Sharing Specialty Services: A Business Guide and Toolkit for Community Clinics

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Prepared by
Bobbie Wunsch, M.B.A.
Catherine Teare, M.P.P.
and Patricia Aguilera, M.B.A.

for
California HealthCare Foundation

About the Authors

Pacific Health Consulting Group has advised numerous safety-net provider and public managed care organizations throughout California on matters such as product development, financial planning, feasibility studies, governance and strategic planning, restructuring and mergers, and meeting facilitation.
Bobbie Wunsch, M.B.A., is a founder and partner of Pacific Health Consulting Group, www.pachealth.org. Catherine Teare, M.P.P., does research, writing, advocacy, and consulting in the fields of health and youth policy. Patricia Aguilera, M.B.A., is an expert on financing for community health centers.

About the Foundation

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Introduction

This business guide is designed to assist community clinics and health centers (CCHCs) and clinic consortia as they consider developing networks to share specialty services. Although each clinic's circumstances are unique, all face a common set of questions in preparing for success in this new strategy.

This guide walks the reader through the relevant planning questions and assists in evaluating and implementing each step. At the guide's core is a series of examples, worksheets, checklists, and sample documents that provide practical information to support the planning process. It is designed to be of use both to CCHCs and consortia considering these issues for the first time, as well as to more experienced organizations seeking to refine their approaches. The guide is designed for use by California CCHCs in particular, though clinics and networks in other settings and other states will find the tools helpful.

Specialty Care Access Problems

Access to specialty services has long been a serious problem for patients of California's nonprofit CCHCs. According to a 2004 report, 85 percent of medical directors of California federally qualified health centers said that their patients "often" or "almost always" had trouble accessing specialty care – and that these problems were increasing.[1] A survey conducted by Pacific Health Consulting Group in 2007 found that in about two-thirds of cases, CCHC patients typically waited between one and three months to see outside specialists.[2] Respondents also estimated that approximately one-third of their primary care providers (PCPs) frequently limited referrals to high-need specialty services, such as neurology, orthopedics and dermatology, because of perceived access difficulties.

One reason for access problems is that diminishing numbers of private providers accept Medi-Cal. Another reason is that medical costs are increasing, while reimbursements are stagnant. Further, there is a greater need for care among the uninsured. In addition, over the last 20 years, many county public hospitals have closed, further limiting access to specialty care for safety-net patients.

Specialty Care Provided by CCHCs

In response to access problems, CCHCs have slowly increased their specialty services to meet the growing needs of their patients. A number have developed productive ongoing relationships with local private specialists who are willing to see patients at the clinic sites on either a paid or volunteer basis. In some cases, CCHCs have made these specialty services available to patients from other clinics, or have made arrangements with other clinics to share specialists' time.

According to the 2007 Specialty Care Access Survey mentioned above, 61 percent of responding CCHCs provided some specialty services onsite, and more than a third of those

offered three or more specialties. Few of the CCHCs that provided onsite specialty care did so with special funding (16 percent), indicating that most had absorbed these services into their annual operating budgets. The provision of onsite specialty care services did appear to improve patients' access to these services. CCHCs reported that their providers were more frequently able to expedite care for patients with urgent need and receive consultation reports back when patients were treated onsite than when patients were referred out for specialty care.

Variety in Shared Specialty Approaches

In some communities, it may be prohibitive for a single clinic to provide all its own specialty services, due to limited availability of local specialists; insufficient demand; or constraints of funding, space, staffing, or expertise. Therefore, a number of CCHCs have created networks of specialty services in which clinics share the resources of specialist providers.

There is no single model for providing specialty services through a shared network. In California, there are a number of examples in which one health center has begun to provide certain specialty services and then offered those services to sister clinics located close by. Such an approach responds to community needs while achieving sufficient economies of scale to fill the schedules of specialists who come onsite. Often, larger clinics develop contractual arrangements with individual specialists who see patients at the clinic site, and clinics in the surrounding geographic area refer patients needing that specialty service to the larger clinic. This configuration has come to be called the "hub" model.

In other areas, clinics share a single specialist who practices at multiple clinic organizations in a "circuit rider" arrangement. A third model calls for clinics to pool resources to employ a referral coordinator who arranges specialty care for patients of all the collaborating clinics. Patients are sent to specialist physicians who work in the community and/or to specialists working within the participating clinics, based on referral protocols and guidelines managed by a centralized referral coordinator.

Using This Guide – Tools in the Toolkit

This guide is designed to assist community clinics with the decisions and analyses necessary to build a strong and solvent shared specialty network. It also provides planning tools such as checklists, sample documents, and interactive financing worksheets. CCHCs just beginning to consider adding or sharing specialty services may choose to focus on the narrative sections of this guide, while those farther along in the process may find the interactive financial forecasting tools useful. Although the guide is geared toward CCHCs planning a shared network, many of the tools are also useful for clinics desiring to provide specialty services on their own. The steps in the process and explanations of associated tools are linked on the 'bookmarks' tab of this document. Attached tools are linked on the 'attachments' tab.

- **I. Planning**
  - **Tool 1 Resource: 2007 Specialty Care Access Survey Template** [pdf]
- **II. Financing**
  - **Tool 2a: Financial Feasibility Workbook Instructions** [pdf]
  - **Tool 2b: Financial Feasibility Workbook Example** [xls]
  - **Tool 2c: Financial Feasibility Workbook Blank** [xls]
- **III. Staffing**
  - **Tool 3 Checklist: Recruiting Specialist Physicians**
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  - **Tool 5 Checklist: Working with Volunteer Physicians**
- **IV. Patient Support and Ancillary Services**
  - **Tool 6 Checklist: Creating Scheduling Policies**
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- **V. Inter-clinic Referrals**
  - **Tool 8 Resource: Referral Procedures from Southside Podiatry** [pdf]
  - **Tool 9 Resource: Referral Guidelines from Shasta Ambulatory Care** [pdf]
  - **Tool 10 Resource: Referral Guidelines from Southside Podiatry** [pdf]
- **VI. Legal and Regulatory Considerations**
  - **Tool 11 Checklist: Scope of Project Modifications**
- **VII. Billing Medi-Cal, Medicare, or Other Insurance**
- **VIII. Technology Tools**
- **IX. Evaluation**
  - **Tool 12 Checklist: Evaluating Specialty Services**

In addition, the Appendix includes a list of discussion papers and technical assistance briefs produced by Kaiser Permanente Northern and Southern California Community Benefit Programs and the California HealthCare Foundation relevant to specialty care in CCHCs.

The guide is based on information from a wide variety of sources, including a literature search, a review of initiatives to expand access to specialty care in California, and extensive interviews with eight California community clinics that employ shared specialty models. The clinics interviewed include:

AltaMed Health Services Corporation (Los Angeles and Orange Counties)

Castle Family Health Center (Merced County)

Marin Community Clinics (Marin County)

Open Door Community Health Centers, Telehealth and Visiting Specialist Center (Humboldt County)

Sacramento Physicians' Initiative to Reach out, Innovate and Teach (SPIRIT) Project (Sacramento County)

Share Our Selves (SOS) Free Medical Clinic (Orange County)

Shasta Community Health Center (Shasta County)

Southside Coalition of Community Health Centers (Los Angeles County).

I. Planning

Tool 1 Resource: 2007 Specialty Care Access Survey Template [pdf]

Before detailed planning and analysis can begin, a clinic or consortium contemplating a shared specialty services network must first address four questions. These questions may best be answered in consultation with a variety of clinic staff and providers; the answers will be specific to each community:

- What are our patients' specialty care needs?
- Does sharing specialty care make sense for us?
- Which specialists are available to provide care?
- What model of shared specialty care will be most successful?

What Are Our Patients' Specialty Care Needs?

Any efforts to improve specialty care access must be based on a specific, local determination of gaps and barriers. The 2007 Specialty Care Access Survey found that, while certain types of care led the list of access problems, there was variation across the state.

- Orthopedics, gastroenterology, neurology, and dermatology were among the specialty services perceived by respondents as being the most difficult to access.
- In the North Coast and far northern region of California, dermatology was more likely to be perceived as difficult to access than was gastroenterology; in the Central Valley, dermatology was second only to orthopedic surgery in perceived difficulty of access.
- Cardiology, high-risk obstetrics, and ophthalmology were ***easiest*** for patients to access.
- About one-third of respondents reported that their primary care providers ***frequently*** limit referrals to high-need specialty services because of perceived access difficulties.
- Primary care providers at CCHCs could access specialists for consultation on fewer than half of the occasions that they needed such assistance.

