Healing Links

A Specialty Care Initiative Case Study on Integrating Care Coordination

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Introduction

The Specialty Care Initiative (SCI) supported community coalitions to develop and implement strategies to address specialty care demand and access in their communities. SCI was jointly funded by the California HealthCare Foundation (CHCF) and Kaiser Permanente's Northern and Southern California Regions' Community Benefit Programs. In 2008, after one year of planning support, 24 coalitions were granted additional funds to implement strategies that increase access to priority specialty areas. Major activities fell within four strategy clusters:

- Embedding guidelines into the referral process,
- Building/expanding specialty care networks,
- Increasing primary care provider (PCP) capacity/scope of practice, and
- Integrating care coordination.

The Center for Community Health and Evaluation in Seattle, Washington conducted the statewide evaluation of SCI, including case studies of the four strategy clusters to highlight areas of progress and lessons learned.

Overview of the case study

There is considerable variation in how care coordination is defined in the literature and by SCI 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).[1] 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—ensuring patients have the information and resources they need to complete their specialty care appointment (transportation, language services) and appropriate follow-up occurs afterward.

[1] *Reducing Care Fragmentation – A Toolkit for Coordinating Care*. Prepared by the MacColl Center for Health Care Innovation for The Commonwealth Fund. April 2011. Available at http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation_april_2011.pdf.

Activities in the Integrating Care Coordination strategy cluster aimed to reduce no-show rates and improve patient satisfaction. SCI grantees integrated care coordination between primary and specialty care through two key strategies:

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

This case study discusses two projects to highlight each type of care coordination. Yolo County Future of the Safety Net assigned a case manger to coordinate care for patients enrolled in its Fair Share program, which entails navigating between various health systems. The San Mateo County Specialty Healthcare Improvement Project (S.S.H.I.P.) focused on improving care coordination through a partnership with Coleman Associates to apply patient visit redesign (PVR) principles to San Mateo Medical Center's specialty clinics.

Efforts in this strategy cluster are closely related to activities implemented as part of the other strategy cluster areas; those interested in understanding the breadth of approaches to address specialty care access for the safety net population are encouraged to review all four case studies.

Fair Share

The Fair Share model aimed to distribute the uninsured/YCHIP referrals in targeted specialty areas equitably among the health care system in Yolo County. Organizations publicly committed to certain specialty services. Referral criteria and processes were collaboratively established for each organization.

Referrals and services provided were centrally tracked and managed by a project coordinator at CommuniCare in accordance with coalition partner agreements. Services provided were assigned a monetary value to assess whether organizations were doing their fair share. The model required comprehensive referral coordination and patient case management to ensure patients were adequately prepared and to reduce no-show rates.

Targeted specialties included: orthopedics, rheumatology, neurology, gastroenterology, and endocrinology (ORNGE).

Participating specialists at:

- Kaiser Permanente – Sacramento
- Sutter Medical Foundation
- Sutter Davis Hospital*
- Woodland Healthcare*
- UC-Davis Medical Center

*Organization also provides specialty care services to the safety net through its emergency department

Background and context—Yolo County

The Safety Net System in Yolo County

Yolo County is a rural, agricultural region in Northern California. The health system is decentralized and many specialty areas are heavily impacted, even for insured populations. There is no public hospital; most safety net specialists are affiliated with one of three private health systems or the University of California (UC)-Davis Medical Center.

Yolo's efforts centered on the implementation of a "Fair Share" model (see box at right) to provide specialty services to the uninsured and YCHIP (Yolo County Healthcare for the Indigent Program) populations. Two primary care organizations served the targeted population—CommuniCare and Winters Healthcare. CommuniCare is a federally-qualified health center (FQHC) with three clinic sites in the county; approximately 90% of Fair Share referrals originate at CommuniCare.

