, coalitions reported that many specialists were resistant to provide diagnostic services if there was nowhere to refer for procedures if needed. Likewise, they were reluctant to participate because they were concerned that if a patient was diagnosed with a condition that required ongoing treatment, it would be their duty to continue to provide care for that patient.

Negotiating changes in the environment: During SCI, there were frequent changes in insurance coverage for the safety net population, which influenced where patients could be referred; additionally, funding for the safety net was decreasing and budgets were being cut, which made it difficult to ask health care organizations and clinics to do more.

Additional challenges were mentioned for specific recruitment strategies, according to whether efforts were aimed at partnering with individual physicians or with institutions.

Recruiting individuals	Recruiting institutions

• Relying on individual charity (not a systematic approach)
• Determining contracts and liability coverage
• Limited capacity of primary care clinics to manage volunteers (need volunteer coordination)
• If volunteers are providing services at the community clinic, additional challenges included:
  o Revising scope of practice for Federally Qualified Health Centers (if a new services are added)
  o Finding clinic space for volunteers to practice and providing necessary supplies and equipment
	• Delays in processing agreements with other health organizations
	• Engaging both administrative and clinical leadership
	• Negotiating and standardizing referral processes, information sharing and data collection between different organizations
	• Coordinating care between organizations and ensuring patients return to their medical home
	• Adapting to changes within organizations (e.g., leadership change, mergers, lay-offs, etc)

While the success factors for telemedicine were similar to other efforts to build networks, a number of unique challenges were mentioned. These included:

- Building telemedicine into a clinic's workflow
- Determining necessary training and capacity needed within the clinic (e.g., certifications, competency exams)
- Getting buy-in from PCPs to use telemedicine (e.g., it takes longer than a referral and does not fit into workflow)
- Determining contracts and liability coverage
- Establishing a cost and reimbursement structure for primary care clinics and specialists
- Ensuring adequate technology/connectivity—resolution, bandwidth—and security between systems (i.e., HIPAA compliance)
- When used for consultation, ensuring that PCPs have the capacity and resources needed to carry out specialists' recommendations (e.g., access to medications and diagnostics)

> "It's very easy to say 'we're going to do telemedicine'…you get all the equipment you need and you plug it in and turn it on and that's it. You use it. But there's so much more to it…a lot of logistics and technical challenges."

Sustainability and Replication

Coalitions indicated that sustainable relationships were developed through work associated with this cluster, and that developing relationships is the most important component of expanding networks. The challenge continues to be that many of the relationships are individually based and need to be institutionalized to be sustained and spread. Additional considerations for sustainability and replication vary by strategy:

- ***Volunteer recruitment:*** There are many lessons learned from SCI that can be applied to recruitment efforts. However, managing a volunteer network requires ongoing resources and operational support to coordinate care and keep volunteers engaged. Many clinics have struggled to establish this infrastructure. Additionally, when reaching out to institutions, much of the success has been in identifying individual champions, and there have been difficulties spreading beyond that one person. Again, attention needs to be paid to forming institutional and individual relationships for sustainability and spread. The Surgery Day model, replicated in partnership with Kaiser Permanente during SCI, continued to spread to other Kaiser Permanente facilities. This required an investment from both the community clinics and Kaiser Permanente to coordinate; but since it is a periodic event, it is easier to take on than ongoing maintenance of a volunteer network.

- ***Telemedicine:*** There is currently a lot of effort focused on telemedicine strategies, and many clinics now have the equipment they need to provide telemedicine services. These strategies have been particularly effective for teledermatology and digital retinal screening. However, the challenge for sustainability and replication is the current lack of adequate business and reimbursement models to maintain engagement of specialists.

- ***Use of mid-levels:*** Two hospitals invested significant resources in training a mid-level to assist with demand in orthopedics. For one organization, this worked well and has become a sustainable position. The other had turnover in the position and the investment was lost; they are uncertain about whether they would invest the resources in training mid-levels in the future.

- ***Recruitment of paid specialists by public hospitals:*** Coalitions employing this strategy used data to indicate demand. There were no concerns about sustaining these added positions as long as they were in demand.

Impact

Coalitions that pursued strategies in this cluster reported progress in many of the outcomes associated with success in the SCI logic model. These included:

- Increased availability of specialty care appointments for underserved populations
- More appropriate referrals to targeted specialties
- Increased access to timely care for targeted specialties
- Improved referral coordination
- Improved ability to track and report data on specialty referrals (discussed more in **Section D**)

Because of the interactivity between strategy clusters, the impact of SCI work on these outcomes will be discussed in more detail in Section E of this report.

Coalitions also reported increased patient and primary care provider satisfaction as a result of easier access to specialists and improved communication between specialists and primary care providers. Coalitions participating in this cluster also shared many stories of the impact on patients' lives:

"With orthopedics, the impact has been substantial. Before the program there was no access at all. People had to drive a long way and wait a long time for care."
– ACCEL (El Dorado) (discussing their orthopedic pathway)

"We are likely preventing blindness among a lot of these folks because they have had diabetes for years and have never had a retinal screening."
– Ventura County Specialty Care Access Coalition (discussing their digital retinopathy program)

Project Access San Diego Success Story:

Mary is a woman in her early 40s with young children. She walked in to a Community Health Center complaining of eye swelling. She was found to have a small mass on the inside of her eyelid. This did not respond to antibiotics, and did not have the typical appearance of a chalazion (plugged oil gland). The primary physician felt that an Ophthalmologist should look at the mass and perhaps perform a biopsy.

Through Project Access and Kaiser Permanente, the patient was scheduled for an outpatient biopsy during a Kaiser Permanente Surgery Day. The biopsy went uneventfully and the patient did well. However, the biopsy result showed that the patient had a rare form of eye melanoma. Project Access arranged a consultation with a 'super-specialist' ophthalmologist at UC San Diego, who was able to outline a treatment plan for Mary. Kaiser and the Kaiser Ophthalmologist donated a second surgery intended to remove the rest of the melanoma while sparing the eye itself. Project Access also arranged a consultation with a volunteer oncologist as well. In addition, Project Access was able to procure a rarely-used form of eye drop not readily available, at no cost to the patient. One year later, Mary remains cancer-free and able to see using two good eyes.

For more information about Building and Expanding Specialty Care Networks:
CCHE developed a case study focusing on the work of the Westside/South Bay Specialty Care Coalition, led by Venice Family Clinic (VFC). Their work has focused on sharing and spreading VFC's internal specialty resources within the coalition, recruiting individual volunteers, partnering with institutions, and implementing Surgery Days with Kaiser Permanente. The coalition's work demonstrates progress and illustrates many of the common themes discussed in this section.

3. Increasing Primary Care Provider Capacity/Scope of Practice

> *"We're improving patient care, treating patients that otherwise wouldn't be treated. It's a better use of resources…making a targeted use of specialty care where needed. We're reserving consults for appropriate cases, getting my skill level increased and improving my ability to reach out to others without a specialty visit."*
>
> – San Diego Countywide Specialty Care Initiative Coalition

The Increasing Primary Care Provider Capacity/Scope of Practice cluster ("Increasing PCP Capacity") included strategies focused on increasing PCP confidence and ability to manage common conditions without referral to a specialist. The aim of these strategies was to improve demand management by ensuring more appropriate referrals to specialists.

Description of Strategies

During SCI, 17 of the 24 coalitions pursued work relevant to the Increasing PCP Capacity cluster. To guide efforts, four coalitions conducted assessments to gauge PCPs' needs for and interest in training on various specialty care topics and inform training structure and curricula. Specific strategies implemented included:

- ***In-person training***: The most commonly pursued approach for increasing PCP capacity was to hold face-to-face meetings and trainings involving primary and specialty care providers (11/17). These meetings took various forms and structures including formal didactic trainings, case conferences or "meet the specialist events to discuss common conditions and referral issues, and interactive, hands-on training for conducting certain basic specialty procedures.

- ***Mini-fellowship programs:*** About half of the coalitions in this cluster (8/18) implemented mini-fellowship programs in key specialty areas (also called "shadowing," "preceptorships" and the "champion model"). This strategy included PCPs training onsite with specialists to learn basic diagnostics or procedures that they could do in their own practice. Often the PCP that received training became the "champion" for that specialty area within their clinic and served as a resource for other PCPs. Common specialty areas for training via mini-fellowships included cardiology, dermatology, orthopedics and rheumatology.

- ***Consultation between specialists and PCPs:*** To support and capitalize on the relationships established through the strategies above, a number of coalitions worked to improve the effectiveness and efficiency of communication between PCPs and specialists. Consultation is a crucial component of the "champion model"—in which PCP champions have access to an identified specialist who is available by telephone to offer advice and help triage patients. Five coalitions explored or implemented an eConsult software system to aid in information exchange. eConsult systems allow for secure, HIPAA-compliant electronic communication between PCPs and specialists. One coalition implemented a call list system that identifies on-call or on-duty specialists PCPs can contact for consultation.

Attachment D provides a high-level summary of coalitions' work related to this cluster to date.

Success Factors

Coalitions that implemented training programs identified several lessons that contributed to their success.

Use training to develop relationships between PCPs and specialists. Coalitions found that trainings and roundtables were an effective way to foster relationship development between individual PCPs and specialists, as well as between their respective organizations.

Engage both PCPs and specialists in the design of training activities. Coalitions recognized the importance of involving both PCPs and specialists in the identification of training needs as well as the design of training sessions and curriculum. Specifically, coalitions indicated it was useful to identify and engage physician champions, both PCP and specialists, to develop and drive the process. This helped build buy-in for and interest in the training and ensure training opportunities were responsive to perceived need and appropriate in terms of content and format.

"The dinner series continues and is very successful. We have about 40 doctors at each dinner….One of the great benefits is that it provides an interface between the PCPs and the subspecialists. It's been great. Of all of the things funded by the grant, this is relatively inexpensive, but has the highest yield."

Make trainings convenient and easy for physicians to attend. Training opportunities were more successful when they were coordinated in response to physician availability. Some coalitions used videoconferencing or telemedicine technology so providers at other sites could participate remotely. Others integrated training into standing meetings at partner clinics or hospitals. A number of coalitions recorded the sessions and archived them online for providers to access later; this approach built a library of resources to which physicians could refer back. If trainings were conducted during clinic hours, it was also helpful to pay for or negotiate provider release time.

Incentivize provider participation. Coalitions stated the importance of incentivizing providers' participation (both PCPs and specialists) and setting clear expectations about training objectives and anticipated outcomes. Providing incentives—like continuing medical education credits (CMEs), provider release time, food or individual payments—increased participation.