How can a clinic determine its population's areas of greatest need? In many cases, clinics have used anecdotal information or the perceptions of clinical staff to make this determination. With relatively little effort, however, a clinic can conduct a robust and reliable local survey. Depending on available resources, efforts to determine the most-needed types of care could include an in-house survey of providers, a review of referrals made to outside providers, or a community-wide survey that includes multiple CCHCs.

Efforts to improve access to specialty care need not always be focused on the most acute shortages. Some specialties that are in high demand may be too difficult to provide in a clinic setting, due to a lack of willing providers in the community or other constraints. Equipment costs or space limitations might similarly put a specialty service out of reach of a CCHC, with cognitive or office-based specialties proving a more logical choice in these circumstances. Even if they do not address the areas of most acute need, specialty services that are feasible and easy to implement may still improve access and quality, with limited added cost to the clinics. For example, when AltaMed Health Services Corporation, an FQHC with 17 locations, was considering expansion into specialty services, they compiled information from a number of sources: a survey of its members by the local clinic consortium, as well as interviews with AltaMed primary care providers, with the local Medi-Cal managed care plans, and with local hospitals. The research identified services that were lacking within the CCHC system and in the community at large. AltaMed's first goal was to create capacity for the uninsured, by focusing on high-volume, low-cost specialty care:

dermatology, ophthalmology (important in AltaMed's comprehensive diabetes program), and podiatry. These services have been added in Los Angeles and are starting up in Orange County.

Another option for gathering information might be a series of focus group discussions with clinic providers and with community specialists. The template from the 2007 Specialty Care Access Survey is also available as a tool.

Resource for Identifying Patients' Needs

Tool 1 Resource: 2007 Specialty Care Access Survey Template [pdf] can be adapted for the needs of specific communities.

Identifying Patients' Needs: Marin Community Clinics

Marin Community Clinics' early efforts at identifying areas of need were largely anecdotal: "Docs would say, 'We can't get enough GI appointments' and we'd go from there." Most recently, the clinic has made a systematic effort to count all the specialty referrals in order to determine which services are in greatest demand. Even this system is less than perfectly accurate, however, because of suppressed demand for services that are unavailable – primary care providers (PCPs) typically don't refer for services such as pain management and addiction medicine, because they know the patients will not get in. Marin Community Clinics asked its PCPs to refer, for one month, to services that they *know* aren't available, such as orthopedics and radiology, in order to improve the accuracy of their needs assessment.

Does Sharing Specialty Care Make Sense for Us?

Clinics' history of collaboration, the relative strengths of potential collaborators, and the relationships among staff should all be factors in deciding whether to share specialty services. For a group of clinics that have populations with similar health and access needs, a shared specialty network may be cost effective and logical. However, for clinics operating in very different environments, with distinct populations and access levels – or clinics that simply have never worked together – such a collaboration may be very challenging.

Key questions to consider:

- Does our clinic have sufficient demand to use all the specialist's capacity? Or, will it be necessary to add patients from other clinics in order to use a specialist's time efficiently?
- What is our clinic's role in the region? Is the clinic large, and already providing services to sister agencies? Is it geographically well-located within a clinic consortium or group of clinics in a region? Does it have especially good relationships in the private medical community or the local public hospital? In these cases, it may be a natural progression to establish a specialty practice and offer specialty services to others. In other situations, it may make sense for clinics to come together in order to achieve economies of scale.
- Have we collaborated successfully with other clinics before? If so, a shared model of specialty care may be easier to develop. Otherwise, a shared specialty model may be more challenging.
- How much responsibility for the project does our clinic want to take on? In some shared networks, the providing clinic takes on all costs, provides and bills for all services, then returns consultation reports to the referring primary care provider. In other networks, some administrative costs are distributed across the referring clinics – as when, for example, participating clinics contribute jointly to the salary of a referral coordinator.

Which Specialists Are Available to Provide Care?

In reality, the availability of specialists willing to provide their services is as likely to drive the services offered as is any needs assessment. Provider availability varies tremendously from community to community, as does the culture of cooperation between CCHCs, hospitals, and private specialists. In some areas, providing services pro bono to uninsured patients is part of the culture of a hospital and a clear expectation of community physicians. In other areas, there may be an overall shortage of at least some specialist providers, regardless of patients' insurance status, resulting in fewer volunteers.

Questions of specialist recruitment and pay are discussed in greater detail in Section III, Staffing. In almost all cases clinics must be persistent and creative in order to find specialists. The 2007 Specialty Care Access Survey findings emphasized that access to specialists greatly depends on personal connections. In almost every instance, CCHCs' successes in finding and retaining specialists also depend on how active and visible the clinics are in the larger community.

What Model of Shared Specialty Care Would Be Most Successful?

Typically, shared specialty models develop over time, as patient populations, clinics, and available resources grow and change.

While each shared specialty arrangement is unique, there are several evolving models of shared specialty services, with significant potential overlap between them. The list that follows is not comprehensive, and should not discourage CCHCs from considering other arrangements for sharing services that may make more sense in their particular communities.

Hub Model

In a hub model, one clinic provides specialty care and makes it available to patients from other clinics in the area. In California, this model has been used with varying degrees of success by a number of clinics: Open Door Community Health Centers and Shasta Community Health Center are two. The size, scope, and range of the hub model can vary significantly. In some cases, clinics may provide some services only to their own patients, using one site to draw in patients from other sites, while other hubs offer services not only to patients of other clinic organizations but even to patients of private primary care providers.

The hub model is most frequently used where one clinic in a region is larger or more experienced with specialty care than others, and already plays a lead role. Establishment of a hub model typically entails the most risk for the providing clinic of any of the models, as it extends services to additional uninsured patients. It can also be very successful, in effect opening a new line of business and attracting additional patients. The hub model also requires the greatest level of collaboration and cooperation among clinics, who refer and consult about patients jointly. The hub model may be easiest on the specialty providers, who need to learn only one system and go to only one location in order to participate.

Circuit Rider Model

In a circuit rider model, two or more clinics share specialty providers who travel between the sites, providing care to patients at their home clinics. This model works well where the specialty in question does not require significant equipment, and where there is ongoing collaboration and good communication between clinics and specialists. It requires careful design of contracts, mutual understanding of scheduling and other constraints by the

specialist and the clinics, and clear lines of communication and supervision at each site. It also requires that a specialist be willing to travel from one site to another and to work with a variety of clinic systems and administrative approaches.

Referral Model

When several clinics use the same referral coordinator, referrals to volunteer specialists are more easily and effectively coordinated. The referral model can be cost-effective, and may minimize risk for any individual clinics, but it also arguably requires commitment from a greater number of individuals and institutions to succeed, particularly to the extent that it relies on volunteer providers.

In California, SPIRIT in Sacramento County and SOS Clinic in Orange County are two examples of referral models.

Established in 1995 with a Robert Wood Johnson Foundation grant to increase physician response to county patients, the Sacramento Physicians' Initiative to Reach Out, Innovate and Teach (SPIRIT) has developed a robust model for providing specialty services through referral to a volunteer network of providers. A collaborative effort of a wide variety of contributing partner organizations, including hospitals, medical groups, community clinics, and the medical society, SPIRIT places primary care volunteers in county and community clinics, operates a central referral system that sends patients to specialists who work in clinics and in their local offices, and refers to volunteer surgery teams for hernia and cataract surgery. SPIRIT is staffed by a program coordinator and a part-time case manager.

Share Our Selves (SOS) Clinic uses a pure referral model, centered around Orange County's Hoag Hospital. Last year SOS connected 8,000 Orange County patients in need of specialty care to 107 specialists who have privileges at Hoag Hospital and who see these patients pro bono in their offices. According to SOS, "When you're a physician granted privileges at Hoag, it's pretty much expected that you'll participate in SOS programs." The program works well, according to SOS staff, because specialists feel they don't need to practice differently – they know they can get the tests and medications, and if SOS can't provide something, such as outpatient chemotherapy, for example, the hospital will. "They don't want to provide a different level of care." The hospital's commitment to volunteer care proceeds from the top down, including the hospital's board of directors, chief hospital administration, and provider members. SOS staff emphasize that the model requires a focus on eliminating waste and striving for a lean service model. "The ultimate goal of efficient, effective, high quality, cost appropriate services must be the focus of all staff."