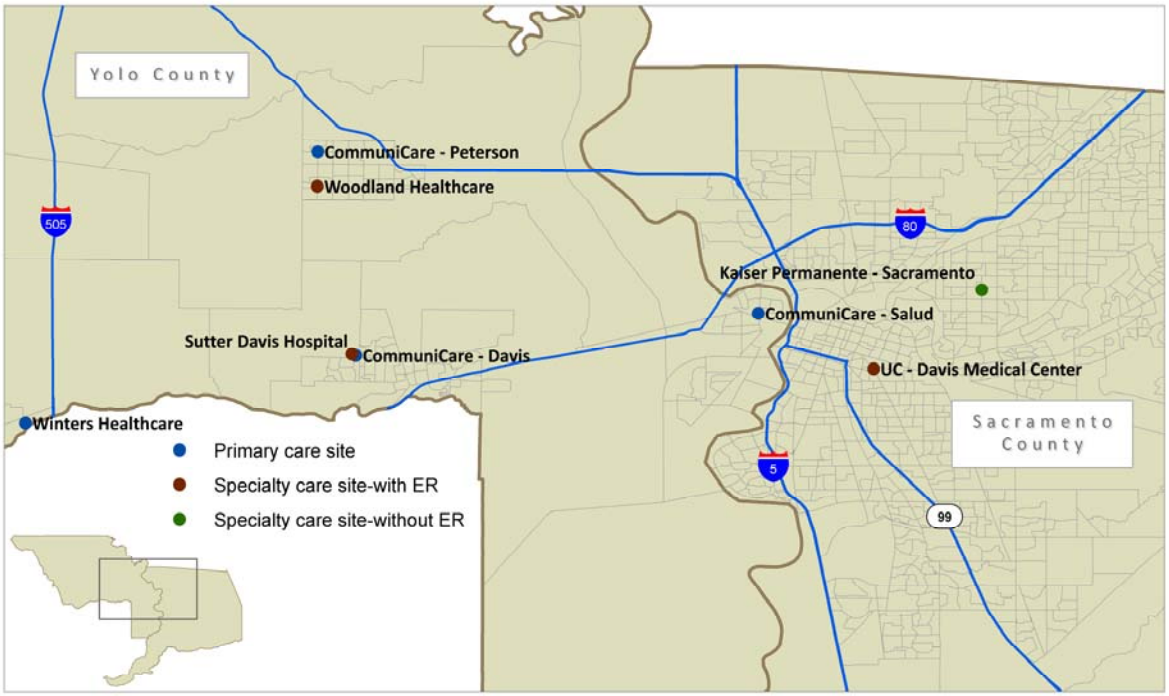
Yolo County Future of the Safety Net

CommuniCare coordinated the coalition's efforts and facilitated the implementation of the Fair Share model. The coalition was a broad health care collaborative that met quarterly to conduct high-level planning and provide vision for SCI activities. CommuniCare also convened a workgroup that met periodically to review referral patterns and address issues related to Fair Share.

CommuniCare implemented a central case manager to coordinate care for all Fair Share referrals. Case management for new and follow-up appointments included:

- Referral coordination to obtain the necessary authorizations.
- Patient communication to remind patients of their appointment and reinforce the importance of them completing their appointment.
- Interpretation services.
- Transportation assistance since care was spread out in two counties.
- Information exchange and follow-up to ensure the required paperwork and health records were sent to the specialist, and the specialist's visit summary was sent back to the PCP.
- Prescription assistance for patients to obtain recommended medications at reduced or no cost.
- Patient advocacy to secure services for patients.

