Vital Connections:
Results of the Specialty Care Initiative, 2008-2013

Evaluation Report

Prepared by the Center for Community Health and Evaluation

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KAISER PERMANENTE®

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Executive Summary

In late 2007, Kaiser Permanente's Northern and Southern California Regions' Community Benefit Programs and the California HealthCare Foundation (CHCF) launched the Specialty Care Initiative (SCI) to address the growing need for specialty care among the safety net population in California. The goals of SCI were to: (1) increase access to specialty care for vulnerable populations; (2) decrease and improve demand management for specialty care; and (3) improve the health care delivery system for the safety net. Kaiser Permanente and CHCF recognized that while the problems of access to specialty care were widely shared across the state, solutions arise based on local strengths and developing community-based solutions requires a coordinated response. As a result, the funders mandated a coalition approach as a mechanism to engage the various partners required to develop and implement strategies to address the complex issues of specialty care demand and access within their community.

At the end of the five-year initiative, the evaluation found that overall SCI coalitions were successful in improving access to specialty care and indicated that they were better positioned to effectively respond to current changes in the health care environment (e.g., implementing health care reform or patient-centered medical home).

A primary outcome of SCI for most participating coalitions was **improved relationships** among safety net providers in their county. These new and strengthened relationships resulted in increased access to specialty care for patients by improving communication, establishing more efficient processes, and building partnerships that helped to establish a more integrated system of care. Coalitions attributed their success in relationship development both to the funded opportunity to work collaboratively toward a common goal (i.e., to improve the system of delivering specialty care) and the requirement that they use or establish a coalition to drive the work. Coalitions indicated that these strengthened relationships created a solid foundation that they could use to more effectively respond to the needs of the safety net in the future.

Additionally, most coalitions reported an **increased ability to track and report on specialty referral data**, which included improved data quality and more frequent use of data for decision making. Qualitatively, many coalitions reported increased understanding of which data they needed to assess their efforts—"*we now know what to look at*." Several coalitions reported that this helped inform the design and implementation of data fields and reports built into new electronic systems and helped them move forward toward meeting Meaningful Use requirements.

Many coalitions reported that the individual strategies implemented through SCI resulted in **systems changes that improved access to specialty care**. By the end of SCI, coalitions reported that more patients were getting the right care, at the right time, in the right place, from the right provider. For example, one coalition was able to decrease wait time in one specialty by over 60% by implementing patient discharge criteria. Another coalition saw a 34% growth in specialty visits after using referral data to demonstrate demand and make the case for specialty expansion at the public hospital.

The following report summarizes the results of the five-year implementation phase of the Specialty Care Initiative. Results are organized by the three evaluation questions that drove the evaluation of SCI implementation: (1) How successful has SCI been in stimulating the implementation of new strategies or models among coalitions?; (2) How successful has SCI been in spurring new, stronger and more sustainable coalitions?; and (3) How successful has SCI been in improving access to specialty care?

I. Description of SCI

A. Context

In 2007, more than one in five Californians lacked health insurance. Since then, that proportion has continued to grow, placing a growing demand on the health care safety net for both primary care and specialty care services.[1] The safety net specialty care system was challenged in many communities, with an inadequate number of specialists available and lack of coordination between primary and specialty care providers.[2]

Kaiser Permanente and The California HealthCare Foundation (CHCF) were committed to supporting interventions that ensure patients' and providers' specialty care needs were met in timely, cost effective, and clinically appropriate ways. In late 2007, Kaiser Permanente's Northern and Southern California Regions' Community Benefit Programs and CHCF launched the jointly funded Specialty Care Initiative (SCI). Kaiser Permanente and CHCF recognized that the problems of access to specialty care were widely shared and solutions needed to arise based on local strengths. Developing community-based solutions required a coordinated response. As a result, the funders mandated a coalition approach as a mechanism to engage the various partners required to develop and implement strategies to address the complex issues of specialty care demand and access within their community.