Combination of Approaches

Most shared specialty arrangements include a combination of approaches, and evolve over time. Southside Coalition of Community Health Centers in Los Angeles offers an example of a clinic coalition that has taken a deliberate approach to developing shared specialty care, using several different approaches to meet their patients' needs.

A Collaborative Model:
Southside Coalition of Community Health Centers

The Southside Coalition of Community Health Centers is a network of seven community clinics that joined together in 2004 to increase access to care in the south Los Angeles area. Southside Coalition's member clinics have defined a mission, vision, and purpose, and formally signed a memorandum of understanding to work collectively. Access to specialty care was among the first issues addressed by the coalition, with business planning about how to jointly provide specialty services a priority. Their first effort was a joint podiatry specialty clinic, since access for uninsured patients in particular was so poor in the area. The podiatrist provides in-service trainings to the clinic's primary care physicians in order to extend their ability to care for patients at the clinics; this has also improved the referrals made to podiatry. Southside has implemented teledermatology as its second specialty area. Clinics share digital retinal screening equipment for diabetic patients, and also share a specialty care referral coordinator.

II. Financing

Tool 2a: Financial Feasibility Workbook Instructions [doc]

Tool 2b: Financial Feasibility Workbook Example [xls]

Tool 2c: Financial Feasibility Workbook Blank [xls]

With the planning questions answered, the next step is to create a financial model to estimate the overall viability of the proposed services. The Health Resources and Services Administration (HRSA) requires clinics to break even on specialty care services; break-even must also be proven in an application to expand an FQHC's Scope of Project. Since so many factors affect the financial viability of specialty services, financial estimates must be highly specific to the particular case and also quite detailed. Fortunately, such an analysis can be made without expert opinion and without great difficulty.

Tool 2b: Financial Feasibility Workbook Example [xls], and
Tool 2c: Financial Feasibility Workbook Blank [xls], are two instances of the same interactive tool. The **Example** is filled out with sample information, and the **Blank** is ready for the clinic to fill out with its own information.

This tool can help clinics develop specifics on the financial feasibility of their chosen models for specialty care. It can be used by clinics adding specialty services on their own, as well as by those planning shared specialty models.

To use the workbook, a clinic must be able to identify the following key parts of the model it proposes:

- The services to be offered;
- The providers to be used; and
- The clinics that will be partners in the shared specialty model.

The workbook is composed of four linked worksheets that call for specific information – or good estimates – on several topics. They allow for easy changes in value assumptions in order to compare various scenarios; for example, to obtain best, worst, and expected outcomes for the specialty services under consideration.

The final calculation of the workbook will be a working financial model of the proposed project. Instructions for each worksheet are in
Tool 2a: Financial Feasibility Workbook Instructions [pdf].

Forecasting Feasibility: Open Door Community Health Centers

According to Open Door Community Health Centers in Humboldt County, which runs a telehealth and specialist clinic, "The biggest challenge is uncertainty." Open Door tries to forecast the financial implications of their specialty care by looking in particular at the number of providers: "Anticipation of the revenue stream and the resources needed are all provider-driven – we run it by how many providers we have." Even with clear expectations about the number of in-house staff and the hours for regularly participating specialists, forecasting revenues and expenses remains challenging.

Open Door cautions other clinics to be careful with their rate-setting year. Typically, specialty care services grow slowly, meaning there are high costs and few patients in the first year, but "you have to be careful with that rate-setting year." If, for example, a clinic bases its rates on its intention to hire a psychiatrist, but then cannot find one, it can run into trouble.

Worksheet I: Market Demand and Clinic Capacity

Determining financial viability of a proposed specialty care model requires, first, that clinics assess market demand (the number of visits that the population could potentially generate for the specialty area) and clinic capacity (the number of visits that the specialist or specialists could provide). This analysis is an essential first step.

For clinics without a history of providing specialty services, estimating market demand and clinic capacity will typically require data from outside sources. Utilization per specialty, for example, may be available from local independent practice associations (IPAs) or HMOs; failing that, commercial sources can provide this information. Similarly, figures for hourly patient capacity for specialists may be available from the specialists themselves, assuming that they have been identified, or may be obtained from the specialty literature. (Worksheet I also requires data on specialists' hourly reimbursements, although these figures are not used in the demand and capacity calculations.)

These two figures – market demand and clinic capacity, which can also be thought of as potential maximum and minimum numbers of visits – give a range of possibilities for the specialty services and specialist providers under consideration. At this preliminary stage, the goal is that market demand *exceed* clinic capacity, since financial success relies on being able to fill all available specialty visit slots. In some cases, maintaining sufficient demand may require a concerted marketing strategy both inside and outside the clinic network. For example, Open Door Community Health Centers have discovered that they need to market their specialty services actively in order to bring in new patients – even within their own clinics. They introduce new specialists to primary care staff by email and in person, including inviting the specialist to lunchtime staff meetings at all the clinics in the organization.

Worksheet II: Patient Mix and Revenue

With estimates of market demand and clinic capacity in hand, the second step in the financial analysis is to predict revenue from the specialty services. This requires information about the likely patient mix and patients' insurance status, and about reimbursement from each insurance source. Predicting revenue requires first determining the payer mix for each type of service – this can be more complex where multiple clinics are involved – and then using that information along with information on reimbursement to predict total revenue.

While Worksheet II itself is straightforward, settling on figures for each clinic's payer mix and on average reimbursement rates can be more complicated. The following questions require particular attention:

- Will the payer mix in your specialty services be substantially different from that in your primary care services? The payer mix may change as a result of the

provision of specialty services themselves, and it is important to project the payer mix for each individual specialty service, rather than assume that the mix will remain constant.

For example, a clinic that typically has 20 percent uninsured in its primary care business is planning to add cardiology services. The clinic's Medi-Cal patients may already have access to cardiologists in the community and may choose to stay with them, meaning a likely shift in the payer mix to 50 percent uninsured patients in cardiology.

Similarly, the patient mix may vary significantly by specialty type. The clinic might expect a 50 percent Medi-Cal mix for cardiology but only a 30 percent Medi-Cal mix for dermatology.

- How will a shared model affect the patient mix? Where a shared specialty model with patients from multiple clinics is planned, projecting the payer mix can be even more complicated. In order to get the most precise estimate of this mix, use specific projected patient counts from each clinic.

  For example, the providing (hub) clinic might expect to send 50 Medi-Cal and 80 uninsured patients to the cardiologist annually, while accepting 20 Medi-Cal and 10 uninsured patients from a referring clinic. These projected numbers should be combined to get a single payer mix for each service.

- Will the average reimbursement rates from Medi-Cal change? As Medi-Cal and uninsured patients are likely to make up the largest percentages of most clinics' payer mixes, the reimbursement figures for each of these sources should be as precise as possible. The worksheet can be used to project the impact of an increase in an average reimbursement rate such as the PPS rate for Medi-Cal.

  For example, if a clinic were to obtain a Scope of Project change that would provide an additional $1.00 per visit for the Medi-Cal population, the results can be forecast using this tool.

- Will the average reimbursement rates from managed care organizations change? If a clinic is in a capitated contract with a payer for primary care services, specialty services should be negotiated outside of the capitation as an additional fee-for-service rate. The average reimbursement rate may change as a result.

  For example, if a clinic is capitated for the commercial Anthem Blue Cross primary care visits and is now planning to provide cardiology services, it would not use the current average reimbursement rate per visit from Anthem Blue Cross in completing this step, but rather a specific cardiology rate. This rate would be negotiated with the IPA (or directly with the HMO if there is no IPA).

Often, such a fee schedule is based on Medicare and a percentage of Medicare rates; for instance, 120 percent of Medicare for cardiology services.

Worksheet III: Expenses

The third step in the financial modeling process involves estimating the additional expenses incurred by the addition of specialty services. Using estimates of expenses for staffing, ancillary services, and facilities, the third worksheet provides an estimated cost per visit, per specialty.

