

## Frequently Asked Questions from the 11/21/14 Webinar

### Vital Connections: Results of the Specialty Care Initiative (SCI) Final Evaluation

The following questions or themes arose during the webinar presentation of the final evaluation results from the Specialty Care Initiative on November 21, 2014. Responses have been provided by the evaluation team from the Center for Community Health and Evaluation (CCHHE). [Click here](#) to be redirected to a recording of the webinar.

#### Coalitions

**Q:** Were there any particular theories or frameworks you drew upon to evaluate coalition functioning?

**A:** We assessed coalition functioning using a coalition survey CCHHE has used in other evaluations of collaborative efforts. The survey is based on research related to partnering and collaboration and adapted from validated tools including the work of Frances Dunn Butterfoss and CoalitionsWork. Survey data was triangulated with qualitative data collected from interviews and site visits with SCI project leads and coalition members.

**Q:** In terms of coalition members – what types of members would create a more effective coalition – e.g., representatives from PCPs, specialists, local health plans? Who were the “must haves”?

**A:** The essential members of a coalition depended on the local health system, but most SCI coalitions included representatives from organizations providing primary care to the safety net and the public hospital where one existed. Other potential partners included the regional clinic consortia, local health collaboratives, Kaiser Permanente, private specialists, health plans, independent practice associations (IPA), and health departments.

**Q:** Did the coalitions involve any specialty care providers, beyond those who were involved with the participating hospitals?

**A:** Yes. Many coalitions attempted to engage private specialists in their SCI efforts (especially in counties with no public hospital), typically to either provide services to patients through volunteer models and/or offering training or consultation to primary care providers. Volunteer models were initially a popular strategy, but coalitions struggled due to various challenges, including establishing the infrastructure to support volunteer specialists, liability concerns, and issues with scopes of practice.

**Q:** What were the motivations of, or incentives to, coalition members to participate in the SCI: hospitals? PCPs? Specialists?

**A:** The SCI grant was awarded to a lead agency that typically convened and coordinated the coalition. There was no uniform way in which SCI coalitions distributed funds. Relatively few coalitions provided monetary incentives to coalition members for participating in the coalition. Coalition members reported participating because they felt that they had access to key

partners in the safety net, their participation was beneficial for their patients or organization, and they saw the success of the coalition in achieving systemic change.

**Q:** How did the coalitions work most effectively with private providers who agreed to take a limited number of uninsured or MediCal patients?

**A:** Successful coalitions focused on engaging private providers, starting with what the specialist offered. They found that once specialists were engaged they were more willing to offer to provide services. Often this engagement began with providing a training to PCPs or participating in round table discussions with other providers. When specialists were willing to see patients, it worked best when there was logistical support and effective systems for communication, information exchange and care coordination. It was critical that the coalition be able to fill the appointment slots available. Generally these coordination tasks were the responsibility of the primary care clinics.

## **Strategies**

**Q:** Were there particular **specialties that were frequently targeted**? That saw traction?

**A:** Orthopedics and gastroenterology were the most frequently targeted specialties throughout SCI, likely due to demand on the system in both of these areas. Addressing these two specialties was a challenge since both require specialist expertise in procedures to meaningfully address access issues. More than five coalitions targeted neurology, cardiology, dermatology, ophthalmology and rheumatology. These specialties often got more traction since there were opportunities to increase primary care and mid-level capacity to address more routine complaints related to these specialties.

**Q:** What best practices emerged around **communicating these guidelines widely**?

**A:** Promising practices for communicating guidelines began with guideline development. Successful coalitions engaged both primary care providers and specialists in the development of the guidelines to ensure they were practical and realistic. Afterward, conducting outreach to the users of the guidelines (i.e., providers, clinical staff, referral coordinators) and engaging them in a dialog about how to use the guidelines as a tool to effectively refer their patients helped to ensure understanding and buy in. This occurred through in-person meetings, training opportunities, roundtable discussions, and case conferences. Guidelines were most effectively implemented when integrated into other systems change efforts.

## **Impact**

**Q:** Do you have any examples of ongoing collaboration between entities who built relationships during the SCI?

**A:** The six SCI coalitions funded in Los Angeles County continue to work together through a county-wide group funded by Kaiser Permanente Southern California Community Benefit. The group is leading the spread of promising practices tested during SCI (integrating care coordination and increasing PCP capacity) throughout the county. Most other coalitions

indicated that collaboration would continue, but no formal follow up has been conducted to assess the extent to which that has occurred.

**Q:** What types of changes did you see in grantees' data collection, tracking and reporting systems?

**A:** Across the initiative, coalitions improved data quality. They achieved that improvement in different ways. For example, some coalitions implemented new, electronic referral systems; others expanded the use of their EHRs and disease registry systems. But often improvements were made by simply asking questions about the data, addressing gaps, improving the process of tracking data.

**Q:** What efforts did you see to make data accessible/transparent across coalitions, between organizations?

**A:** Coalition members said that SCI helped them to understand what data were available. Several coalitions reported that SCI required that they share data with partners for the first time. In some cases, partners set up formal systems or processes for regularly sharing relevant data. In others, partners brought print outs of graphs to show trends as the basis for discussions at coalition meetings. A few coalitions reported that sharing the data in coalition meetings and comparing data across clinics helped them to share promising practices and discuss challenges, which helped facilitate further improvements.

**Q:** Can you give examples of coalitions using data to drive decisions?

**A:** One example, discussed as an example in the webinar, is the Alameda County Specialty Care Task Force. This coalition extensively reviewed and discussed the public hospital's referral data to better understand the relationship between specialty care capacity and demand. The quality and reliability of the data improved to the point that it was used to drive hiring decisions at the hospital. As a result of targeted recruitment and hiring of specialists, the number of specialty appointment slots increased by over 30% during the SCI period.