Standardize training processes and curricula with clear, measurable objectives to assess competency. Coalitions identified the need to ensure training curricula were tied to clear objectives. This ensured agreement between PCPs and specialists about what was expected to result from the training and that outcomes were appropriate and realistic. Clear objectives were also important in assessing PCP competency after training.

Tips for eConsult

Coalitions identified several factors that aided the development and implementation of an eConsult system.

- Engage and get feedback from key stakeholders and potential users throughout the process. This increases buy-in and utilization of the tool.
- Develop a user-friendly and intuitive system.
- Explore and adapt existing technology solutions when appropriate; leveraging previous efforts can expedite the development process.
- Use the system to maintain and expand relationships built through other venues (e.g., trainings).
- Consider how eConsult will integrate into existing clinic workflows. Some coalitions opened the system up for use by mid-levels and other medical staff to address challenges with workflow and provider time.

Structure training opportunities as discussions focused on practical advice and patient management guidance. Trainings were well received when they included dialog between specialists and PCPs to increase understanding and identify issues in the referral process. Through collaborating on referral guidelines or using "case conference" format, these discussions focused on highlighting appropriate and inappropriate referrals.

Challenges

Coalitions reported challenges associated with coordinating the logistics of face-to-face training activities, evaluating the impact of training activities, and managing the practice of trained PCPs.

Coordination	Evaluation	Practice management
• Recruiting specialists to participate in training efforts • Securing CME credits • Scheduling the training (i.e., finding a time that works for both specialists and PCPs)	• Assessing PCPs' competency after completing training • Tracking if/how the training activity changed participants' practice • Determining if/how training activities are improving access to specialty care	• Ensuring PCPs have the opportunity to utilize their new skills • Not placing additional burdens on PCPs, already working at capacity • Addressing financial disincentives for PCPs to use new skills (e.g., procedures take more time, but many PCPs in the safety net are reimbursed per visit regardless of how long the visit takes) • Mitigating operational barriers such as scheduling, workflow, equipment availability, and support staff training

Coalitions pursuing eConsult reported challenges associated with developing and implementing this new system. These challenges included:

"The one thing the PCPs have been more resistant to is increasing their scope of practice. They are already stretched. And it's a concern—if the PCPs are seeing more specialty patients then that might cause a back up in primary care."

- Integrating the system into provider and clinic workflows
- Resolving privacy and liability concerns to assure physicians that they were in compliance with regulations and protected should an adverse event occur
- Ensuring PCPs' comfort, confidence and ability to carry out specialists' recommendations (once system is operational)
- Encouraging physicians—primary and specialty care—to participate because, currently, neither PCPs nor specialists can be reimbursed for time spent using eConsult.

Sustainability and Replication

Most activities in this cluster require some ongoing financial investment for coordinating the activities, providing incentives to providers, and additional monitoring and evaluation. When offered, coalitions paid for provider incentives (such as CMEs or provider release time) out of the SCI grant. Coalitions have begun exploring how to better monitor and evaluate the impact of training activities in terms of providers' practice and patient care in an effort to build leadership support for continuing training activities. A number of coalitions reported they would be able to integrate training into one member's ongoing activities since it aligned with their mission and is a relatively inexpensive way to build relationships and increase communication within the health system.

Replicating and spreading mini-fellowship models also would require ongoing resources for coordination and incentives. Moreover, policies and regulations differ by institution and may create a barrier to implementing mini-fellowships. For example, credentialing requirements at the specialty institution may limit the benefit of a shadowing opportunity for PCPs—PCPs might be allowed to observe but not permitted to practice injecting a joint without being credentialed. Training programs that rely on one specialty physician champion are often limited in scope and can be challenged by organizational changes and turnover.

EConsult systems garnered a lot of interest and support through the last half of SCI. However, the potential sustainability and replication of eConsult systems depends on creating a mechanism for reimbursement for the physicians interacting with the system. At the time of this report, the physicians engaged in eConsult were performing these activities in their administrative or personal time. This limits the potential spread of existing systems and the feasibility and usefulness of implementing such systems in other settings.

Impact

Coalitions that pursued strategies in this cluster reported progress in many of the outcomes associated with success on the SCI logic model. These included:

- More appropriate referrals to targeted specialties
- Improved demand management for available specialist appointments
- Increased access to timely care for targeted specialties

Because of the interactivity between strategy cluster areas, the impact of SCI work will be discussed in more detail in Section E of this report.

In addition, coalitions perceived their work in this strategy cluster to be successful in:

- Building relationships between individual PCPs and specialists. Coalitions reported success in building trust and establishing communication so PCPs had easier access to specialists for consultation.
- Increasing understanding of systems and the realities of "the other side." Coalitions indicated training opportunities facilitated a dialog that increased PCPs' awareness of specialists' organizational processes and capacity and vice versa.

"We found that neither party was really aware of the challenges the other was facing. For example, the specialists didn't know about all of the work that the PCPs were doing. The PCPs didn't know what resources were available at the specialty care clinics, how capacity is limited, and that specialists aren't able to see all of the patients that PCPs would like seen."

– LAC+USC Camino del Salud Network Specialty Care Access Project (on their community ground rounds with primary care and specialty physicians)

For more information on Increasing PCP Capacity/Scope of Practice:
CCHE developed a case study focusing on the work of the San Diego Countywide Specialty Care Initiative Coalition. They have pursued a variety of approaches to increasing PCP capacity—including different training modalities and implementing eConsult. The coalition's work demonstrates progress and illustrates many of the common themes discussed in this section.

4. Integrating Care Coordination

> *"[Care coordination is] one of those things that is absolutely necessary and is needed across institutions, particularly when dealing with the safety net population who have different needs. It ensures that patients can get quality care and that patients are satisfied and have a good experience with the health system."* - Access El Dorado (ACCEL)

There is considerable variation in how care coordination is defined in the literature and by the coalitions. A toolkit developed by the MacColl Center for Health Care Innovation, for the Commonwealth Fund, identifies four domains that need to be addressed to improve care coordination: accountability, patient support, relationships and agreements (e.g., creation of a referral network), and connectivity (e.g., referral systems).[4] Given that all of the work conducted in SCI is related to care coordination, the Integrating Care Coordination cluster ("Care Coordination") was limited to strategies focused on providing patient support (e.g., ensuring patients have the information and resources (transportation, language services) they need for their specialty care appointment, and to make sure the appropriate follow-up occurs after the appointment). The work in this cluster aimed to reduce no-show rates and improve patient satisfaction.

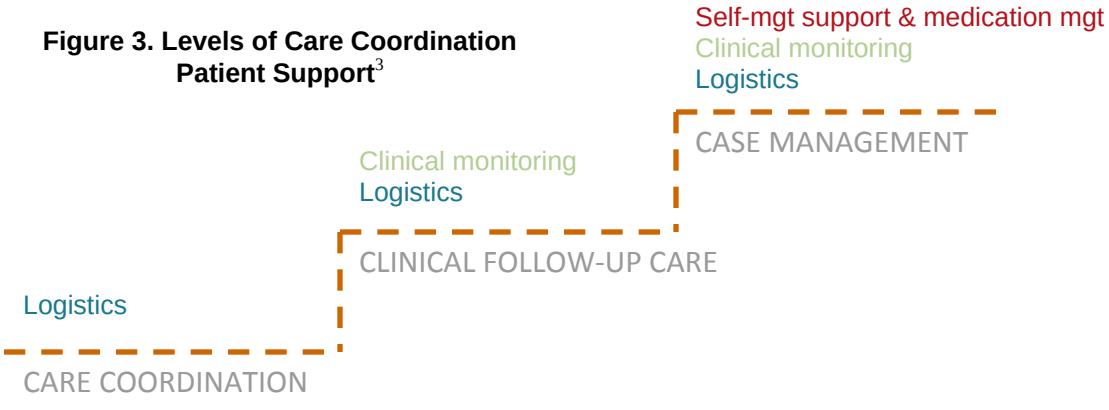
Description of Strategies

Ten of 24 coalitions pursued work relevant to the Care Coordination cluster. Generally, coalitions took two different approaches to providing patient support:

1) Coordinating care between many health systems/clinics within a geographic area through a care coordinator/patient navigator position or referral coordinators; and
2) Coordinating care within a large health care system by streamlining and improving operations, communication and information exchange.

<u>Coordination between health systems/clinics</u>
Different levels of care coordination may be appropriate depending on the needs of the patient population. Many patients need logistical support for coordinating referrals and transitioning care; other patients with more complicated health care needs may require more intensive follow-up and self management or medication management assistance (Figure 3).

Figure 3. Levels of Care Coordination
Patient Support[3]



[4] *Reducing Care Fragmentation – A Toolkit for Coordinating Care*. The Commonwealth Fund. April 2011. Available at http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation_april_2011.pdf.

In most cases, these roles are managed by a specific position(s) designated to coordinate care (rather than distributed across clinic staff). In SCI, six coalitions focused on the logistical component of care coordination by adding or improving individual referral coordination to track referrals, ensure patients knew about available resources, and help patients with the referral process. Two coalitions implemented a more intensive case management model, where a care coordinator supported the patient from referral to the appointment and back to their medical home; they made sure the patient had the information (tests, documents, etc) and resources (transportation, language services, etc) required for the appointment and coordinated any follow-up care needed. The more intensive care coordination model was typically utilized for specific programs, like Surgery Days.

Coordination within a health system

The other approach to care coordination was improving logistical processes to better support patients within a health system. This was done at San Mateo Medical Center by their specialty clinic redesign efforts, which included reminder calls and helping patients to better navigate within the medical center (see Integrating Care Coordination case study for more details). Another coalition focused on implementing an automated patient reminder system to decrease no-show rates at one of the public hospitals in Los Angeles County.

Coalitions focused more on care coordination later in SCI. It was typically a secondary strategy to help facilitate expanded specialty care networks or improvements in the referral process; in fact, effective care coordination was identified as a success factor for the Building Networks cluster. For example, when a coalition identified a need to increase the availability of specialists to see safety net patients, it was important to focus on building their networks before shifting the focus to care coordination. In the words of one coalition, "You have to have access before you have care coordination. There has to be somewhere for the patients to go to coordinate care."

Attachment E provides a high-level summary of the coalitions' work to date.

Success Factors

Coalitions that have successfully implemented care coordination strategies to improve patient support services identified several factors that were important to their progress.

Build leadership support for care coordination activities. Because there is no payment mechanism for care coordination activities, it was critical for organizations to have leadership that were willing to make care coordination a priority within their organizations and devote resources to it, including supporting and empowering the individuals working to coordinate care.

Identify and implement tools/systems to support more effective coordination. Care coordination activities were more effective when supported by the implementation of systems that helped to track referrals, facilitate follow up and manage data.