Most of the expenses will relate to staffing – paying the specialist, of course, as well as paying additional staff to support the specialty services. (Even if the specialist volunteers his/her time, as is sometimes the case, support staff likely will not.) The worksheet prompts for staffing costs in the most commonly needed support staff categories: medical assistant, billing staff, receptionist, and referral coordinator; but every clinic's staffing pattern is different. A shared specialty network may require a new nursing position, for example.

If a clinic has excess staff capacity and does not need to hire additional staff to support specialty services, then most of Worksheet III may be unnecessary. Typically, however, the addition of any new provider creates additional workload for support staff, and new specialist providers may create even more as referrals, authorizations, and appointments may make up a larger part of the clinic's workload. Realistic calculation of staff support hours is critical to getting accurate estimates from this workbook tool. Sections III, Staffing, and IV, Patient Support and Ancillary Services, can help in estimating the total workload and necessary staffing ratios. Ratio estimates may also be available from individual specialists' offices, or from commercial sources.

The expense calculation requires estimating the costs of ancillary services (lab, imaging, pharmacy) arising from the specialty visit. (Worksheet III calculates these costs only for uninsured patients; if a clinic provides these services in-house to all patients, then the workbook will require adjustments on both the revenue and expense worksheets.) Facility costs also must be included in the analysis, if the specialty services will require the clinic to incur additional facility expenses.

Worksheet IV: The Bottom Line

By comparing market capacity, average revenue per visit, and average expense per visit, it is possible to derive a net profit or loss per visit as well as an overall net profit or loss. The financial worksheets calculate this "bottom line" automatically, by consolidating calculations from previous worksheets to provide estimates of the overall financial viability of specialty services in the given model.

The final forecast from the Financial Feasibility Workbook permits an analysis of the clinic's financial capacity to provide the specialty services. Grant funding or other unrestricted

funding sources can be added to the overall estimate in order to derive a more accurate picture of how specialty services will be funded.

Using Results Calculated with the Financial Feasibility Workbook

If the results of the financing tool indicate that a clinic is not likely to break even on the proposed specialty services, it may be useful to alter some of the assumptions. A clinic might model an expanded patient population, including patients from other clinics; it might alter the payer mix for some services; or it might try increasing or decreasing specialists' hours or rates. A clinic could also decide, as a result of this analysis, to pursue outside grant funding or assistance in order to start a specialty care program. A clinic or consortium might also decide against adding some – or all – of the specialty services.

The results of the financing tool are best used as one piece of an overall strategic business plan for providing specialty services. The tool can be used in conversations with boards of directors, potential partner clinics, providers, funders, or other stakeholders to plan the shared specialty network. The results of the tool can also be used to negotiate rates with payers when adding specialists to a managed care or PPO contract.

III. Staffing

Tool 3 Checklist: Recruiting Specialist Physicians

Tool 4 Checklist: Retaining Specialist Physicians

Tool 5 Checklist: Working with Volunteer Physicians

Physician staffing of specialty services in CCHCs is a highly individualized process, frequently based on personal relationships. Some clinics have worked extremely hard to develop relationships with the private medical community or with their local public or community hospital in order to solidify relationships with specialist providers. Increasing numbers of CCHCs are also employing mid-level providers to extend the reach of specialty services.

Specialist Physicians

Clinics must consider three important topics regarding specialist physicians: recruitment, retention, and compensation.

Recruitment

Recruitment of specialist physicians requires tenacity and creativity. Personal connections are invaluable, and the most successful recruiting efforts take advantage of the connections of clinic administrators, providers, and board members, as well as allied organizations and even news media. Clinics proposing shared specialty services should meet to develop a recruiting plan, and those participating in the effort should stay in close communication as recruiting moves forward.

Recruiting Specialists: Castle Family Health Center

Castle Family Health Center in Merced started with one ENT in 1996, and now offers 15 specialty services. Many community providers have chosen to make Castle the home for their Medi-Cal patients, and even refer their own Medi-Cal patients into Castle, but finding services for the uninsured is far more difficult. Some specialist providers will do a first consult in their offices, but few will take on patients who cannot pay. Castle has recruited a number of specialists – cardiologists, ENT specialists, orthopedists, audiologists, and allergists, among others – by promoting the value of community service through affiliation with Castle.

In some communities, it will be apparent that there are one or two providers who are the recruitment targets. In other communities, the efforts may be more diffuse. Specific strategies will vary according to the needs and circumstances of each clinic or group of clinics, but the following checklist includes ideas that clinics considering shared specialty services should consider.

Tool 3 Checklist: Recruiting Specialist Physicians

- ❑ Ask the primary care providers in your clinic to identify the specialists that they commonly refer patients to. These will usually be people with whom they have personal relationships, and these relationships are the leading source of specialist assistance.
- ❑ Ask your local medical society to help with recruiting. Through publications, meetings, and word of mouth, the medical society may be able to reach the specialists you need.
- ❑ Keep tabs on providers who are new to the community and may be seeking to build their practices, and on retiring providers who may be looking to work part time.
- ❑ Make sure that your providers are on the medical staff at your local hospital. Talk up your clinic's needs at hospital events, grand rounds, and hospital staff meetings. Be visible.
- ❑ Talk to other members of your clinic consortium. Compare notes with other clinics – especially if you intend to share services, but even if you don't. Compare lists of specialist providers.
- ❑ Network with allied organizations. Other partners in the community – regional centers, or the local cancer society, for example, may have contacts with the specialists you need.
- ❑ Use the news media. Place a human interest story about your patients' needs and your efforts to meet them, including the types of specialists you seek.
- ❑ Remember that there is no one-size-fits-all solution. Some specialists will join your clinic as contractors or staff; others may be willing to volunteer.
  As long as the arrangement meets the needs of your clinic and the specialists, any number of models may be successful.

Retention

Turnover among part-time specialists can be just as damaging to a clinic practice as turnover among full-time staff – and since specialists are difficult to locate, and recruiting is time-consuming, it is critical to ensuring the specialists' satisfaction. The following checklist includes a number of practices to encourage retention.

Tool 4 Checklist: Retaining Specialist Physicians

- ❑ Provide malpractice insurance. FTCA coverage often will be unavailable to specialist providers in an FQHC, particularly if they are independent contractors. Clinics may have to make other arrangements for specialists' malpractice insurance.
- ❑ Assign dedicated nursing and support staff. Specialists should expect to work with the same support staff every time they work at a clinic; the clinic should provide any additional training that these staff people need. For example, Open Door Community Health Centers reports that when they hire a specialist with an office in town, the clinic's medical assistants go to that office to shadow the staff there and learn the specialists' routines.
- ❑ Develop clear lines of communication. Specialists should know where to turn for assistance with clinical and administrative issues, and ideally should have one primary point of contact at each clinic site if they work at more than one.
- ❑ Make sure patients keep their appointments.
- ❑ Make sure patients have all needed ancillary services in advance of their specialty consultation. Work with the specialists to identify the lab and other diagnostic services that patients need prior to specialist appointments, and make sure that those services are in place and completed in time.
- ❑ Make specialists part of your clinic staff. Provide an orientation to the clinic, organize grand rounds or trainings so that they can introduce themselves and their work to the staff, invite them to relevant staff meetings and encourage them to participate as staff to the extent they desire and are able.
- ❑ Involve specialists in the management of your specialty network. Solicit input about how to make services run more smoothly; ask them to assist in recruiting other specialists.
- ❑ Thank the specialists. Have regular recognition events and give awards to recognize the specialists' contributions to the patients and the clinic.

Several of these recommendations proved important at Marin Community Clinics, where part-time specialists were given a clear structure and made to feel part of the clinic. According to the clinic, "It made all the difference. Some endocrinologists were going to come in, but kept putting it off – it turned out they were unsure whether our systems would support them, whether there would be translators, and whether people would be friendly. We learned that, if we're going to keep our specialists, we need good systems in place."

Compensation

Although pay rates for specialty care vary considerably by type and community, several clinicians interviewed for this project, including the staff of Open Door Community Health Centers, emphasized that they pay all or most specialists at the same rate, with increases based on seniority and good work.

Compensation for specialists may have legal implications for clinics under both state and federal law. The structure of reimbursement, particularly if the specialist is an independent contractor, will be affected by federal anti-kickback laws, and clinics should be careful to draw up contracts that meet the requirements of the relevant laws.[3]

Many specialists working in CCHCs are not paid at all, but volunteer their time. Having specialist physicians volunteer at a clinic can have a tremendous positive impact on patients' access to care. Working with volunteer physicians can also be costly, however, and in some cases both clinics and physicians have taken their responsibilities to each other less seriously when no payment is involved.