The goals of SCI were to: (1) increase access to specialty care for vulnerable populations; (2) improve demand management for specialty care; and (3) improve the health care delivery system for the safety net. SCI aimed to reach these goals by supporting community coalitions, consisting of providers and other key partners in the safety net, in implementing comprehensive, long-term strategies that would result in systems change and increase the capacity of local safety net organizations to effectively address the specialty care needs of uninsured/underinsured populations in their communities.

During the five years of the initiative, there were significant changes in the health care environment that provided both opportunities and challenges for the funded coalitions. These changes included (but were not limited to):

- Inclusion of funding for health information technology through the American Recovery and Reinvestment Act (ARRA), which expanded implementation of electronic health records (EHR) to be in compliance with Meaningful Use requirements;
- Federal Patient Protection and Affordable Care Act (health care reform) passed, which included the expansion of Medicaid;

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

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

- Various modifications to Medi-Cal (California's Medicaid program) affecting patient enrollment and benefits including implementation of the 1115 Waiver supporting the development of Low-Income Health Plans and the establishment of patient-centered medical homes;
- Economic recession resulting in increased numbers of un- and under-insured patients and decreased tax revenue supporting local public health and medical systems.

B. SCI Overview

Late 2007: 28 coalitions across the state received funding for a one-year planning phase (21 funded by Kaiser Permanente and seven by CHCF). During planning, coalitions were required to conduct a needs assessment to determine specialty care priority areas and develop an implementation plan detailing the strategies and activities the coalition would employ to increase access in those specialty areas identified as high need in their assessment (e.g., dermatology, neurology).

2009: 24 grantees received funding for implementation (21 funded by Kaiser Permanente and three by CHCF). CHCF and Kaiser Permanente Northern California awarded two-year grants; Kaiser Permanente Southern California awarded three-year grants.

2011: Kaiser Permanente Northern California awarded two years additional funding to five of its grantees implementing promising strategies.

2012: Kaiser Permanente Southern California awarded one year additional funding to five of its grantees to support sustainability and spread (Table 1).

Table 1: SCI Implementation Grant Awards 2009-2012

	# of implementation grants awarded (duration of grant)	Total implementation grant award for each coalition*	# of continuation grants awarded (duration of grant)	Total continuation grant award for each coalition
Kaiser Permanente Southern California Region's Community Benefit Program	11 (3 years)	$900,000	5 (1 year)	$150,000
Kaiser Permanente Northern California Region's Community Benefit Program	10 (2 years)	$600,000	5 (2 years)	$200,000
California HealthCare Foundation	3 (2 years)	$250,000	0	N/A

*does not include 3 coalitions that ended participation in SCI in year 1

In addition to grant funding, SCI coalitions participated in a Technical Assistance Program coordinated by Community Partners in Los Angeles. In October 2008, Kaiser Permanente and CHCF contracted with the Center for Community Health and Evaluation (CCHE) to evaluate SCI's implementation phase.

C. Participating coalitions

Twenty-four coalitions were granted implementation funds through SCI in 2009. Within the first year, three coalitions ceased participation in SCI due to staff turnover, shifts in organizational priorities, and/or the funder opting to discontinue the grant. SCI coalitions were located throughout the state of California (see map). The majority of coalitions targeted one county; however, one CHCF grantee worked in four counties in northern California and six separate coalitions targeted different parts of Los Angeles County (**Table 2**).