Standardize communication and processes across clinics and specialty areas. Clinics benefited from having a standardized process for care coordination across specialty areas; this helped to reduce confusion for patients, providers and staff. When multiple primary care clinics referred to a single specialty office, it is also beneficial to have consistent processes so the specialty office could know what to expect. In a few coalitions, this was facilitated by convening referral coordinators for all the coalition clinics to determine best practices and appropriate processes.

Understand the specialty care environment and know the access points. Coordinating care in health care environments that were always in flux—programs and resources available, eligibility criteria, and roles of staff—was challenging. As a result, care coordinators had to be aware of and communicate changes across the health systems; this was also benefited by convening referral/care coordinators across clinics to share information about the changing environment.

Strategically determine the most appropriate approach for care coordination. The needs for care coordination and patient support differed by coalition—some focused on coordinating care from primary care, while others focused on having a referral coordinator at the specialist clinic to facilitate the process on that side. Successful coalitions assessed their needs for care coordination and planned accordingly for appropriate staffing, scope of work, and processes to help facilitate effective coordination.

Engage physicians and medical staff. Integrating care coordination required that people change their work flow, learn a new system, or use different communication mechanisms. When physicians and medical staff understood the goals of the care coordination efforts, it increased buy-in for and compliance to the new processes.

Challenges

"Without the grant it would become very difficult to dedicate time and staffing to this effort."

Care coordination can be resource intensive; it typically required devoted staff, whose salaries are not currently paid through reimbursement. Most coalitions that hired referral or care coordinators used grant funds and reported concerns about sustaining the positions after the completion of the grant period. There were ongoing questions about who should pay for care coordination within a health system, since it is benefiting the entire safety net system. Internal care coordination improvements that involved process changes were easier to build into operations and sustain, but the benefits are limited to a specific clinic or medical center.

Additionally, this work was usually handled by a few individuals and was relationship-based. Recruiting the right person for the job and retaining that person can be difficult. To prevent burn-out, it was important that the referral or care coordinator had a support team, programmatic and clinical supervision, and a reasonable scope of work and volume of referrals or patients to manage. If referral or patient volume increases, there may be a need to offer fewer care coordination services or hire additional coordinators.

Integrating additional care coordination activities into a practice had an impact on clinic workflow. Making changes to clinic practice was often a challenge; to be done well, the affected staff should be consulted about revised workflow decisions.

Sustainability and Replication

Sustainability and replication considerations for the two models of care coordination vary greatly. As mentioned above, strategies addressing internal care coordination can often be implemented through process improvements, revised workflows, and renegotiating job descriptions. It is possible, with leadership support, to institutionalize these changes and sustain them with little ongoing financial investment. The key components for sustainability are establishing leadership buy-in and building and maintaining staff support for these changes. The full implementation of these changes requires a team that is experienced and

comfortable with managing internal change, and negotiating the potential for "change fatigue" on the part of staff. The changes made by San Mateo Medical Center could be replicated by other public hospitals. Even though this approach to care coordination is limited in scope, it can have a large impact when implemented at an organization that is the primary source of care for the safety net population in a community.

Sustaining and replicating external care coordination—coordinating care between health care systems and clinics—is challenged since there is currently no reimbursement mechanism for these activities. The various expectations of this role make it more effective when centralized in a person or team of people, and not distributed among staff that already have full-time responsibilities. Typically this position is located in a primary care setting—in SCI, most of these primary care clinics were community clinics with limited resources to fund care coordinator positions. Like the internal model of care coordination, establishing leadership support is crucial, but there is an ongoing question about how to sustain these types of positions during budget cuts. If the organization is committed to sustaining the position, attention must also be paid to retaining the individual in the position by ensuring that they have support, a reasonable work load, and a manageable number of patients. Ensuring the sustainability and likelihood of replicating these external care coordination models, in a difficult economic environment, requires a reimbursement mechanism for this role.

Impact

Coalitions that pursued strategies in this cluster reported progress in many of the outcomes associated with success in the SCI logic model. These included:

- Decreased no-show rates
- Improved referral coordination
- Increased access to timely care for targeted specialties
- Improved ability to track and report data on specialty referrals (discussed more in **Section D**)

Because of the interactivity between strategy clusters, the impact of SCI work on these outcomes will be discussed in more detail in Section E of this report.

Coalitions also reported improved patient experience and increased patient satisfaction, as well as improved communication between specialists and primary care providers.

"We've been able to establish a relationship with our patients; they are able to count on us and feel comfortable that someone is paying attention. They have a person that they can talk to about the referral other than their provider, which helps the providers too."

– Yolo County Future of the Safety Net (on care coordination within the Fair Share model)

"Now we feel like we have a coordinated system of care"

– Contra Costa's Specialty Care Stakeholder Committee (on the collaboration of referral coordinators)

For more information about Integrating Care Coordination:
CCHE developed a comparative case study focusing on the work of two coalitions—Yolo County Future of the Safety Net and San Mateo S.S.H.I.P. Yolo pursued coordination between health systems and clinics, while San Mateo focused on improving coordination within San Mateo Medical Center. The coalitions' work demonstrates progress and illustrates many of the common themes discussed in this section.

C. Building Community-Based Health Coalitions

> "For us it has been a great forum to discuss issues, share ideas, problem solve and troubleshoot in a collaborative way rather than a competitive way. We do our best to collaborate and leverage each other's resources. That's very valuable."

A key outcome in SCI was that coalitions of stakeholders would develop a community-based and coordinated response to increasing access to specialty care. For most coalitions, this meant that any strategy needed to actively involve multiple institutions. One mechanism to do this effectively is establishing a high-functioning coalition to direct the work. Overall, grantees valued the coalition approach and credited it for their ability to secure buy-in from key stakeholders and make progress in implementing appropriate strategies to increase access to specialty care in their communities.

To determine the extent to which the initiative was successful at creating new, stronger and more sustainable coalitions, the evaluation assessed coalition engagement and functioning for all SCI coalitions. The primary source of data was a web-based survey of all coalition members administered twice during the initiative, once in November 2009 and again in April 2011. When appropriate, comparisons were made between (1) different types of coalitions within SCI (e.g., those that existed prior to the initiative versus those that did not) and (2) coalitions over time.

1. Coalition Engagement

SCI aimed to engage and empower community health coalitions in developing local solutions to specialty care access. Coalition engagement was assessed using (1) response rates to the coalition surveys; (2) sustained coalition membership over time; (3) attendance at coalition meetings; and (4) member assessment of and satisfaction with coalition progress.

- **Response Rates:** The response rates for the two surveys were: 64% (238/369) in 2009 and 58% (228/393) in 2011. The difference in response rates between years may be an indication of engagement, but might also be associated with coalitions' changes in structure and additions of working groups, which demand different levels of engagement from different members.

- **Coalition Membership:** Coalition membership was compared over time to assess continued engagement in the coalition through the planning and implementation process. The membership of most coalitions has been relatively stable over the two years, particularly in terms of organizational representation. Although individuals may have stopped participating in the coalition due to employment changes, typically they were replaced by other representatives of that organization.

  Most coalitions had relatively stable membership. Coalitions that expanded did so because they identified gaps in perspectives or organizational representation. Some coalitions intentionally wanted to keep their core group small, so engaged stakeholders in other ways. A few coalitions added significant membership after successfully engaging a specific group or organization (e.g., LAC+USC Camino del Salud Network Specialty Care Access Project recruited additional community clinics to participate in their coalition). Other coalitions added workgroup members to their membership lists for the second round of the survey (e.g., Kern Medical Center Specialty Care Coalition included their referral coordinator group).

- **Attendance at Meetings:** Coalition engagement was also assessed by attendance at coalition meetings. Attendance in 2011 decreased significantly from 2009; 84% of coalition members attended more than half of coalition meetings in 2009 compared with 70% in 2011 (p=.000). The timeline suggests that some members may have become less engaged as coalitions moved from planning to implementing certain strategies.

  In addition, attendance in 2011 for coalitions in existence prior to the initiative (existing coalitions) was higher than for those coalitions that convened for the purpose of SCI (new coalitions); 75% of existing coalition members attended more than half the meetings compared with 64% of new coalitions (approaching significance at p=.066). There was no significant difference in attendance between existing and new coalitions in 2009 suggesting additional challenges in sustaining member engagement for coalitions established for SCI (see **Attachment F**).

- **Assessment of Progress and Satisfaction:** Coalition members were asked to rate their progress toward their key current project goal on a scale from 1 to 10 (1 is "No progress" and 10 is "Goal accomplished"). On average, the coalitions' rating of progress increased slightly from 5.7 in 2009 to 6.2 in 2011, a change that was not statistically significant. Overall, coalition members are satisfied with the functioning of their coalition; over 80% indicated that they were satisfied or very satisfied in both 2009 and 2011.

Factors influencing engagement

In oral progress reports, coalition leads identified three critical factors that increased member engagement. The first was its participation in the SCI–the ability to allocate resources to coalition activities and funders' support of a collaborative approach to specialty care access. Even coalitions that existed prior to SCI spoke about how SCI gave them permission to tackle specialty care access systematically and created a collective sense of accountability.

The second factor was the composition of the coalition. Coalition leads discussed the importance of broad participation in the coalition, convening representatives from key organizations in the safety net system, including primary care and specialty perspectives. One consideration was how to adequately engage key decision makers in the coalition. A number of grantees said participation of decision makers expedited progress since it enabled the coalition to be a decision-making entity. However, as with other efforts requiring leadership and clinician input, it was often difficult to engage them regularly enough to keep strategies moving forward. In response, a number of grantees created an advisory coalition made up of decision makers, to provide vision, oversight and feedback, but also convened one or more workgroups that engaged on-the-ground stakeholders to focus on implementing the strategies once approved. Subsequently, many workgroups were successful in strengthening ties among peers across organizations, sometimes building positive relationships between organizations that had a history of tension.

The third factor was the strength of the coalition. Grantees credited the coalition with creating a forum for dialog and building trust, increasing understanding of the different realities for various organizations, and putting aside organizational allegiances to strengthen the safety net as a whole. These, and other indicators of coalition functioning, are discussed in the next section.

2. **Coalition Functioning**

Assessment of coalition functioning included consideration of six domains: shared vision and planning, community participation, decision making, leadership, sense of community and sustainability.

Overall, respondents indicated a high level of agreement that their coalition was effective. Over 75% of respondents either *agreed* or *strongly agreed* with statements assessing coalition functioning in each domain. To highlight differences between items, the analysis dichotomized responses into those who *strongly agreed* with statements assessing each aspect of the coalition and all other responses. There were no significant differences between 2009 and 2011 in any domain (see **Table 3**)

Overall, the domain with the **highest level of agreement** was ***sense of community***. Qualitative data supported this finding, indicating that coalitions attracted individuals who were committed to working collaboratively to improve their safety net system. While the levels of satisfaction remained high overall, there was a slight decrease from 2009 to 2011.