When physicians volunteer to provide services at a CCHC, the clinic's goal should be to create a fully professional work environment. This means following the same guidelines as for all physicians, though special attention to issues such as malpractice insurance and recognition may apply.

Tool 5 Checklist: Working with Volunteer Physicians

- ❑ Work with a contract or written agreement.
- ❑ Set a schedule and keep to it.
- ❑ Train the volunteer specialist on your clinic's policies and procedures, and on how to work with the patient population.
- ❑ Evaluate the volunteer physician, and give frequent feedback.
- ❑ Document the value of the volunteer physicians' contributions.
- ❑ Work carefully to meet the insurance needs of the physician and the clinic.
- ❑ Set up time for the volunteer physicians to instruct the primary care providers.
- ❑ Provide staff, including translators, to support the physicians' work with patients.

Contracts

All specialist providers – whether part time or full time, paid or volunteer – should work under a valid contract.[4] Contracts with specialist providers should, at minimum:

- Be in writing and signed by both parties;
- List the services provided by the specialty physician;
- Specify the schedule, length of, and charge for the time worked, if the specialty provider works on a part-time or sporadic basis;
- Cover a contract period that is not less than one year;
- Specify compensation that is consistent with fair market value and does not take into account the volume or value of referrals;
- Avoid any business arrangement or other activity that violates any state or federal law;
- State that the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; and
- Include specific delineation of malpractice insurance arrangements.

Contracts should document supervision arrangements, responsibilities for equipment, and other specific issues, including those pertaining to specialists who may work at multiple sites. In addition, clinics must credential every physician provider. Most shared specialty networks use the same credentialing process that they use for primary care physicians.

Responsibility for equipment used by specialists varies. In some instances, the clinic purchases and maintains minor equipment while the specialist provides more specialized or more costly tools and equipment. As the volume of services increases, clinics often relieve the specialist of the burden of carrying the equipment around by buying the equipment, which then remains at the clinic. Equipment arrangements, including responsibility for maintenance and repairs, should be spelled out in each specialist's contract.

Mid-level Providers

Another opportunity for the shared specialty network is to train nurse practitioners (NPs) and/or physician assistants (PAs) to extend the role of specialists in the clinic.[5] There is evidence from around the country that mid-level providers have improved access and reduced waiting time in a number of specialty areas.

NPs and PAs have been particularly successful in the areas of orthopedics, gastroenterology, and dermatology. In orthopedics, nurse practitioners and physician assistants perform assessments, set fractures, apply casts, and provide injections. In gastroenterology they perform sigmoidoscopies, treat patients for reflux disease, and provide ongoing counseling for hepatitis patients. In dermatology they see patients for acne, eczema, and other common skin disorders.

Mid-level Providers in Specialty Care: Open Door Community Health Centers

The Humboldt County specialty clinic is staffed with three medical assistants and two nurses with significant specialty nursing experience. Open Door also uses mid-level providers to provide specialty care, including a family nurse practitioner who is a certified diabetes educator and an LCSW who sees patients primarily through telemedicine visits. As soon as Open Door hired a cardiologist to staff their specialty clinic, he was booked six weeks out. In response the clinic sent a physician assistant to do a mini–cardiology fellowship. With the PA working alongside the cardiologist, wait times have been cut in half.

Often, the role of the mid-level provider in specialty care evolves as a nurse practitioner or physician assistant works closely with a particular specialist. This could easily happen in a community clinic setting, where the mid-level provider could be the bridge between primary care and specialty care, and could shadow the specialist for training. The mid-level providers' familiarity with the clinic patients and, often, their language capabilities, can also make the transition from primary to specialty care easier for the patients. Generally, when mid-level

providers and specialist physicians work closely together, they share responsibilities for patients. For example, mid-level providers commonly order diagnostic tests and create treatment plans. Supervising specialists are usually onsite or available by phone, and primary care physicians at clinics are always available onsite for consultation about their patients.

For NPs and PAs to be successful in extending specialty access, they must have individual training, either through one-on-one mentoring with a specific specialist physician or through course work that the specialist physician has endorsed. In this way, specialists can become confident in the mid-level providers' clinical skills and judgment about complex cases. At the same time, the clinic system and all staff must respect patients' and the referring physicians' requests that the patient see the specialist physician, particularly for the initial work-up and confirming diagnoses.

Administrative and Other Support Staff

In addition to estimating the amount of additional staff time and expense that specialty services will entail (as discussed in Section II, Financing), clinics adding specialty services should also consider the importance of support staff:

- Does your clinic have the right staff to support specialty care? Specialty care may require nursing and other support staff with a higher level of skill than that of staff in the primary care setting, and the ratio of support staff to physicians may also be higher. The availability of appropriately trained staff is the clinic's responsibility; specific needs must be worked out as part of the initial negotiations with the specialty provider.
- What kind of training does staff need to support specialty care? All staff should be oriented to the new specialty services. This can be accomplished through presentations at staff and team meetings. All employees should be sufficiently familiar with the protocols for specialty care that they can direct patients – and specialists – seeking assistance.

  Those administrative and support staff working most closely with the specialists and specialty care patients may need additional training, particularly if referral procedures for specialty care differ from those used elsewhere in the clinic.
- Who on staff is the primary point of contact for specialist providers? This may be an office manager, a nursing supervisor, or another person who can troubleshoot with the specialist providers. Clarity about this point of contact is an important strategy for retention.

IV. Patient Support and Ancillary Services

Tool 6 Checklist: Creating Policies for Scheduling

Tool 7 Checklist: Creating Access to Ancillary Services

Adding specialty services, particularly in a shared network, may require CCHCs to rethink their patient support services, from scheduling to transportation to health education. Specialty services differ from primary care services in ways that have significant implications for these support services. For example, many specialty appointments are urgent, and the average specialty patient is sicker than the average primary care patient. This means that the triage function in scheduling is more important; in some cases it may also mean that patients are more likely to need transportation services. At the same time, the fact that many specialist providers are not experienced in working with the clinic population may mean an increased need for language-specific materials and translation and/or case management services.

Specialty patients frequently need ancillary services such as lab and X-ray, and typically the specialist providers need the results of these tests at the time of the first specialty visit. Similarly, medical records must be transmitted between the primary care provider and specialist, sometimes across clinic systems.

These factors and others make support services in specialty care a critical issue.

Scheduling Support

With limited specialist hours, patient no-shows can put the clinic at particular risk. The goals in scheduling specialty care in a shared network include, first, decreasing no-shows and second, supporting efficiency by ensuring that patients arrive with proper records and documentation. While some clinics that provide specialty services treat the scheduling of these services just as they do primary care scheduling, other clinics have recognized that efficiency is improved when the clinic takes a more active role in appointment scheduling.

Among the approaches followed by CCHCs:

- Create a separate scheduling system for specialty appointments. This would typically incorporate a stepped-up reminder and follow-up system for specialty appointments, to decrease no-show rates.
- Make specialty appointments for patients. Under this approach, the patient has no direct role in scheduling – instead, staff at the providing clinic and at the referring clinic, if there is one, make the appointment directly and coordinate with the patient. Schedulers also typically work with the referring clinic and the specialist to ensure that the patient arrives at the specialist appointment with complete records and test results, as needed.

- Employ a referral and scheduling coordinator. A shared referral coordinator is sometimes used where specialty services are provided at multiple sites, or where the shared services model involves referral to community providers. In addition to finding providers and scheduling appointments, the referral coordinator may triage patients, manage wait lists, and coordinate case management as necessary.

  For example, SOS Clinic in Orange County has a referral coordinator who makes appointments with doctors' offices, handles translation and transportation, and calls patients with appointment reminders.

Regardless of the system chosen, all scheduling arrangements should be documented in writing, with clear protocols that describe the procedures in detail. The following checklist includes items to address in a scheduling policy.