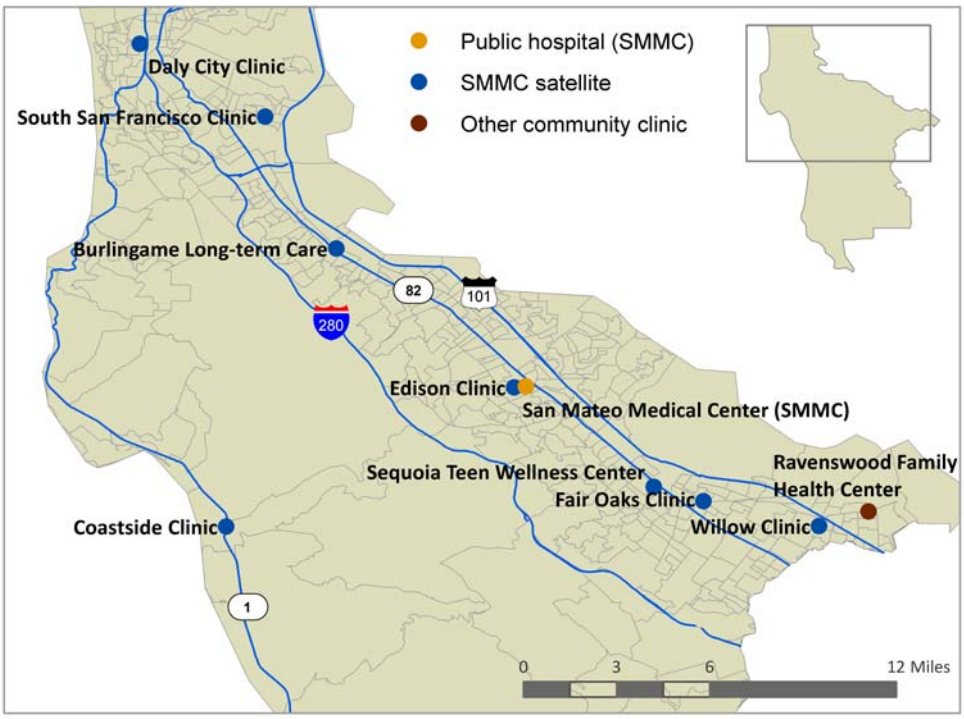
"We could not do our [Fair Share] model without a central case manger and management system."



Background and context—San Mateo County

The Safety Net System in San Mateo County

San Mateo County is a suburban county located just south of San Francisco. About 90% of specialty care for the safety net occurs at the public hospital, San Mateo Medical Center (SMMC). The SMMC system has nine satellite primary care clinics and a formal partnership with Ravenswood Family Health Center, a near-by FQHC. The SMMC system has mostly integrated health information exchange systems and recently implemented an electronic health record (EHR).



SMMC has approximately 70 specialist contracts for 15 specialty areas. SMMC specialists are contracted employees who typically also work in private practice. Many of the specialists have worked at SMMC for a number of years (mean tenure=15 years); however, the frequency that they practice at SMMC varies ranging from as little as one session every two weeks to several days per week. Such variability resulted in inefficiencies within and inconsistencies between processes in the specialty clinics.

San Mateo S.S.H.I.P. coalition

San Mateo's coalition membership includes representatives from the key health organizations in San Mateo County—SMMC, Ravenswood, the county health department, and county health plan. The S.S.H.I.P. coalition was formed for SCI and provided high level oversight and feedback. Implementation efforts were led by a small team of medical staff, physicians and administrators at SMMC.

San Mateo's primary strategy to integrate care coordination was through a specialty clinic redesign process that involved systemic changes to improve patient experience by increasing consistency and efficiency. They worked with Coleman Associates to implement a team-based approach to care utilizing the Coleman Associates' patient visit redesign (PVR) principles for primary care clinics (described at right).

The goals of the redesign process were to: 1) decrease cycle times (the amount of time a patient spends at the clinic); 2) decrease no-show rates; and 3) increase confirmations of appointments. They implemented redesign in all 15 specialty clinics. This effort was supported by parallel efforts to implement a Smart Referral (eReferral) system, implement a centralized call center, and develop provider contact sheets to further increase communication and coordination between specialists and PCPs.

Specialty Clinic Redesign Strategies

- Pre-registration – phone calls to patients to remind them of their appointment, update contact and insurance information, and prepare them for their visit
- Central registration – checking all specialty patients in at one location
- Rational scheduling – working with specialists to create a realistic schedule
- Clinic prep – preparing clinics for patient visits ahead of time (e.g., collecting charts, lab work)
- Quick start – clinic staff arrive and start on time
- Referral guidelines – compiling and distributing guidelines for referral for each specialty

Lessons from work to date

The progress made by both of these projects was possible because of dedicated staff/project managers assigned to keep things moving forward. They coordinated with their coalitions and built on ongoing efforts in their respective communities. The following are lessons learned from the activities carried out that may be useful for other communities doing similar work.