Table 3: Coalition Functioning Summary
(% respondents indicating 'strongly agree' to statements assessing each domain)

Domain	Survey Year	
	2009	2011
	N=239	N=228[5]
Shared Vision & Planning	41%	34%
Community Participation	30%	27%
Decision Making	30%	29%
Leadership	36%	33%
Sense of Community	51%	49%
Sustainability	44%	32%*

* Significant at p<.05

Community participation and decision making were areas where coalition members indicated the **lowest level of agreement**.

Within ***community participation***, only 16% of respondents *strongly agreed* that their coalitions had adequate involvement of specialists in both 2009 and 2011. This challenge was greater among coalitions that were led by an organization other than a public hospital. Qualitative data also indicated that identifying and engaging specialists was an ongoing challenge for coalitions. A few coalitions paid specialists to incentivize participation in the coalition; other coalitions engaged specialists in more targeted ways (e.g., training activities, guideline development) and opted to not include them in coalition membership.

Survey responses also showed a significant decrease from 2009 to 2011 in the number of coalition members who *strongly agreed* that the coalition meets regularly enough to facilitate collegial relationships among members (p<.05). As discussed previously, qualitative data indicated that relationship building between individuals and organizations was identified as a primary benefit of the coalition approach. However, over the course of the initiative, coalition leads reported reducing the frequency of coalition meetings in an effort to maximize the time of coalition members. Survey responses suggest that decision might have had a negative effect on coalition members' ability to build trust and collegial relationships.

For ***decision making processes***, the level of agreement decreased slightly in five of the six areas assessing decision making from 2009 to 2011 across SCI coalitions. However, in 2011, there were significant differences (p<.05) between existing and new coalitions with regard to two components: 1) having clear procedures for making decisions; and 2) having fair and transparent

[5] Does not include Access OC, San Bernardino Specialty Care Coalition, or Solano County Specialty Care Committee.

decision-making processes. Members of new coalitions were less likely to *strongly agree* that their coalitions had clear and fair processes for decision making in 2011; in 2009, there were no significant differences between the two. This suggests that initial planning and coalition building efforts may have been more intentional in their decision making processes than subsequent decisions about implementation activities. Qualitative data indicated that many coalitions changed strategies based on opportunities that arose, which may have resulted in the perception that there were no clear processes for decision making.

The coalition survey also revealed a significant decline from 2009 to 2011 in two components of ***shared vision and planning*** ($p<.05$)**.** Fewer coalition members reported *strongly agreeing* that: 1) there is agreement within the coalition on what work should be done and who should do it; and 2) the work plan and budget were shared. Again, this difference may have been caused by coalition's taking a more opportunistic approach to implementation; this responsive approach may have influenced members' satisfaction with coalition vision and planning.

Survey responses from 2009 to 2011 showed a significant decrease in coalition members' agreement that the coalition and project activities were likely to sustain after the end of the initiative ($p<.05$). Qualitatively, coalitions discussed an ongoing struggle with ***sustainability*** over the course of the initiative. Many coalitions were surprised by the amount of time it took to make small systems changes, which may explain some of the initial optimism (and recent concerns) about sustainability. In spite of these uncertainties, a number of grantees reported that the coalition itself will sustain and enable them to move forward with these and other systems-wide, health improvement efforts.

"There is definitely a benefit to having the coalition. There are a lot of great minds with different experiences that come to a meeting. The meetings are very powerful. Sometimes you don't even know where an idea is going to come from… As we look at the end of SCI and sustainability, I think that our coalition engagement is key to sustaining the work we have started."

The complete 2009 and 2011 survey results on coalition functioning are available in **Attachment F.**

D. Coalition Data Collection Efforts

Background

A key outcome identified in the SCI logic model was to increase coalitions' ability to track and report on data related to specialty care referrals. Common measures to be collected by all coalitions were selected using a collaborative approach that included input from the funders, technical assistance provider, and the funded coalitions. Through this process, four measures were identified: referral volume, wait time, disposition of referral, and no-show rates. Initial assessment indicated that the funded coalitions were at different stages in their ability to collect these data. Some had access to electronic systems that could pull reports on most of these data, while others had not even reached agreement about which measures to collect. Even those with existing systems were often defining the measures and collecting data differently than the recommended approach (see **Recommended Definitions**).[6]

Recommended Definitions

Referral Volume: # of new referrals made by primary care providers in targeted specialty care areas

Wait Time: For routine (non-urgent) specialty care appointments, average # of days between date referral is written and the scheduled appointment date

Disposition of Referral: For targeted specialty care areas, # of referrals initially denied or sent back for more information. *(Note: coalitions are asked to report on # of referrals approved, # denied, and # pending review; from that data, % denied is calculated)*

No-Show Rates: # of no-shows for specialist appointments (i.e., patients who did not appear for their scheduled appointment nor called to cancel or reschedule) divided by number of specialist appointments that are on calendar for a given month

As a result of this variation across coalitions, in both capacity and approach, the SCI evaluation tailored data collection and allowed coalitions to collect and report on these measures in the way that was most useful to them. This focused on building capacity for data collection in a way that was meaningful for each coalition, but resulted in significant enough differences in how the measures were defined and how data was collected to make aggregating data across the initiative not feasible.

Coalitions reported on these data quarterly from July 2009 through the end of their grant period using a standardized reporting template developed by CCHE. CCHE reviewed all reports to identify inconsistencies and data quality issues, provided feedback to the coalitions, and tracked the data for each coalition over time.

Increased capacity to track and report on specialty care access data

Collecting data on these four measures was challenging for many of the coalitions. The first several reports submitted were incomplete and contained many data quality issues. As coalitions progressed through the initiative, many were able to resolve data quality issues, while others were able to recognize the limitations of their data and begin to have conversations about improvements to data collection systems. When reflecting on the data

[6] Coalitions with existing data collection systems were permitted to continue to use definitions and systems that were already in place as long as (a) the definitions were based on commonly accepted definitions/conventions, and (b) coalitions were satisfied with the quality of the data they were collecting. If coalitions decided to use definitions that differed from the SCI recommended definitions, they were required to explicitly define their operational definitions for each of the measures.

they were able to collect during SCI, most coalitions indicated that the data were useful to collect and review but it was difficult to make any definitive statements about the impact of their work based on their data.

Project managers reported that the data collected for the initiative was shared at coalition meetings and 87% of coalition members (respondents to the coalition survey) indicated they were at least *somewhat familiar* with the data. A few coalitions identified the willingness and ability to share data between coalition partners as a significant accomplishment.

Of survey respondents, 97% indicated the data were at least *somewhat useful*, with 33% saying the data were *very useful*. The most common ways that coalition members reported using the data were:

- Identifying areas for improvement (80%)
- Informing decision making (62%)
- Prompting dialog (59%)

"[The data] gives us all a chance to see areas of improvement as well as how we are all doing individually and as a collective group."

"Now we can see what is going on, where before we couldn't. We can go to the specialty office and say, we noticed that this is going on—is there anything you can do about it? And many times they can resolve it."

Many coalitions reported increased understanding of which data they needed to talk about their efforts—"we now know what to look at;" this helped to inform the design and implementation of data fields and reports built into new electronic health records. Coalitions also discussed an increased awareness of the value of using data for monitoring progress and identifying areas for improvement; one coalition stated "we never looked at these data before." Several coalitions used the data to look at variation between clinics or regions to identify strengths and potential areas for improvement.

When people responded that the data was only somewhat or not useful, they indicated that this was because of ongoing challenges with data availability and quality. Coalition members said the data collection requirement forced conversations with organizations about the issues with data collection so they can begin to identify solutions. One coalition member stated, "The most effective use of the data has been that our clinics have said it has opened their eyes as to what data they should be collecting. However, identifying trends and correlations to SCI programs is a challenge."

The most common data collection challenges included:

- Incompatible systems and processes between health care organizations, making coalition-level data difficult to aggregate
- Inability to extract data in a meaningful and a timely way from partners' IT or data tracking systems
- Redundancies in data entry, which caused a burden on responsible staff
- Mid-initiative changes to data collection systems, which typically improved the data quality but made them not comparable to earlier reports

Even coalitions that overcame these challenges reported that the data did not capture the impact of their work because of external factors and the time it can take to see changes from system improvements.

Changes in the external environment had a substantial impact on coalitions' ability to improve access in their communities. Several coalition members discussed these external factors when discussing the limitations in interpreting their data:

- *"Due to changes in the environment (for example, general surgeons in the community no longer accepting MediCal) we have seen some great increases [in patient volume] that we did not predict."*
- *"Too many external factors impact this work that we cannot control. For example, a major specialty physician group stops taking MediCal because of state budget cuts."*
- *"I think it is important to know what is currently happening and to be able to try and measure if any of the interventions are working; the down side is that there is so much demand and fluctuation in the data that it is difficult to tell if it is our work that is making a difference or if other factors are contributing."*

The issue of specialty care access for the safety net population is complex for any coalition, and implementation for many coalitions was slower than expected due to the time it took to build the necessary relationships and work through decision-making processes. Many of the strategies expected to influence these measures were not operating long enough to detect any definitive trends in the data. However, coalitions indicated they have more capacity to collect these data than at the beginning of the initiative, which may make it possible for them to show their work's influence on these measures in the future.

E. Impact of SCI Work

In the three years coalitions have been participating in SCI, a number of models and strategies have been developed and are just now beginning to be fully implemented. In many cases, implementation was a slower process than anticipated and the full impact of SCI efforts remain to be seen. However, providers and staff working on SCI projects have qualitatively highlighted several areas of impact on patient care and the safety net system as a result of their efforts.[7]

Outcome	Discussion	Example
Increased access to timely specialty care	Most grantees (18/21) reported increased access to timely specialty care in at least one targeted specialty. Coalitions attributed this to various types of activities: improved referral processes, additional capacity by increasing the number of specialty appointments, established systems for communicating with specialists to expedite the referral process, and increased PCP capacity to handle basic specialty needs without referring.	"[Our specialist champion] has helped with patients and we've been able to more effectively facilitate the referral process. Now in cardiology the wait time is down to three months for a routine visit, and we can get urgent appointments in more quickly." - Westside/South Bay Specialty Care Coalition (on their champion model)
Improved referral coordination	Over half of grantees (12/21) reported improved referral coordination through increased communication and more efficient referral processes. All except one were participating in the Embedding Guidelines cluster, and half were working to Integrate Care Coordination. All of the grantees that convened referral coordinators to share best practices and problem solve reported improved referral coordination.	"The public hospital is really interested in improving efficiencies—like what tests should be ordered and what information is included in the referral. It had been common practice to just deny any referral that didn't have all the required components. So this has been a really great opportunity to improve communication between the two parties." – Long Beach Community Increased Access Specialty Care Coalition (on the improved relationship between the community clinics and the public hospital's rheumatology department)
Improved demand management for specialty care services	Over one-third (9/21) of grantees reported improved demand management for specialty services. This occurred primarily through strategies that (1) increased consultation between specialists and PCPs helping to identify patients more appropriately managed without a specialty referral (e.g., eConsult, training, teledermatology) and (2) focused on utilizing more accurate modalities for screening patients.	"I'm thinking about the application [of the skills]…two PCPs have done training in orthopedics [through a mini-fellowship] and now pretty much everyday one of them is injecting joints. It's a win/win because it means fewer referrals to specialists." – Alameda County Specialty Care Task Force on their mini-fellowship program

[7] This includes only the 21 coalitions for which CCHE has data about the results of their efforts. It does not include data from those coalitions who did not complete the implementation phase (i.e., Solano County Specialty Care Committee, AccessOC Coalition, and San Bernardino Specialty Care Coalition).