Tool 6 Checklist: Creating Scheduling Policies

- ❑ Take responsibility for scheduling appointments. Specialty services often require a more hands-on approach to scheduling than primary care services do. This is particularly true if the specialist is present for very limited hours or if pre-appointment tests are required. When staff at the specialty site can ensure that clinical guidelines have been followed, and that appropriate test results are available at the time of the appointment, efficiency of a specialty practice is enhanced.
- ❑ Develop an appointment reminder system. Specialty services often use a more aggressive appointment reminder system in order to minimize no-shows. Multiple phone calls, coordination with translation and transportation services, and even formal case management may be appropriate means by which to ensure that specialty patients show up for their scheduled visits.
- ❑ Create a triage policy. Most patients who need to see specialists are sick, but some are much sicker than others. A specialty clinic's triage policy should be in writing, clearly understood by all staff, and linked to clinical guidelines.
- ❑ Determine how far in advance to schedule appointments. Long wait times for specialty care are the very reason that many CCHCs have entered the specialty care business in the first place, so if appointment wait times remain long for clinic-based specialists, the problem has not been solved. Scheduling specialist appointments no more than a few days or a few weeks out will decrease no-shows and reduce staff time spent on rescheduling.
- ❑ Implement a no-show policy. Typically, CCHCs have no-show policies for patients who miss three or more appointments, though they generally do not charge patients for missed appointments as is common in private practice. Patients should be told of a clinic's no-show policy both in person and in writing, and the policy should be enforced.

Ancillary Services

Ancillary services such as lab, X-ray, and pharmacy are often needed either in preparation for a specialist visit or as a result of one. For many clinics, accessing these services can be particularly frustrating: a volunteer cardiologist may be available to see a patient, for example, but necessary tests are neither available at the clinic nor affordable in the community, especially for uninsured patients.

Some clinics are able to refer patients to local hospitals for these ancillary services. In other communities, specialist physicians may be able to negotiate access for small numbers of patients. However, many clinics report that at least some ancillary services remain difficult to access, and that the problem is particularly severe for high-cost tests such as CAT scans. A clinician at AltaMed described the problem: "You want to refer to a specialist, but the patient needs a lab first – if we go ahead and refer without the lab, the specialist won't be able to do anything and it's a waste of everyone's time. We're trying to broaden the scope of primary care and use limited specialist resources appropriately."

Tool 7 Checklist: Creating Access to Ancillary Services

- ❑ Determine what the ancillary service needs are. Initial discussions with specialist physicians should include determining which ancillary services are needed in advance of a specialist consultation. These requirements should be documented in clinical practice guidelines, as discussed in Section V, Inter-clinic Referrals.
- ❑ Involve your clinic's usual ancillary sources. Ask the labs, radiology groups, and other providers to whom you commonly refer your primary care patients to work as partners in making sure that uninsured patients can effectively use the specialist services you offer – which requires access to ancillary services. Ask nonprofit hospitals how to access their community benefits programs.
- ❑ Get help from your specialist physicians. Encourage them to talk to the ancillary providers to whom they refer about their work with your clinic and the needs of the community.

Arrangements with ancillary providers should be spelled out in written agreements that address, at minimum:

- Fee structures;
- Provider capacity, including any limits on numbers of patients to be referred;
- Consultation reports and diagnostic testing results;
- Access to electronic connectivity;
- Translation services for patients; and
- Ongoing feedback to referring providers and clinic administration.

Since lab and X-ray are designated health services under the Stark law, clinics should have these arrangements reviewed by an attorney experienced in this area in order to ensure that they are in compliance with all relevant laws. In addition, clinics should be aware of contractual requirements of any federal, state, or county contracts as they relate to providing ancillary services, since the costs of these services can become unmanageable without formularies and utilization controls in place. For example, Expanded Access to Primary Care (EAPC) grants require that lab, imaging, and pharmacy services be provided for patients when medically necessary. Such a requirement could potentially put a clinic at risk as they increase specialty care for the uninsured.

Other Patient Support Services

CCHCs that provide shared specialty services should pay particular attention to other key support services that patients need to successfully complete their specialty visits, including:

- Transportation;
- Translation;
- Health education on specific conditions or testing that will be provided for the specialty visit;
- Patient advocates to accompany patients to appointments; and
- Care management, care coordination, and referral follow-up.

The expense worksheet in Section II, Financing, accounts for the cost of these services.

V. Inter-clinic Referrals

Tool 8 Resource: Referral Procedures from Southside Podiatry [pdf]

Tool 9 Resource: Referral Guidelines from Shasta Ambulatory Care [pdf]

Tool 10 Resource: Referral Guidelines from Southside Podiatry [pdf]

One significant finding of the 2007 Specialty Care Access Survey was the absence of clinical guidelines or written protocols for specialty referrals. Among the findings:

- Almost 30 percent of safety-net respondents reported that their institutions did not track specialty referrals. Of those that tracked referrals, most (68 percent) used manual handwritten logs or notes in patient charts.
- Only four of the responding CCHCs (3.5 percent) reported use of electronic medical records.
- Only 26 percent of CCHC respondents reported that staff "frequently" provided patient reminders for specialty visits.
- Fewer than 15 percent of CCHCs reported use of email to communicate with specialists.

In interviews, most clinics described their arrangements as informal; one respondent called their referral process "relationship-based and evolving."

Referral Procedures

Specialty referrals can be complicated by the fact that some are urgent, and by the need for appropriate documentation and records to be transmitted to the specialist from the primary care provider.

Referral arrangements need not be complex, but having clear documentation of referral procedures, and of relationships between referring and receiving entities, can make care more efficient, preserve scarce specialty services for higher-need cases, and improve provider relations and communication.

One CCHC that has thoroughly documented referral arrangements is Shasta Community Health Center. Shasta has developed its own specialty referral form. A referral nurse – typically an LVN or RN – works with the referral form and a set of clinical guidelines to determine if the patient is ready to see the specialist. If the patient needs more tests or information, the nurse coordinates with the referring primary care provider to order these. Only then is a specialty appointment scheduled.

Resource for Referral Procedures

Southside Coalition of Community Health Centers uses this tool:
Tool 8 Resource: Referral Procedures from Southside Podiatry [pdf]
It can be adapted to the specific circumstances of your shared specialty network.

Resources for Clinical Guidelines

A portion of Shasta Community Health Center's clinical guidelines are included as **Tool 9 Resource: Referral Guidelines from Shasta Ambulatory Care** [pdf], and those of Southside Coalition of Community Health Centers are included as **Tool 10 Resource: Referral Guidelines from Southside Podiatry** [pdf].

Clinical Guidelines

Like referral protocols (with which they are often combined), clinical guidelines for specialty services are not in common use by CCHCs. They are essential, however, to a well-run specialty practice, in that they make clear expectations for all personnel involved, and assist in the efficient use of resources by ensuring that patients are appropriately triaged and prepared for their specialist visits.

Clinical guidelines should include patient work-up requirements for each specialist provider and for common referring conditions. They should be clear about the expectations for the patient, primary care provider, specialty provider, and support staff. They can be organized by referring condition (allergy, HIV, rheumatology) and should include referral procedures, diagnostic guidelines, and contact information, among other topics.

VI. Legal and Regulatory Considerations

Tool 11 Checklist: Scope of Project Modifications

Federally Qualified Health Centers (FQHCs) considering adding specialty care services, whether individually or as part of a shared network, must comply with a variety of laws and policies addressing where and how they provide health care services, how they are paid for these services, and how they in turn pay their medical providers. Many of these rules exist in federal law, in policy areas including FQHC Scope of Project, the Federal Tort Claims Act (FTCA), sliding fee scale regulations, Medicaid and Medicare policies, and laws governing referral and compensation arrangements.

Given that enhanced Medi-Cal reimbursement is the critical linchpin to financing specialty care services at FQHCs, the ability of CCHCs to expand their scopes of project to include these services is important. Recent policy notices and continuing discussions in federal policies for specialty care are likely to have significant impact.

A full discussion of the federal and state legal and regulatory schemes relevant to the provision of shared specialty services is beyond the scope of this guide. A companion piece, *Adding Medical Specialty Services to a California FQHC: Legal and Regulatory Issues* by Regina

Boyle, J.D., treats these issues in greater detail. This section is adapted from that document, which is cited in the Appendix.

Scope of Project Modifications

An FQHC's Scope of Project defines the services, sites, providers, target population, and service area for which federal grant funds may be used. Any significant changes to an FQHC's Scope of Project – including the addition of specialty services – requires the prior approval of the Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA). The prior approval process is referred to as modification of the FQHC's Scope of Project.