Build leadership support for care coordination activities.
Across SCI, leadership support was an important success factor. However, because there is no payment mechanism for care coordination activities, it was even more critical for the organizations to have leadership that were willing to make care coordination a priority within their organizations and devote resources to it. In addition, leadership must be willing to provide the infrastructure to support and empower the individuals working to coordinate care. This was true for both models of care coordination.

Strategically determine the most appropriate approach for care coordination. Needs for care coordination and patient support differ—while Yolo focused on coordinating care from primary care, San Mateo made systems changes within the specialty clinics. Both coalitions assessed their needs for care coordination and planned accordingly for appropriate staffing, scope of work, and systems/processes to facilitate effective coordination.

"It's all about leadership and communication, having the leaders from the various players, the clinics, the hospital, the health department, in the same room on a semi-regular basis. It keeps the lines of communication open. Without the coalition, this would not function properly. There's no way we could go out there and do the work without having the context to put it in."

"I really believe that success comes from a grassroots effort, but ultimately you have to have leadership support and they have to see it as a priority and an action item."

Care Coordinator Position in Yolo County

The Person

- Clinical background.
- Familiar with both primary and specialty care environments.
- Strong communication skills to (1) be the liaison between the PCP, the specialist, and the patient in a system with limited resources; (2) be able to communicate clearly with the patient (language and health literacy are important components).
- "Thick skin"—Sometimes there is no availability for patients; must be able to demonstrate empathy without getting too close to patients.
- Ability to focus on case management related to Fair Share and not get overwhelmed with assisting patients with other needs

The Work

The care coordinator needs to:

- Be integrated into clinic functions. Have a support team with clinical and programmatic supervision.
- Have a reasonable case load, which depends on severity of illness, amount of follow up needed, and cooperation of health system.

Find the "right staff" to support your model. Depending on the care coordination model, the ideal staff person was different. Yolo's care coordination model relied on the skills of the person in the position to support patients (see box on page 6). In San Mateo, success was

dependent on people who saw themselves as "change agents" and were willing to think of creative ways to organize and delegate the work.

"Liberate people. Let people work to the top of their abilities, licenses, and imagination."

Identify and implement tools/systems to support more effective coordination.
Care coordination activities at both sites benefitted from the implementation of an electronic health record (EHR). The EHR created a more effective and efficient system for information exchange and communication between primary and specialty care providers, making the information more easily accessible and the process more transparent. The EHR also proved to be an effective tool for facilitating patient movement between primary and specialty care; however, it did not replace the importance of individuals assisting and supporting patients.

"Technology didn't fix our problems…[it's a] caring person that stands up and says to the specialists this is what we need to do for the patient. The computer just provides accountability."

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 systems/processes.

Standardize communication and processes across clinics and specialty areas. Both sites initially attempted to integrate care coordination in targeted specialty areas only, which led to confusion among patients, providers and staff.

- In Yolo, the case manager coordinated referrals for the five Fair Share specialties. Other referrals went through referral coordinators at the various clinic sites. There was ongoing confusion among providers and staff about which patients should go through which referral process, which resulted in some inconsistency in communications and information sharing.
- San Mateo piloted clinic redesign in five specialty clinics only. Project staff learned piloting it was more difficult than implementing across all specialty areas since the clinics share staff and it was confusing to switch back and forth between a redesign clinic and a non-redesign clinic. As a result, they quickly spread the redesign efforts to all 15 specialty care clinics.

"You have to have access before you have care coordination, there has to be somewhere for the patients to go to coordinate care."

Understand the specialty care environment and know the access points. At both sites, coordinating care in an environment that was always in flux—programs and resources available, eligibility criteria, and roles of staff—was challenging. As a result, both projects required ongoing monitoring and communication of changes across the health systems. There was acknowledgment that focusing on coordination is only possible when there are access points for specialty care. In communities where access is limited, initial focus may need to be on identifying alternate points of access before focusing on care coordination.

Results

Physicians and staff working on both projects highlighted several areas of impact on patient care based on their observations and experiences.

Increased access to timely specialty care. Both sites reported an increased ability to get patients access to needed specialty care services in an appropriate timeframe.