Increased availability of specialty care appointments	One-third (7/21) of grantees reported increased availability of specialty care appointments. All of these participated in the Building Networks cluster. They cited increased capacity through expanding clinic hours; using data to influence recruitment of specialists; using mid-levels in specialty clinics; recruiting volunteer providers; connecting patients to existing resources; and implementing Surgery Days.	"We have been working with the [community] clinics to educate them on how to refer into Operation Access (OA). In 2008, 84 referrals were made to OA; in 2010, 361 referrals were made to OA from the clinics. That's a giant jump…our partners are providing more access to services." - Contra Costa's Specialty Care Stakeholder Committee (on their improved partnership with Operation Access)
More appropriate referrals to specialty care	Six grantees reported more appropriate referrals as a result of SCI. This occurred through implementation of and training on referral guidelines; providing PCPs opportunities for training and consultation with specialists; and improving screening practices to be more accurate.	"One of our goals for the program was to more appropriately refer patients to county. We have accomplished that. We have a better standard. We are able to provide better care for patients." - SPA 3 Specialty Care Planning Coalition on their improved colorectal cancer screening modality (iFOBT)
Decreased no-show rates	Three grantees reported decreased no-show rates in targeted specialties. All of these grantees explicitly integrated care coordination into their strategies, one through assigning a case manager, one by "pre-registering" patients over the phone prior to their appointment, and one through intensive referral coordination.	"A key to success [is that the clinic staff] are wonderful at case management. There's only a 4% no show rate and they deserve a ton of the credit for that. If they had a 40-50% no-show [rate], the specialists would get tired of it quickly." - Yolo County Future of the Safety Net (on the care coordination within the Fair Share model)
Increased participation of specialists in coalition	Although grantees did not often explicitly mention increased participation as an impact of their efforts, most strategies depended on the involvement of specialists to be successful. Many grantees discussed their ongoing efforts to engage specialists throughout the initiative.	"We were definitely able to get access in some high need areas. We were able to see 600-700 patients and developed relationships with specialists in the community." – Access El Dorado (on their orthopedic and pain management pathways)
Improved ability to track and report on data	As discussed in Section D, coalitions reported increased capacity to collect and report on specialty care quantitative data.	"The grant has been fantastic to provide the data we need to be able to make good decisions. We give monthly reports to each specialist on their wait time and to administration about what specialty areas we need. It helped to make the case for why we need another ENT." - Ventura County Safety Net Specialty Care Access Coalition

San Joaquin Success Story

"Remarkable stories are coming out. The [dermatology] equipment is being used well. For example, we had a patient with a large, undefined cancer. The champion did a biopsy on her face, tried to get her into [other hospitals] but couldn't do it. It required plastic surgery and the patient had no insurance. The champion removed the cancer, and the patient is now recovering and expecting a baby."

Southside Success Story

"Specific to podiatry, one of the doctors said the difference between now and how it was before this program is 'the difference between heaven and hell.' They are seeing positive outcomes. They are seeing saved limbs. They are seeing dramatic things with access to care now because of this program."

Perhaps the most significant outcome of SCI was the extent to which **formalized relationships** were developed as a result of participating in the initiative. Many grantees indicated that establishing and strengthening health coalitions that included representation from key organizations in the safety net was one of the most beneficial components of the initiative. They believed that this well positioned them to make additional improvements in the safety net system and respond to changes that will occur as part of federal health care reform.

> *"During the process of this grant, a lot of awareness has been raised. And because of the way we have been able to work across specialties, there have been a lot of opportunities for communication and collaboration… We have already broken down the walls between the specialty areas—that's just how we do business now."*

> "*We are seeing that what we are doing is strengthening relationships and thinking more big picture. We're thinking about taking that to the next level where we create a regional network, a collaborative network, and have this be the foundation for an ACO [accountable care organization]....Partnerships and communication are the key pieces."*

Recently, SCI began to focus on **spread of successful models and strategies**; this is expected to be a component of any subsequent grants that Kaiser Permanente awards related to this work. Efforts to spread the Kaiser Permanente Surgery Day model—to open up access to diagnostic and surgical procedures—are already underway.

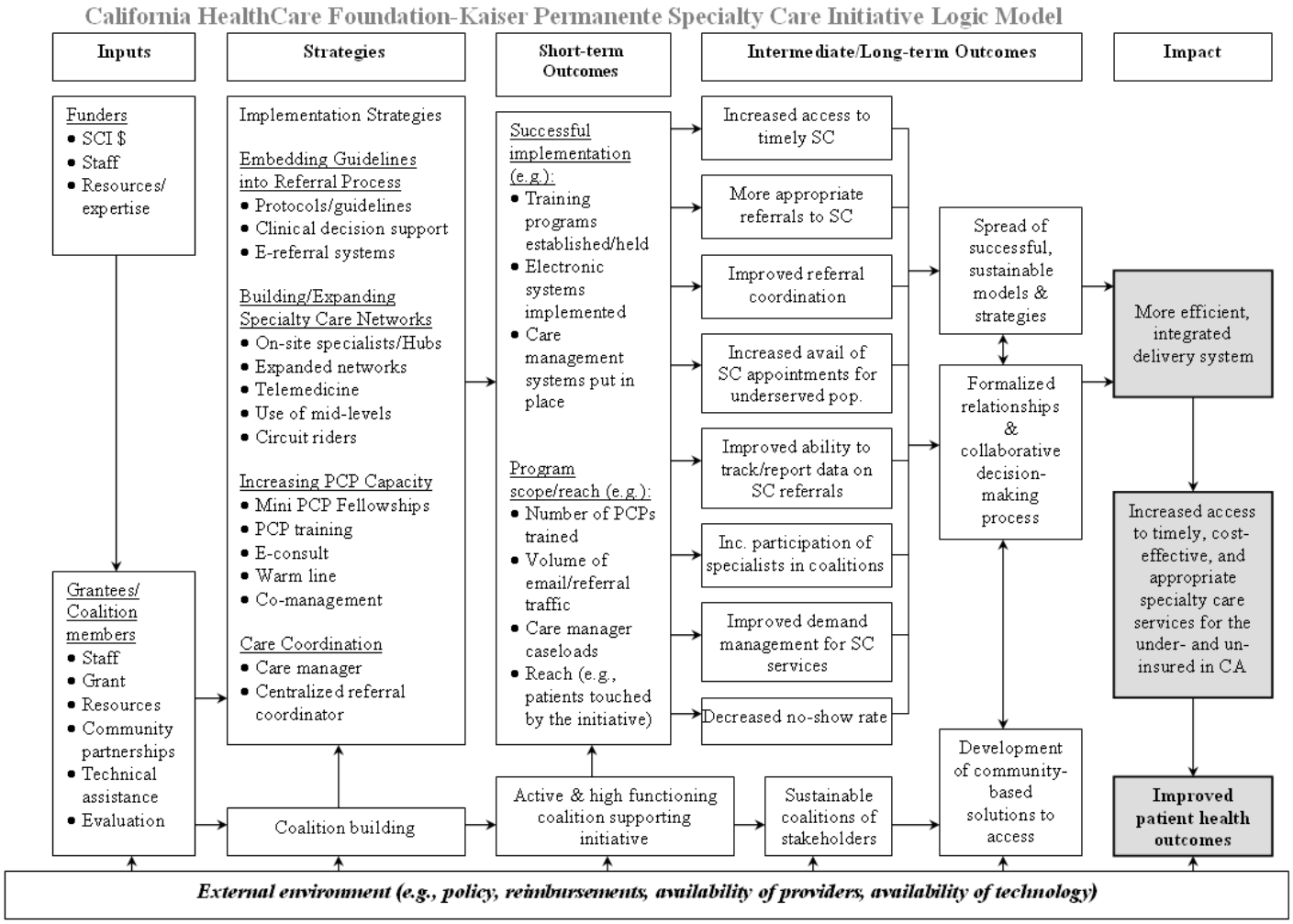
V. Next Steps

Kaiser Permanente has continued interest in supporting their funded coalitions' work around specialty care access and has committed to providing additional resources to selected grantees for the next two years. In early 2011, Kaiser Permanente Northern California Region's Community Benefit Program awarded an additional two years of funding to five coalitions that demonstrated satisfactory progress, have a strong coalition, and have potential for informing future efforts to increase specialty care access. Kaiser Permanente Southern California Region's Community Benefit Program is currently exploring providing additional funding to expand and spread promising practices. This investment is anticipated to include: (1) a small number of one-year individual grants to coalitions to build on existing work; and (2) a larger grant to connect the coalitions in Los Angeles County in an effort to influence county systems and spread innovations demonstrated to be successful in the first phase of SCI.

Many coalitions indicated that for future investments, the funders should consider spreading their investment out over a longer time period. Several of Kaiser Permanente's grantees have requested no-cost extensions to complete the work associated with their grant; this is in large part because often relationship building and systems change takes a long time without requiring many financial resources.

For most of the coalitions, the work they have done in SCI is ongoing—either through additional investments from Kaiser Permanente, securing other funding, or sustainable system improvements that have been implemented. The initiative has generated much momentum, discussion and energy around specialty care access for safety net populations in California. Ongoing evaluation and tracking of these efforts will be important to capture opportunities for learning from and building on SCI efforts in the future.

Attachment A: SCI Logic Model



Attachment B: SCI Evaluation Plan

Evaluation Questions	Measurement Constructs & Indicators	Data Sources
1. How successful is the overall initiative in terms of improving appropriate access to specialty care services through the implementation of innovative strategies/models?		