The threshold question for FQHCs seeking to add specialty services is whether or not BPHC will approve the FQHC's request to add the services to its Scope of Project.

In the last two years, BPHC has issued new guidance regarding both Scope of Project generally – in Program Information Notice (PIN) 2008-01 – and their inclusion of specialty services in particular – in PIN 2009-02.[6]

PIN 2008-01 elaborates on the requirements contained in the federal law. It describes the five components of a Scope of Project application or modification, and generally offers guidance for FQHCs seeking to add or change services or sites. None of the requirements are specific to shared services.[7]

In PIN 2009-02, the BPHC has identified the following four key areas of focus when reviewing Scope of Project applications to add specialty services in particular:

1. FQHCs are required to establish that the services are "necessary for the adequate support of [the required] primary health services." The BPHC has interpreted this as requiring the FQHC to demonstrate that the proposed services "function as a logical extension of the required primary care services already provided by the health center." The PIN gives the following examples of specialty services that support required primary care services:

    - Pulmonary consultations, and/or examinations, where the health center serves a substantial number of patients with asthma, COPD (chronic obstructive pulmonary disease), black lung, or tuberculosis;

    - Cardiology screenings and diagnoses, where the health center serves a substantial number of patients at risk for heart disease or high blood pressure;

    - Minor podiatry outpatient procedures or examinations, where the health center serves a population with a high prevalence of diabetes;

- Psychiatric consultations, examinations, and diagnoses, where the health center serves a substantial number of patients with mental health and/or substance abuse diagnoses;
- Periodontic services, where the health center serves a significant population of children with poor oral health;
- Colonoscopies; and
- Appropriate oncological care of health center patients with cancer.

2. The FQHC must show that the target population needs the specialty services. The application must demonstrate this need in narrative format and with relevant data, and the FQHC must additionally "demonstrate its ability to maintain the level and quality of the required primary health services currently provided to the target population."

3. The Scope of Project change must not require additional Section 330 grant support. The application must address whether or not the services that the FQHC proposes to add will meet the Medicare and Medicaid definitions of "FQHC services" and whether the site and/or services proposed will generate sufficient revenue to sustain both the services themselves and associated overhead costs. According to the PIN, the application also should reflect an understanding by the FQHC that it must provide the services to all patients regardless of ability to pay, and not just to insured patients.

4. The location of the services must be a site that is within the FQHC's Scope of Project, such that the proposed new service will be accessible to the FQHC's patients, and the FQHC "will be able to maintain appropriate control over service delivery." FQHCs are required to provide the services:

    - At an approved "service site" as defined by the PIN;
    - At a site within the FQHC's Scope of Project;
    - At a new site that will be proximate to available FQHC services; or
    - At a location where in-Scope services are provided, but which does not meet the definition of a service site.

Tool 11 Checklist: Scope of Project Modifications

- ❑ Make sure the services to be provided are "FQHC services" as defined by Medicaid/Medi-Cal and Medicare, and "covered services" under other third-party payer agreements.
- ❑ Demonstrate that the new services would improve or maintain access and quality of care for the target population.
- ❑ Establish that the services are "necessary for the adequate support of the required primary health services" and function as a "logical extension" of the primary care services already provided by the health center.
- ❑ Demonstrate (through narrative and data) that the target population needs the specialty services.
- ❑ Demonstrate that the FQHC is able to provide the services equally to uninsured and insured patients.
- ❑ Make sure the services will be provided at a site within the FQHC's Scope of Project.
- ❑ Make sure that the FQHC appropriately credentials and privileges the added providers.
- ❑ Establish the availability of necessary enabling services, such as translation and transportation, associated with the proposed services.
- ❑ Make sure the governing board approves the application.
- ❑ Submit the application at least 30 days in advance of the planned commencement of services.
- ❑ Make sure that any proposed professional services agreement accounts for the possibility of delayed approval, or denial, of the Scope of Project modification application.

VII. Billing Medi-Cal, Medicare, or Other Insurance

Specialty care billing, whether or not the care is provided in a shared network, is significantly different from primary care billing, and may be challenging for community clinics. Similarities in visit codes end with the office visit evaluation and management, so there is significantly more room for error – and thus for findings of fraud. These issues are as important when billing FQHC Medi-Cal as when billing a private insurance company.

Consultation Codes

A consultation is defined in CPT literature as a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The specialist's initial encounter with a patient is typically a consultation requested by the primary care provider, so consultation codes (99241–99245) are usually more appropriate than a new patient evaluation code (99201–99205).

When a patient requires further specialist evaluation or management, the primary care physician writes up a request for a specialist to see the patient. This request is important as it is the primary requirement for billing the specialty visit with the consultation code. Without the request from another provider (or other appropriate source), the visit may not be billed as a consultation.

There is no differentiation between a new and established patient when using the consultation codes. However, follow-up visits for treatment management or additional diagnostics necessary to complete the consultation are billed with the established patient office visit E/M codes, 99211–99215. At the completion of the consultant's evaluation or management of the patient's condition, the specialist sends a written report of findings and recommendations to the referring provider. If at a later time the primary care provider makes another request for the specialist to see the same patient – whether for the same problem or a new one – the specialist may again bill for this visit as a consultation using the 99241–99245 codes.

The documentation requirements and determination of the level of consultation codes are the same as with the office visit E/M codes. This means all three key components: history, exam, and medical decision-making, must meet the documentation requirements for the specific level. For a consultation code to be reported, all of the following requirements must be in place:

- The referring provider must request the consultation;
- The request for the consultation must be documented in the patient's medical record;

- The consulting physician's opinion and services ordered or performed must be documented in the patient's medical record; and
- The consulting physician must communicate his or her opinion to the requesting physician by a written report.

Other Coding and Billing Issues

Diagnostic tests in the office must be carefully coded. Many diagnostic tests are routinely performed in the office; some tests may have similar names but different codes. For example, electrocardiography and echocardiography have different sets of CPT codes, with different reimbursement amounts. Sometimes the specialist may only be interpreting a test. The correct CPT code (and modifier if appropriate) must be used to accurately report the service and avoid "up-coding" or "under-coding."

Attention to diagnosis codes is very important. Generally, symptoms would be the first reason for the consultation. However, once the specialist has established the specific problem through diagnostic tests and procedures, the condition or disease becomes the primary diagnosis that will justify follow-up visits or treatments.

Specialty services require greater use of certain modifiers. Billers will need to familiarize themselves with certain modifiers such as 24, 25, 51, and 59. Each of these indicates a different type of service done during the same encounter, and will generate a separate charge.

VIII. Technology Tools

In order to effectively organize and exchange health information in a shared specialty network, attention to technology is essential. Most health centers currently do not have electronic medical records, nor do they have more than a limited ability to exchange electronic information.

Community clinics in a shared specialty network should think ahead about how they want referring providers and specialty providers to communicate. Various strategies for improving coordination of specialty care referrals include technologically enhanced tracking, electronic health records, email and Web-based referral and appointment systems, and patient reminders.

Referrals between clinics and providers are a key area in which technology can be used to avoid inappropriate or ambiguous referrals and to transfer appointment or medical information to the site where the specialist is seeing the patient. Having referral guidelines built into the referral system brings consistency to the process. At the Open Door Community Health Centers, for example, the referral protocols and clinical guidelines are available to referring providers on the clinic's Web site. Open Door is investigating a

community-wide electronic referral system that can prioritize appointments, and would also reduce the need for clinic staff to faxing records and materials back and forth between sites and providers.

Using E-Referral

Referral technologies and e-referral programs represent another major strategy with significant financial implications. The advantages of this approach include improved allocation of scarce resources, reduced waste and inefficiency, improved communication between PCPs and specialists, and enhanced capacity to track and report on referral metrics. However, the costs can be significant, including intensive commitment of staff resources, hardware, software licensing, subscription and maintenance fees, implementation support, training, and maintenance. An additional obstacle is that some specialist offices in the community may be unequipped to connect electronically to the referral system. Currently there is no ongoing funding to support the maintenance and staffing of e-referral systems.