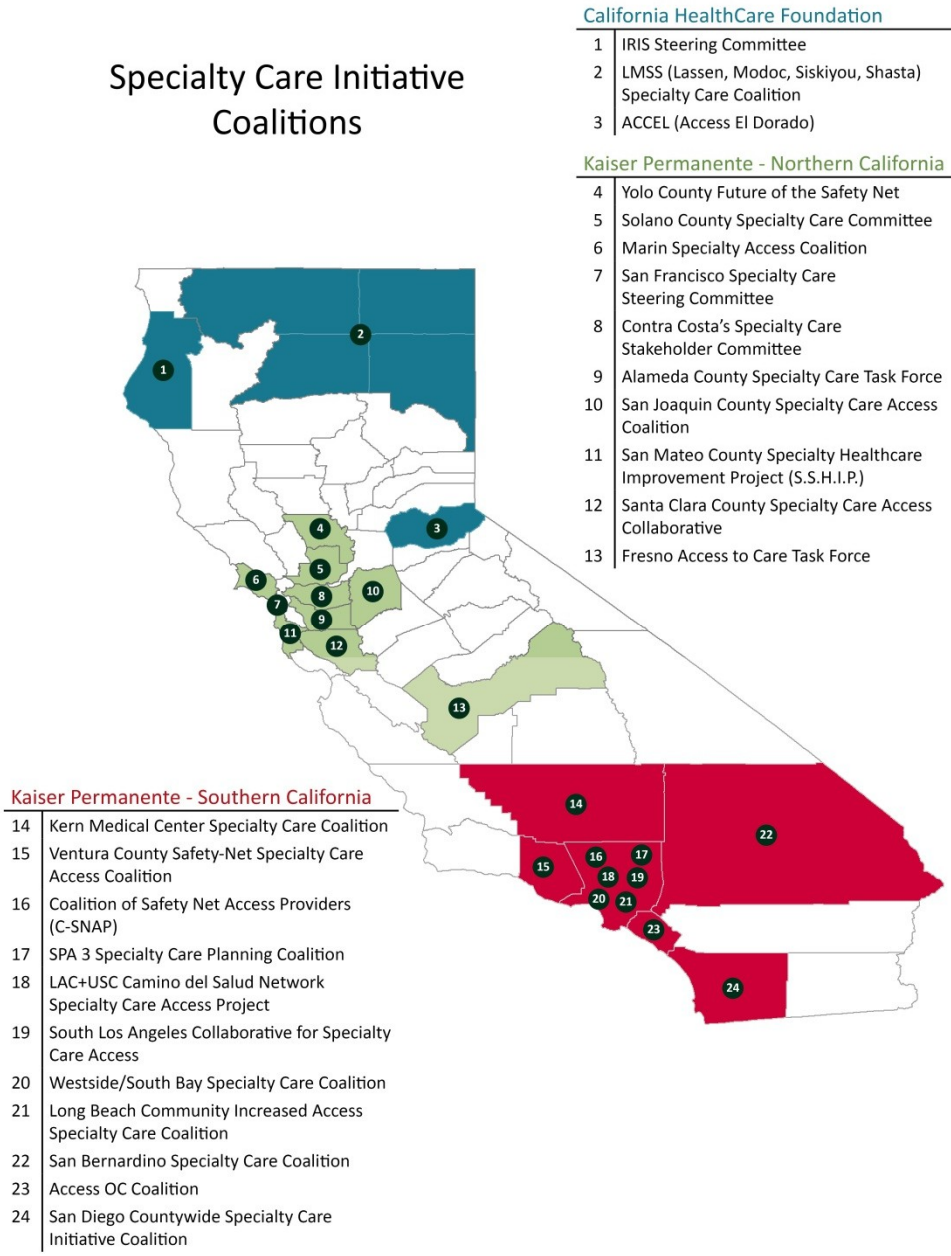


Table 2: Description of Participating Coalitions

Funder	Coalition	Grantee (Lead Agency)	Lead Agency Type	Existing Coalition	Length of funded period
CHCF	ACCEL (Access El Dorado)	El Dorado Department of Public Health	Health Department	Yes	Grant ended June 2011
CHCF	LMSS (Lassen, Modoc Siskiyou, Shasta) Specialty Care Coalition	Health Alliance of Northern California	Clinic Consortium	No	Grant ended June 2011
CHCF	IRIS Steering Committee	Humboldt-Del Norte IPA	IPA/Health Plan	Yes	Grant ended June 2011
Kaiser Permanente NCAL	Alameda County Specialty Care Task Force	Alameda County Medical Center	Public Hospital	Yes	Grant scheduled to end December 2013
Kaiser Permanente NCAL	Santa Clara County Specialty Care Access Collaborative	Community Health Partnership	Clinic Consortium	No	Grant ended March 2013
Kaiser Permanente NCAL	Contra Costa's Specialty Care Stakeholder Committee	Community Clinic Consortium of Contra Costa	Clinic Consortium	No	Grant ended June 2011
Kaiser Permanente NCAL	Fresno Access to Care Task Force	Fresno HCAP	Health-related Coalition/ Collaborative	Yes	Grant ended March 2013
Kaiser Permanente NCAL	Marin Specialty Access Coalition	Marin Community Clinic	Community Clinic	No	Grant ended December 2010
Kaiser Permanente NCAL	San Francisco Specialty Care Steering Committee	San Francisco General Hospital	Public Hospital	No	Grant ended August 2013
Kaiser Permanente NCAL	San Joaquin County Specialty Care Access Coalition	San Joaquin Health Plan	IPA/Health Plan	No	Grant ended March 2012
Kaiser Permanente NCAL	San Mateo County Specialty Healthcare Improvement Project (S.S.H.I.P.)	San Mateo Medical Center	Public Hospital	No	Grant ended March 2012
Kaiser Permanente NCAL	Solano County Specialty Care Committee	Solano Coalition for Better Health	Health-related Coalition/ Collaborative	Yes	Discontinued in Spring 2010
Kaiser Permanente NCAL	Yolo County Future of the Safety Net	CommuniCare Health Centers	Community Clinic	Yes	Grant ended May 2013