1a. How successful is the initiative in stimulating the implementation of strategies/models that are new to the targeted community?	• Degree of strategy development (planning)
	• Success of implementation:
	  o Completed action plan—goals and objectives
	  o Scope/reach of the intervention
	  o Grantee perception of success and impact
	• Status of working models
		Grantee & program officer interviews; document review; case studies; coalition survey

1b. To what degree did the implementation of new strategies/models improve access to specialty care services?	• Grantee perception of improved access and/or reduced barriers, may include perceptions of:
	  o Sufficient availability of:
	  ▪ Appointment slots
	  ▪ Specialty care providers
	  ▪ Providers accepting un/underinsured patients
	  ▪ Culturally and linguistically appropriate services
	  o Shared guidelines and communication
	  o Appropriateness of referrals/work-up
	• See strategy-specific measures
		Grantee interviews; document review; case studies; coalition survey; provider survey
		
		Clinical access & usage data *(provided by grantees)*

1c. What has been the funders' contribution to the success of the initiative (other than grants)?	• Funder and grantee satisfaction with and perceived value of technical assistance and support, including:
	  o Community Clinic Voice website
	  o Peer networks
	  o Grantee convenings
	  o Webinars
	  o Reports
	  o other
	• Grantee identification of the impact of technical assistance on individual or coalition capacities/skills
	• Role of Kaiser Permanente (clinical)—internal asset sharing (e.g., guidelines)
		Grantee & program officer interviews; coalition survey

Evaluation Questions	Measurement Constructs & Indicators	Data Sources
2. Which strategies/models implemented through the specialty care initiative appear to be the most successful and have the greatest potential to expand to additional specialty disciplines or health care delivery systems/settings?		
2a. What factors are associated with successful specialty care access programs?	• Most frequently identified commitments and resources required to implement the model: o Shared vision for the project/alignment with organizational strategic plan o Support of executive leadership and medical staff o Characteristics of the "champion" o Resource allocation/Financial investments made (i.e., how was the grant money used and implications for sustainability?) o Decision involvement (involving impacted staff from the beginning) o Expectation setting (articulating short/long-term goals & measurable objectives) o Communication process (e.g., established plan, various methods used) o Staffing/project management (e.g., dedicated role, internal/external, skill set) o Education plan to train impacted staff o Allocation of support resources and expertise o Use of QI processes/PDSA cycles/"interactive evaluation" o Technology (pre-existing and newly implemented) o Organizational partnerships o Community characteristics/setting • Systemic changes (i.e., the degree to which it is embedded into the "way we do business") and implications for sustainability • Strategy-specific factors identified by grantees	Grantee & program officer interviews; document review; focus groups; case studies
2b. Which models of care have faced challenges in implementation and achieving sustainability? Why?	• Most frequently cited explanations of setbacks, challenges, barriers to successful implementation and sustainability (typology) • Strategy-specific measures (see grantee oral progress report protocol) • Environmental changes (e.g., budget issues)	Grantee & program officer interviews; document review; focus groups; case studies
2c. What are the lessons for sustainability and spread to other safety-net health care delivery systems?	• Lessons learned for successful implementation, sustainability and replication	Grantee & program officer interviews; document review; focus groups; case studies
2d. What, if any, is the value-added of engaging cross-organizational coalitions in the development of new SC service models/strategies?	• Capacity built by the coalitions • Perceptions of contribution of the coalition in planning and implementation • Extent to which the coalition accomplished its goals/objectives • Extent to which relationships between segments of the health care delivery system have been formalized • Extent to which a collaborative decision-making has been established within coalition	Grantee & program officer interviews; document review; focus groups; case studies; coalition survey

Evaluation Questions	Measurement Constructs & Indicators	Data Sources
3. How successful has the initiative been in spurring new, stronger and sustainable coalitions of providers and what are the characteristics that lead to successful and sustainable community and regional coalitions?		
3a. What factors are associated with *successful partnerships* and *long-term sustainability of the coalitions*?	• Coalition implementation and development (typology) • Coalition functioning and track record (currently and historically) • Leadership functioning • Degree of member commitment • Breadth of coalition membership/composition of coalition • Decision-making structure (e.g., top-down or bottom-up) • Degree of sustainability of coalition or coalition's work (i.e., is it institutionalized?) • Participation of specialists • Focus of the coalition—was it only working on the specialty care initiative or was their other work? How was work prioritized? Leveraged?	Grantee & program officer interviews; document review; coalition survey
3b. What factors are associated with coalition success/failure in different arenas, such as, new program implementation, advocacy and policy, or ongoing communication and collaboration?	• Commonly identified coalition and environmental factors associated with: o Successful program implementation o Success in informing advocacy and policy change o Ongoing collaboration among coalition members • Factors may include (*examples*): o Coalition indicators (see Q3a) o Resource availability o Demographic change in population o Change in health care environment/health reform o Changes in reimbursement and funding environment o Coalitions' ability to problem-solve and respond to changes in environment	Grantee & program officer interviews; focus groups; case studies
3c. What lessons are there to inform the composition of and activities of coalitions within future initiatives?	• Lessons learned for successful implementation, sustainability and replication	Grantee & program officer interviews; focus groups; case studies

Attachment C.

Embedding Guidelines into the Referral Process: Description of Coalition Work

Coalition	Lead Agency	Description of Work	Targeted Specialties
Access EL Dorado (ACCEL)	El Dorado Department of Public Health	Designed and implemented two countywide care pathways and referral tracking templates that include referral requirements and feedback about inappropriate referrals. Served over 600 patients through the pathways.	Orthopedics Pain Management
LMSS Specialty Care Coalition	Health Alliance of Northern California	Purchased new eReferral system (IRIS). Recruited and trained providers and staff on the system. Worked with specialists to build and embed "rules" for referral to their practice into the system. Over 1750 referrals submitted November 2010 – June 2011.	Various
CHA-IT/IRIS Steering Committee	Humboldt-Del Norte IPA	Purchased new eReferral system (IRIS). Enrolled 553 users in IRIS including 60 PCPs from 16 practices and 72 specialists from 34 practices. Worked with specialists to build "rules" for referral to their practice.	All specialty clinics
Alameda County Specialty Care Task Force	Alameda County Medical Center	Updated ACMC's existing electronic referral system (RefTrack). Reviewed, revised and standardized guidelines with specialists; building them into RefTrack. Updates are short-term solution until EHR implementation occurs; plan to coordinate referral through the EHR.	Gastroenterology Eye clinic Orthopedics Rheumatology
Santa Clara County Specialty Care Access Collaborative	Community Health Partnership	Improved and streamlined the referral process into Valley Medical Center (VMC). Established systems to facilitate and expedite PCP access to their patients' specialty consult notes. Created a secure website to post guidelines and referral information so that all referring providers have access.	Neurology Orthopedics Ophthalmology General surgery
Contra Costa's Specialty Care Stakeholder Committee	Community Clinic Consortium of Contra Costa	Developed a standardized, in-house tracking system for specialty referrals.	Breast Care OB/GYN Gastroenterology
Fresno Access to Care Task Force	Fresno HCAP	Analyzed specialty referral and demand data to identify areas of high telemedicine applicability and high need clinics.	Neurology Gastroenterology Dermatology
Marin Specialty Access Coalition	Marin Community Clinic	Developed an in-house electronic referral system at Marin Community Clinic that coalition members can access. Developed and implemented GI referral guidelines.	Gastroenterology Orthopedic Surgery Neurology

Coalition	Lead Agency	Description of Work	Targeted Specialties
San Francisco Specialty Care Steering Committee	San Francisco General Hospital	Established workgroups for each targeted specialty; each group identified opportunities to create efficiencies in the current eReferral system and process. Included updating guidelines; implementing a colonoscopy class and expanding direct colonoscopy by changing the screening modality; adding a diabetes portal in eReferral that houses both clinical and patient education resources; development of a primary care clinic-based spirometry network; and embedded a rating tool into eReferral to evaluate physicians' experience.	Pulmonary Endocrinology Gastroenterology
San Joaquin County Specialty Care Access Coalition	San Joaquin Health Plan	Strategy delayed due to challenges identifying appropriate candidates for the project coordinator position. Hired a project coordinator in June 2011.	Orthopedics Dermatology
San Mateo Specialty Healthcare Improvement Project (S.S.H.I.P.)	San Mateo Medical Center (SMMC)	Developed a Smart Referral system that integrates with existing EHR. Implementation has been delayed; waiting to roll out after updating EHR. Identified guidelines in the public domain; SMMC specialists adapted for use in San Mateo county. Guidelines will be integrated into the Smart Referral system. Developed specialist and PCP contact sheets to embed into the EHR. Included photo, contact information, overview of guidelines (for specialists), preferred method of contact, and anticipated response time.	All specialty clinics
Yolo County Future of the Safety Net	CommuniCare Health Centers	Convened a referral coordination workgroup to improve the "Fair Share" referral process. Guidelines were reviewed and revised as needed. All referrals for Fair Share participants were reviewed for appropriateness.	Orthopedics Rheumatology Neurology Gastroenterology Endocrinology
Kern Medical Center Specialty Care Coalition	Kern Medical Center	Identified existing guidelines to adapt and standardize; completed guidelines for headaches, seizures, diabetes, orthopedics, and psychiatry. Integrated eReferral system, referral forms and guidelines into the new EMR. Explored ways to provide external clinics access to the system for referrals. Process was informed by a countywide referral workgroup.	All specialty clinics
LAC+USC Camino del Salud Network Specialty Care Access Project	LAC+USC Healthcare Network	Completed 15 guidelines for identified specialty areas; worked with the county to update the county-wide guidelines. Developed a system for the primary care champions, using the guidelines, to get faster access to specialists through bypassing steps in the review process.	Rheumatology Cardiology Ophthalmology/ Optometry Gastroenterology Orthopedics

Coalition	Lead Agency	Description of Work	Targeted Specialties
Long Beach Community Increased Access Specialty Care Coalition	The Children's Clinic	Collaborated with LA County to identify, review and revise guidelines in specialty areas where there are high rates of denials. Developed recommendations for the LA County's Referral Processing System (RPS) to automatically provide consult reports back to the PCP.	Cardiology OB/GYN
San Diego Countywide Specialty Care Initiative Coalition	Council of Community Clinics	Created over 90 guidelines that are posted online so that PCPs and referral coordinators can easily access. Provided training for participating clinics to integrate guidelines and referral tracking into standard workflow.	Dermatology Rheumatology Endocrinology Orthopedics Neurology Gastroenterology Pain management
SPA 3 Specialty Care Planning Coalition	East Valley Community Health Center	Developed a guide for diagnostic colonoscopies that explains program guidelines, eligibility, identifying patients, referral process (only available for under and uninsured patients through this grant); guidelines were adapted from ACS. Participating clinics were trained on the new screening methodology.	Gastroenterology
Ventura County Safety-Net Specialty Care Access Coalition	Health Care Agency of Ventura County	Developed and implemented guidelines in many specialty areas; guidelines were "living documents" and presented as a tool to make more effective referrals rather than a mandate. Developed a new eReferral system for Ventura County, which went live early in 2011. All referrals go to the Referral Center where a nurse reviews to ensure it meets guidelines before approving it. Provided user trainings to all clinics.	All specialty clinics

Attachment D.