E-referral systems can be highly sophisticated, providing full integration with electronic health records and interoperability with other systems management tools. Others are more modest, focused solely on specific specialty areas, or only on standardizing protocols for email communication, for example. Some possible functions for e-referral programs are:

- Automation of appointment reminders;
- Integration of guidelines;
- Enabling convenient review and triage of requests;
- Increase in legibility and completeness of referral and scheduling;
- Ability to expedite urgent referrals;
- Ability to track referral progress;
- Capacity to store and forward diagnostic information and images; and
- Standardization of consultation reports.

Using Telemedicine

Telemedicine is another major strategy to address the gap in specialty care access for both urban and rural clinics. Although California has been a pioneer in telemedicine policy, enacting one of the first state telemedicine laws in 1996 and expanding it in 2005, reimbursement policies lag behind current practice. Though a "site fee" designed to cover the costs of telecommunication, setup, and administration of the program for referring provider sites is provided by some payers, significant confusion remains among providers about whether and how to bill for telemedicine consultations. In addition, primary care sites continue to have difficulty finding specialists who are equipped and willing to see their

patients via telemedicine, particularly if patients are uninsured or on Medi-Cal. To date, it has been a challenge for most telemedicine providers to develop a viable business model, and safety-net providers have relied heavily on grant funding to support telemedicine activities.

Infrastructure and broadband connectivity have also been barriers to more widespread use of telemedicine. The California Telehealth Network, established in 2008 under a federal grant from the FCC, will provide access to subsidized, high-speed broadband for hundreds of safety-net providers throughout the state, allowing them to connect to one another more easily and with the security and service level guarantees necessary for telemedicine. Funds available through the American Recovery and Reinvestment Act (ARRA) will also offer funding opportunities for the advancement of broadband and telehealth programs.

Clinics interested in using telemedicine to expand specialty access within the shared network will need to research and investigate best practices and assess the financial impact of telemedicine on their network approaches.

Resources for Telemedicine

Extensive resources on telemedicine for CCHCs are available at the California Center for Connected Health (www.connectedhealthca.org) and at CHCF's telehealth Web site (www.chcf.org/topics/index.cfm?topic=CL707).

IX. Evaluation

Tool 12 Checklist: Evaluating Specialty Services

There is little data on the provision of specialty care in California CCHCs. Most clinics do not systematically evaluate the impact of their specialty services, shared or not, on access to care, on clinic operations, or on clinical outcomes. Such evaluation and data collection are essential to identify continuing access gaps, to ensure the efficient use of resources and the fiscal health of the CCHC, and to demonstrate improvements in access (or lack thereof).

Some clinic managers fear that evaluation will take too much time, or cost too much money. However, evaluation of the impact of shared specialty services can be done with information already collected for other purposes, such as scheduling and billing.

What to Measure and Report

At a minimum, CCHCs providing specialty care should measure, monitor, and report the items on the following checklist, both for internal services, and for services provided to specialty network partners.

Tool 12 Checklist: Evaluating Specialty Services

Clinics should evaluate:

- ❑ Wait times for specialty services, by type of service and by provider;
- ❑ No-show rates, by type of service and provider;
- ❑ Percentage of visits in which patients arrive with necessary ancillary services complete and results available for the specialists;
- ❑ Provider retention rate by specialty;
- ❑ Specialist's reported satisfaction with clinic systems and staff support;
- ❑ Ratio of regular support staff to specialist;
- ❑ Reimbursement rates for each specialty for various types of services;
- ❑ Payer mix for each specialty;
- ❑ Referral patterns of primary care providers, in order to track over- and under-utilization of specialists;
- ❑ Referral patterns for specialty services by type and payer mix from clinic partners in shared services;
- ❑ Increased knowledge of primary care providers in each specialty area; and
- ❑ Increased skill of primary care providers to expand their scope of practice with specialty skills.

It is important to consider setting goals or benchmarks that can be regularly monitored in advance of implementing a shared services specialty program. Each organization or group of clinics will have different goals for specialty services but most will include:

- Access to specialty care, often measured by wait times for specialty appointments in key specialty areas;
- Change in referral patterns for outside specialty services as a result of offering more specialty care in house at the clinic; and/or
- Impact of cost of specialty care on the clinic budget as reflected by the payer mix and use of the sliding fee schedule to pay for the services.

Regular reporting to clinic staff, boards of directors, and clinic partners participating in the network are essential to ongoing quality improvement and successful collaboration.

Open Door Community Health Centers provides an example of successful use of evaluation data. The specialty center at Open Door tracks wait times carefully. "For each specialty service we have benchmarks. If cardio is more than three weeks out, if diabetes education is more than two weeks out, we want to hear about it. If our soonest appointment is six to eight weeks out, we feel we have negated much of the value of having the specialist available." Open Door uses the data on wait times, among other measures, to improve its service and meet its goals.

Appendix: Discussion Papers and Technical Assistance Briefs on Specialty Care in the Safety Net

The following resources are available from Kaiser Permanente Northern and Southern California Community Benefit Programs (KPCB), the Specialty Care Access Initiative (SCAI), and the California HealthCare Foundation (CHCF).

		Date	Funder/ Organizer
Title	Fuller Scope of Practice for Primary Care Providers: A Strategy to Improve Access to Specialty Care in the Safety Net	February 2008	KPCB/SCAI
Author	Pacific Health Consulting Group		
Resource Location	www.pachealth.org/publications.aspx		
Title	Weaving Webs in the Safety Net: Public Hospital Systems and Community Health Centers Collaborating to Improve Specialty Care	July 2008	KPCB/SCAI
Author	Pacific Health Consulting Group		
Resource Location	www.cpca.org/clinical/specialtycare/index.cfm		
Title	Bridging the Care Gap: Using Web Technology for Patient Referrals	September 2008	CHCF
Author	Jane Metzger and Walt Zywiak, CSC		
Resource Location	www.chcf.org/topics/view.cfm?itemID=133761		

		Date	Funder/ Organizer
Title	A Slippery Slope: Financing Specialty Services in California's Safety Net	January 2009	KPCB/SCAI
Author	Pacific Health Consulting Group		
Resource Location	www.pachealth.org/publications.aspx		
Title	Understanding Common Referral Reasons in Difficult-to-Access Specialties	May 2009	CHCF
Author	Neil A. Solomon, M.D.		
Resource Location	www.chcf.org/topics/view.cfm?itemID=133941		
Title	Physician Assistants and Nurse Practitioners in Specialty Care: Six Practices Make It Work	June 2009	CHCF
Author	Center for the Health Professions, University of California, San Francisco		
Resource Location	www.chcf.org/topics/view.cfm?itemID=133961		
Title	Four Models Bring Specialty Services to the Safety Net: Enhancing Scope of Practice and Referral Efficiency	July 2009	CHCF
Author	Gail Patrick, M.D., and John Hickner, M.D.		
Resource Location	www.chcf.org/topics/view.cfm?itemID=133983		

		Date	Funder/ Organizer
Title	Adding Specialty Services to a California FQHC: Legal and Regulatory Issues	July 2009	CHCF
Author	Regina M. Boyle, J.D.		
Resource Location	www.chcf.org/topics/view.cfm?itemID=133998		

Endnotes

[1] Mathematica Policy Research, Inc. *Examining Access to Specialty Care for California's Uninsured*, June 2004.

[2] Pacific Health Consulting Group. *Preliminary Findings: Specialty Care Access Survey, A Joint Project of Kaiser Permanente, California Primary Care Association, California Association of Public Hospitals and Health Systems*, December 17, 2007.

[3] These issues are discussed in greater detail in Regina M. Boyle, J.D., *Adding Specialty Services to a California FQHC: Legal and Regulatory Issues*, July 2009.

[4] This discussion of contracting is based in part on the work of Regina Boyle, J.D. For additional information, see *Adding Specialty Services to a California FQHC: Legal and Regulatory Issues*, July 2009.

[5] The material in this section is based in part on Catherine Dower, J.D., and Sharon Christian, J.D., UCSF Center for the Health Professions, *Physician Assistants and Nurse Practitioners in Specialty Care: Six Practices Make It Work,*, June 2009.

[6] HRSA Policy Information Notice 2009-02, "Specialty Services and Health Centers' Scope of Project," available on HRSA's Web site at bphc.hrsa.gov/policy/pin0902/ (visited July 17, 2009).

[7] HRSA Policy Information Notice 2008-01, "Defining Scope of Project and Policy for Requesting Changes," available on HRSA's Web site at bphc.hrsa.gov/policy/pin0801/ (visited July 17, 2009).