> *"It has increased access for our patients, without question. We went from a 172 day wait to see a neurologist to around 4….That is access."*

Decreased no-show rates. Both sites reported decreased no show rates. In San Mateo, this is perceived to be influenced by pre-registration. In Yolo, no-show rates for Fair Share patients were lower than for other types of referral.

> *"A key to success [is that] Amy and her 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."*

Improved patient experience and increased patient satisfaction. Results suggest both types of care coordination improve patient experience.

> *"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."*

> *"Our patients are very satisfied with the changes that we have made. They are learning that they don't need to show up 2-3 hours early because we will no longer disrupt our schedule to put others in. And they will be seen on time."*

Formalized relationships. At both sites, the collaborative approach to designing and implementing these projects and models have built relationships, improved communication and established or strengthened an infrastructure for developing solutions to specialty care access.

> *"I think that we have opened access. [But] more importantly, we have opened the doors of communication so that when access is cut off, we can still move forward."*

Yolo Success Story

"I was thanked the other day by this lady who had needed to see a neurologist for more than a year. The PCP was struggling to get her access and was trying to do things in the primary care setting. The patient was unsure if she was being referred to a neurologist or not. We were able to get her into a neurologist at Kaiser–Sacramento, but she lived in Davis without transportation to the facility, which was an hour drive away. We have money in our grant to pay for transportation if needed, so we were able to send her to her appointment in a taxi. She was so grateful. But that's my job. You forget that this woman has been waiting for over a year to make that happen. So it's nice to be able to help people out. It has a huge impact on those individual lives."

Improved care coordination. Both patient and system-level models were perceived to improve overall care coordination.

> *"Also on an individual patient level, our case management is really different than the way CommuniCare has managed referrals in the past. Typically it was that you call the health system and make sure the referral was scheduled and put the chart away. Now we don't wait for our patients to do anything, we are really proactive and hands on. In addition to managing referrals, we do things like help people get their YCHIP coverage reinstated….We help them get the services they need."*

> *"The work improvement on the flow of patients from primary care to specialty paralleled the change-over to EMRs. This improved the level of communication, created a paper trail and helped patients know they are going where they need to go."*

Sustainability and next steps

Yolo has demonstrated the benefits of a dedicated case manager to coordinate care for patients. However, it is a resource intensive model. As the Fair Share program grows, the sole case manager has struggled to keep up with the demand for services. With no reimbursement mechanism in place, it is difficult to spread this position to meet demand for services. One approach may be to provide case management for a small volume of high-need patients, participating in a specific program. The definition of "high need" is still unclear and this approach would not resolve the ongoing confusion among providers and staff when there are different referral processes for different patients. In addition, there are ongoing questions about who should pay for care coordination, since it is benefiting the entire safety net system in Yolo County.

In San Mateo, pre-registration and central registration have been fully integrated in SMMC operations and will be sustained. Other redesign strategies have not gotten as much traction and require ongoing efforts to fully implement and sustain those activities. Redesign efforts also created linkages with the internal Community Health Advocates to more effectively connect patients to other community resources. An ongoing challenge is fully extending improvements in communication patterns and referral methods and processes to their external partner, Ravenswood, to better coordinate care for patients being referred into SMMC Specialty Clinics. This challenge is partly due to differences in management agendas and technology platforms (e.g., EMR).

Both sites must address considerations regarding continued staff engagement. For Yolo, the concern is centered on the care coordinator being overburdened and potentially burning out. It is a stressful position trying to meet the needs of the primary care provider, specialist and patient within a resource limited environment. San Mateo requires ongoing effort to fully implement the other four strategies in their specialty care redesign project. However, SMMC's Specialty Clinics recently implemented EMR and other process improvement initiatives, which may have shifted priorities to other projects and created some change fatigue.

Both Yolo and San Mateo may have opportunities to strengthen and sustain their models through federal health care reform. Care coordination is a key component of the Affordable Care Act and there may be new mechanisms for funding it; although there continue to be questions about how that will be structured and how to sustain activities in the meantime.

For more information about other work that was conducted as part of the Embedding Guidelines into the Referral Process cluster or SCI as a whole, please see the full initiative evaluation report from October 2011.