Building/Expanding Specialty Care Networks: Description of Coalition Work

Coalition	Lead Agency	Description of Work	Targeted Specialties
ACCEL	El Dorado Department of Public Health	Recruited specialists to participate in care pathways for safety net patients. Implemented two countywide specialty care pathways—an Orthopedic Pathway with Marshall Orthopedics and a Pain Management pathway via telemedicine with the University of California (UC), Davis Pain Management Department.	Orthopedics Pain Management
LMSS Specialty Care Coalition	Health Alliance of Northern California	Purchased new eReferral system (IRIS). Recruited and trained providers and staff on the system. Worked with specialists to build and embed "rules" for referral to their practice into the system.	All specialty clinics
CHA-IT/IRIS Steering Committee	Humboldt-Del Norte IPA	Purchased new eReferral system (IRIS). Enrolled 553 users including 60 PCPs from 16 practices and 72 specialists from 34 practices. Worked with specialists to build "rules" for referral to their practice.	All specialty clincs
Alameda County Specialty Care Task Force	Alameda County Medical Center	Planned to decentralize orthopedics and expand services to Newark clinic. Anticipated to launch in November 2011. Implemented a teledermatology pilot program; contracted with UCSF for specialty review.	Dermatology Orthopedics
Contra Costa's Specialty Care Stakeholder Committee	Community Clinic Consortium of Contra Costa	Recruited volunteer specialists to provide services to the uninsured through outreach to local hospitals and formalizing partnership with Operation Access. Explored recruiting individual specialists through the local medical association.	Breast Care OB/GYN Gastroenterology
Fresno Access to Care Task Force	Fresno HCAP	In year 1, provided specialty data to the local hospital to identify areas of need and inform specialist recruiting efforts. Assessed and “staged” community clinics for telemedicine spread; included technical screening, IT coordination, workflow mapping and sustainability planning. Implemented teledermatology program at one community clinic and worked on expanding it to others. Tracked impact of telemedicine on reducing demand for specialty referrals.	Neurology Gastroenterology Dermatology
Marin Specialty Access Coalition	Marin Community Clinic	Opened up excess capacity of Marin Community Clinic's volunteer network to coalition clinics. Expanded and coordinated efforts to recruit additional volunteers; partnered with Operation Access in this effort.	Gastroenterology Orthopedic Surgery Neurology

Coalition	Lead Agency	Description of Work	Targeted Specialties
San Joaquin County Specialty Care Access Coalition	San Joaquin Health Plan	Expanded access to orthopedics by adding an orthopedic surgeon. Trained an orthopedic physician assistant (PA) to handle basic consults and procedures, but lost that resource due to medical problems. Identified a PCP with a sports medicine background to work in the orthopedic clinic. Added capacity through mid-level providers in cardiology, ENT, and nephrology. Created a dermatology clinic at San Joaquin General Hospital, which is staffed by trained family medicine physicians. Clinic serves approximately 100 patients per month. Established a website for teledermatology consult from UC Davis. Started a diabetic retinopathy store-and-forward telemedicine project.	Orthopedics Dermatology
San Mateo Specialty Healthcare Improvement Project (S.S.H.I.P.)	San Mateo Medical Center	Implemented a teledermatology program with specialty review at UCSF using a web-based program; in use at two primary care clinics and planning expansion to a third. Trained a PA to support the orthopedic clinic.	Dermatology Orthopedics
Solano County Specialty Care Committee	Solano Coalition for Better Health	Developed physician recruitment materials. Built relationships directly with local hospitals and with private specialists through the medical association	Breast Care Cardiology Gastroenterology
Yolo County Future of the Safety Net	CommuniCare Health Centers	Implemented a "Fair Share Model" with four local health systems (Kaiser Permanente, Sutter, Woodland and University of California, Davis); each agreed to take certain referrals from the participating clinics. Services were tracked and assigned a dollar value by the Specialty Care Project Manger to ensure fairness. Received funding from CA Center for Connected Health Policy to implement telemedicine.	Orthopedics Rheumatology Neurology Gastroenterology Endocrinology
AccessOC Coalition	AccessOC	Partnered with Kaiser Permanente to offer surgery days twice per year for uninsured patients below 250% of the federal poverty line.	Gastroenterology ENT Orthopedics General Surgery
San Bernardino Specialty Care Coalition	Latino Health Collaborative	Planned to recruit volunteer specialists to provide specialty care at a centralized Specialty Care Hub.	Cardiology Orthopedics
Coalition of Safety Net Access Providers (C-SNAP)	Valley Care Community Consortium	Implemented a teledermatology program with a specialist in partnership with a private dermatologist champion. Completed 77 scans to date; 80% could be handled appropriately in primary care.	Dermatology
LAC+USC Camino del Salud Network Specialty Care Access Project	LAC+USC Healthcare Network	Expanded availability of diagnostics that will accept referrals directly from a PCP, including: mobile echocardiogram services, gastroenterology equipment, optometry suite, and stress treadmill. Conducted an assessment to identify a potential site for a specialty care hub, identified assets and needs, and support logistics.	Rheumatology Cardiology Ophthalmology/ Optometry Gastroenterology Orthopedics

Coalition	Lead Agency	Description of Work	Targeted Specialties
Long Beach Community Increased Access Specialty Care Coalition	The Children's Clinic	Engaged the cardiology clinic at Harbor-UCLA Medical Center to provide consultation to PCPs and to fast-track urgent referrals; explored expanding to OB/GYN and rheumatology. Recruited a private OB/GYN practice to accept referrals and see patients at the primary care clinics. Recruited a dermatologist into the coalition and exploring possibility for implementing a rotating service to coalition clinics. Partnered with KP South Bay to conduct an annual Surgery Day.	Cardiology OB/GYN Dermatology
San Diego Countywide Specialty Care Initiative Coalition	Council of Community Clinics	Promoted the use of Project Access (a separately funded initiative). Through Project Access, recruited over 585 specialists to provide free care to coalition clinics' patients. Hired a Medical Community Liaison to lead recruitment efforts.	Dermatology Rheumatology Endocrinology Orthopedics Neurology Gastroenterology Pain management
South Los Angeles Collaborative for Specialty Care Access	Southside Coalition of Community Health Centers	Increased hours of podiatrists at two sites and opened up access to other participating clinics; one podiatrist was credentialed to provide surgeries (and pre/post op visits) at the county facility; county provided necessary radiology and labs. Assessed patient experiences with the podiatry services. Implemented telemedicine to provide digital retinal scans (scans were funded through a NIH grant).	Podiatry Ophthalmology
SPA 3 Specialty Care Planning Coalition	East Valley Community Health Center	Implemented teledermatology at six clinics. Supplied equipment to four clinics. Provided training to 1) PCPs on teledermatology consults and biopsy procedures, and 2) care coordinators on program guidelines, workflow and capturing images.	Dermatology
Ventura County Safety-Net Specialty Care Access Coalition	Health Care Agency of Ventura County	Used data from the Referral Center to inform the Health Care Agency's recruiting efforts. Implemented telemedicine for retinal screening; medical assistants were trained to do the scans; four specialists were trained to read the scans by ophthalmologists at UC Berkeley. Established the infrastructure for a teledermatology program.	All specialty clinics
Westside/ South Bay Specialty Care Coalition	Venice Family Clinic	Built on Venice Family Clinic's volunteer network; explored feasibility of opening capacity to other Westside and South Bay clinics. Partnered with KP West LA and KP Harbor City to implement Surgery Days. Worked with Harbor-UCLA Medical Center to increase access to identified specialty areas using a provider champion model.	Ophthalmology Cardiology Rheumatology General Surgery Gastroenterology

Attachment E.

Increasing PCP Capacity/Scope of Practice: Description of Coalition Work

Coalition	Lead Agency	Description of Work	Targeted Specialties
ACCEL (Access El Dorado)	El Dorado Department of Public Health	Provided five countywide CME sessions (both didactic trainings and case conferences) to physicians & other clinical staff; training program included both in-person and distance learning.	Orthopedics Pain Management
LMSS Specialty Care Coalition	Health Alliance of Northern California	Conducted provider needs assessment. Linked providers to free CME opportunities occurring at a local hospital.	Various
Alameda County Specialty Care Task Force	Alameda County Medical Center (ACMC)	Coordinated dinner series with ACMC and community clinics PCPs and ACMC specialists on various specialty topics. Included discussion on updated referral guidelines. Nine events annually with 30-40 PCPs attending. Implemented mini-fellowship program in dermatology, orthopedics, neurology, and rheumatology. Nine PCPs trained to date. Developed urology primer training curriculum. Held neurology case conferences.	Neurology Urology Orthopedics Dermatology Rheumatology Gastroenterology
Santa Clara County Specialty Care Access Collaborative	Community Health Partnership	Held "meet the specialist" luncheons to discuss referral guidelines and process and build relationships between PCPs & specialists. Facilitated the implementation of a call list system (AMION) that identifies on-call/on-duty specialists that PCPs can contact for questions or short phone consults and receive same-day or a response within 48-hours.	Neurology Orthopedics Ophthalmology General surgery
Contra Costa's Specialty Care Stakeholder Committee	Community Clinic Consortium of Contra Costa	Linked consortium PCPs to weekly ground rounds at East Bay Kaiser Permanente. Free training, lunch and CME credits were provided. Tapped into videoconferencing capacity at one clinic so providers can attend remotely.	Various
San Joaquin County Specialty Care Access Coalition	San Joaquin Health Plan	Created curriculum for training PCPs in basic dermatologic procedures; two San Joaquin General Hospital physicians trained.	Orthopedics Dermatology Rheumatology
San Mateo Specialty Healthcare Improvement Project (S.S.H.I.P.)	San Mateo Medical Center	Surveyed PC clinics to determine areas of interest. Held "meet the specialist" sessions to discuss guidelines and Smart Referral system.	All specialty clinics

Coalition	Lead Agency	Description of Work	Targeted Specialties
Yolo County Future of the Safety Net	CommuniCare Health Centers	Used telemedicine program as educational opportunities for PCPs to observe and dialog with the specialist. Explored ways to maximize use of current PCP capacity (e.g., utilizing existing internal expertise in specialty areas).	Orthopedics Rheumatology Neurology Gastroenterology Endocrinology
AccessOC Coalition	AccessOC	Purchased and developed an eConsult system, which enables PCPs to access to guidelines that have been uploaded by specialists and communicate with specialists via secure email. Recruited providers to participate in eConsult.	Neurology
Coalition of Safety Net Access Providers (C-SNAP)	Valley Care Community Consortium	Convened a physician committee to develop the training curriculum. Held case conferences with PCPs and specialists to discuss referral process and guidelines. Often included some practice management guidelines. Completed a neurology chart audit to identify training needs. Completed the approval process to have one doctor credentialed in neurology though a shadowing opportunity.	Neurology Dermatology
Kern Medical Center Specialty Care Coalition	Kern Medical Center	Trained a diabetes champion at one of the clinics. Conducted community round tables, facilitated trainings and discussions on referrals at clinic provider meetings. Coordinated lunch-time lectures on different specialty areas for internal staff and residents; sessions are taped and archived in an online library.	Orthopedics Endocrinology Psychiatry
LAC+USC Camino del Salud Network Specialty Care Access Project	LAC+USC Healthcare Network	Completed mini-fellowships for cardiology, rheumatology and OB/GYN; 15 champions have been trained. Identified and finalized outcomes for all three areas, and had them approved by the LA Department of Health Services to help assess competency of champions. Piloted an eConsult system to support communication between champions and specialists. Held monthly community grand rounds; the grand rounds were either a CME session with Q&A or a facilitated dialogue between PCPs and specialists.	Rheumatology Cardiology Ophthalmology Optometry Gastroenterology Orthopedics

Coalition	Lead Agency	Description of Work	Targeted Specialties
Long Beach Community Increased Access Specialty Care Coalition	The Children's Clinic	Partnered with Harbor-UCLA's cardiology clinic to implement a cardiology champion program; have cardiology champions in each of the participating PC clinics. Recruited a private sector cardiologist to provide additional support to champions. Explored expanding model to OB/GYN and rheumatology. Consulted dermatology specialist on potential roles for PCPs related to dermatology. Conducted community grand rounds, CME lectures, and case conferences on identified specialty topics.	Cardiology OB/GYN Dermatology
San Diego Countywide Specialty Care Initiative Coalition	Council of Community Clinics (CCC)	Partnered with the Medical Society Foundation to provide diverse training offerings to PCPs, including round tables, lectures, webinars, and procedural trainings. CCC conducted an annual survey of PCPs training interests, which informed offerings. Launched an eConsult system to allow PCPs to ask volunteer specialists questions about patient care in a timely, HIPAA-compliant manner.	Dermatology Rheumatology Endocrinology Orthopedics Neurology Gastroenterology Pain management
South LA Collaborative for Specialty Care Access	Southside Coalition of Community Health Centers	Held luncheons on podiatry issues that were identified as areas of interest.	Podiatry Ophthalmology
Ventura County Safety-Net Specialty Care Access Coalition	Health Care Agency of Ventura County	Provided shadowing opportunities to interested PCPs in rheumatology, dermatology, podiatry and gastroenterology (for colonoscopies). Coordinated mini-lectures on specialty areas of interest.	Rheumatology Dermatology Gastroenterology
Westside/ South Bay Specialty Care Coalition	Venice Family Clinic	Identified cardiology and rheumatology PCP champions at each clinic; these providers had access to consultation from specialists at Harbor-UCLA. Quarterly calls held with cardiologist and provider champions to discuss lessons learned. Explored spreading this model to OB-GYN.	Cardiology Rheumatology

Attachment F.

Integrating Care Coordination: Description of Coalition Work

Coalition	Lead Agency	Description of Work	Targeted Specialties
Access El Dorado (ACCEL)	El Dorado Department of Public Health	Integrated referral and care coordination activities into their specialty care pathways.	Orthopedics Pain Management
Contra Costa's Specialty Care Stakeholder Committee	Community Clinic Consortium of Contra Costa	Convened community clinic referral coordinators to facilitate peer learning and sharing of best practices. Developed a provider database to aid referral coordinators in linking patients to specialty care.	Various
Marin Specialty Access Coalition	Marin Community Clinic	Planned to hire a bilingual care coordinator, but encountered challenges identifying an appropriate candidate. Used volunteer specialists to review and triage referrals.	Gastroenterology Orthopedic Surgery Neurology
San Mateo Specialty Healthcare Improvement Project (S.S.H.I.P.)	San Mateo Medical Center	Care coordination is a part of SMMC's specialty care redesign effort with Coleman Associates. Redesign process had six strategies: 1) Quick start (all staff showing up on time); 2) Clinic prep (getting ready for the next day--e.g., reviewing charts); 3) pre-registration (calling patients to remind them of appointment, tell them what to bring, and confirm pt. contact info); central registration in the lobby (which includes close proximity to the Community Health Advocates to connect patients with other resources; 5) implementing guidelines; 6) rational scheduling determined by specialists. Implemented a centralized call center.	All specialty clinics
Solano County Specialty Care Committee	Solano Coalition for Better Health	Created referral coordinator collaboratives to share lessons and information about available resources; coordinators track referrals and serve as patient navigators.	Breast Care Cardiology Gastroenterology
Yolo County Future of the Safety Net	CommuniCare Health Centers	All referrals for “Fair Share” patients went through a central case manager; case manager tracked the referral and worked with patients one-on-one to make sure they have what they need to complete the appointments (e.g., transportation, interpretation services). Case management for new and follow up appointments. Also assisted with patients transition back to primary care.	Orthopedics Rheumatology Neurology Gastroenterology Endocrinology
San Bernardino Specialty Care Coalition	Latino Health Collaborative	Exploring use of community health workers to provide training, outreach and information to Spanish-speaking patients about how to navigate the health care system	Cardiology Orthopedics
Coalition of Safety Net Access Providers (C-SNAP)	Valley Care Community Consortium	Implemented 4PatientCare, an automated patient reminder system at Olive View in five specialty clinics with high no-show rates. Exploring possibilities for spread within LA County.	Neurology Cardiology

Coalition	Lead Agency	Description of Work	Targeted Specialties
San Diego Countywide Specialty Care Initiative Coalition	Council of Community Clinics	Coordinated referral managers to share best practices on tracking referrals. Created a script for patient reminder calls, to reduce no-shows at specialist visits.	Dermatology Rheumatology Endocrinology Orthopedics Neurology Gastroenterology Pain management
South Los Angeles Collaborative for Specialty Care Access	Southside Coalition of Community Health Centers	Hired patient navigator to work at MLK; navigator is able to fast track urgent referrals and get patients into open slots with a retinal specialist.	Podiatry Ophthalmology
SPA 3 Specialty Care Planning Coalition	East Valley Community Health Center	Care coordinators were hired at each clinic; role is to ensure patient education is provided, track program data, provide patient with follow-up care provider options, and coordinate follow-up care for patients referred for diagnostic colonoscopy.	Gastroenterology
Westside/ South Bay Specialty Care Coalition	Venice Family Clinic	Specialty Care Coordinators for surgery day helped to identify patients, make sure patients had what they need for the surgery and ensured that they show up for surgery day; for the volunteer model, referral coordinators tracked referrals and ensured that patients are able to make it to their appointments.	General Surgery Cardiology Rheumatology Ophthalmology

Attachment G.

Coalition Survey Results

1) Coalition Engagement – Member Attendance

Number of coalition meetings attended in last 6 months	Number (2009)	Percent (2009)	Number (2011)	Percent (2011)
All of the meetings	**97**	42%	**29**	13%
More than half of the meetings	**98**	42%	**38**	17%
Less than half of the meetings	**28**	12%	**73**	33%
None of the meetings	**9**	4%	**83**	37%
Total Responses	**232**	100%	**223**	100%

2) Coalition Functioning Domains

This section highlights the average scores for each item related to the coalition functioning domains discussed in the narrative. The scale was 0-4, with 4 being "strongly agree."

Shared Vision and Planning	Average Scores	
	2009	2011
a) There is general agreement with respect to the priorities of the coalition.	**3.5**	**3.4**
b) Coalition members balance their own interests with the shared interests of the coalition.	**3.3**	**3.3**
c) There is general agreement on what work should be done and who should do it.	**3.3**	**3.2**
d) The grant budget and work plan have been shared with coalition members.	**3.4**	**3.3**
Average	**3.4**	**3.3**

Community Participation	Average Scores	
	2009	2011
a) The coalition has diverse perspectives represented.	3.4	3.4
b) Coalition membership includes the "right" people from the community.	3.3	3.2
c) The coalition has adequate involvement of specialists.	2.8	2.8
d) Coalition members share responsibility and workload.	3.0	3.0
e) The coalition meets regularly enough to facilitate collegial relationships among members.	3.3	3.2
Average	3.2	3.1

Decision Making	Average Scores	
	2009	2011
a) The coalition has clear and explicit procedures for making important decisions.	3.2	3.1
b) Ideas of all members are heard and respected before making decisions.	3.4	3.4
c) The decision-making process used by the coalition is transparent and fair.	3.3	3.3
d) There is sufficient partipication in coalition meetings to make effective decisions.	3.2	3.2
e) The coalition is able to effectively resolve conflict in order to reach decisions.	3.3	3.3
f) Resources and funding are allocated fairly among coalition members.	3.2	3.2
Average	3.3	3.2

Sense of Community	Average Scores	
	2009	2011
a) I can talk openly and honestly at the coalition meetings.	3.5	3.5
b) Coalition members freely share information, knowledge, expertise, resources, and connections.	3.5	3.5
c) Coalition members respect each others' points of view even if they might disagree.	3.5	3.5
Average	3.5	3.5

Leadership	Average Scores	
	2009	2011
a) Leadership roles and responsibilities are clearly articulated.	3.3	3.2
b) The coalition's leadership works collaboratively with coalition members.	3.4	3.3
c) The coalition's leadership is effective in moving the work forward and getting things done.	3.3	3.2
d) Coalition members have the opportunity to take leadership roles.	3.3	3.3
e) The leadership recognizes and uses the abilities and skills of coalition members.	3.3	3.2
f) The coalition's leadership effectively communicates to the coalition members about upcoming events and activities.	3.3	3.3
Average	3.3	3.3

Sustainability	Average Scores	
	2009	2011
a) The coalition has been successful in getting community support for its activities.	-	3.0
b) The coalition has been successful in obtaining resources to support its work (grants, donations, in-kind support, etc.).	-	3.1
c) The changes in the community brought about by the coalition will continue beyond the period of the Specialty Care Initiative.	3.5	3.3
d) The coalition will continue to work together beyond the Specialty Care Initiative grant period.	3.5	3.3
e) The coalition has begun planning for how to address additional priority issues.	-	3.2
Average	3.5	3.2