Kaiser Permanente SCAL	AccessOC Coalition	AccessOC	Health-related Coalition/ Collaborative	Yes	Discontinued in Spring 2010
Kaiser Permanente SCAL	San Bernardino Specialty Care Coalition	Latino Health Collaborative	Health-related Coalition/ Collaborative	No	Discontinued in Fall 2009
Kaiser Permanente SCAL	Coalition of Safety Net Access Providers (C-SNAP)*	Valley Care Community Consortium	Health-related Coalition/ Collaborative	Yes	Grant ended December 2012
Kaiser Permanente SCAL	Kern Medical Center Specialty Care Coalition	Kern Medical Center	Public Hospital	No	Grant ended March 2012
Kaiser Permanente SCAL	LAC+USC Camino del Salud Network Specialty Care Access Project*	LAC+USC Healthcare Network	Public Hospital	Yes	Grant ended March 2013

Funder	Coalition	Grantee (Lead Agency)	Lead Agency Type	Existing Coalition	Length of funded period
Kaiser Permanente SCAL	Long Beach Community Increased Access Specialty Care Coalition*	The Children's Clinic	Community Clinic	No	Grant ended December 2011
Kaiser Permanente SCAL	San Diego Countywide Specialty Care Initiative Coalition	Council of Community Clinics	Clinic Consortium	Yes	Grant scheduled to end December 2013
Kaiser Permanente SCAL	South Los Angeles Collaborative for Specialty Care Access*	Southside Coalition of Community Health Centers	Health-related Coalition/ Collaborative	Yes	Grant scheduled to end September 2013
Kaiser Permanente SCAL	SPA 3 Specialty Care Planning Coalition*	East Valley Community Health Center	Community Clinic	Yes	Grant scheduled to end September 2013
Kaiser Permanente SCAL	Ventura County Safety-Net Specialty Care Access Coalition	Health Care Agency of Ventura County	Public Hospital	No	Grant scheduled to end December 2013
Kaiser Permanente SCAL	Westside/South Bay Specialty Care Coalition*	Venice Family Clinic	Community Clinic	No	Grant ended March 2013

*Coalition located in Los Angeles County

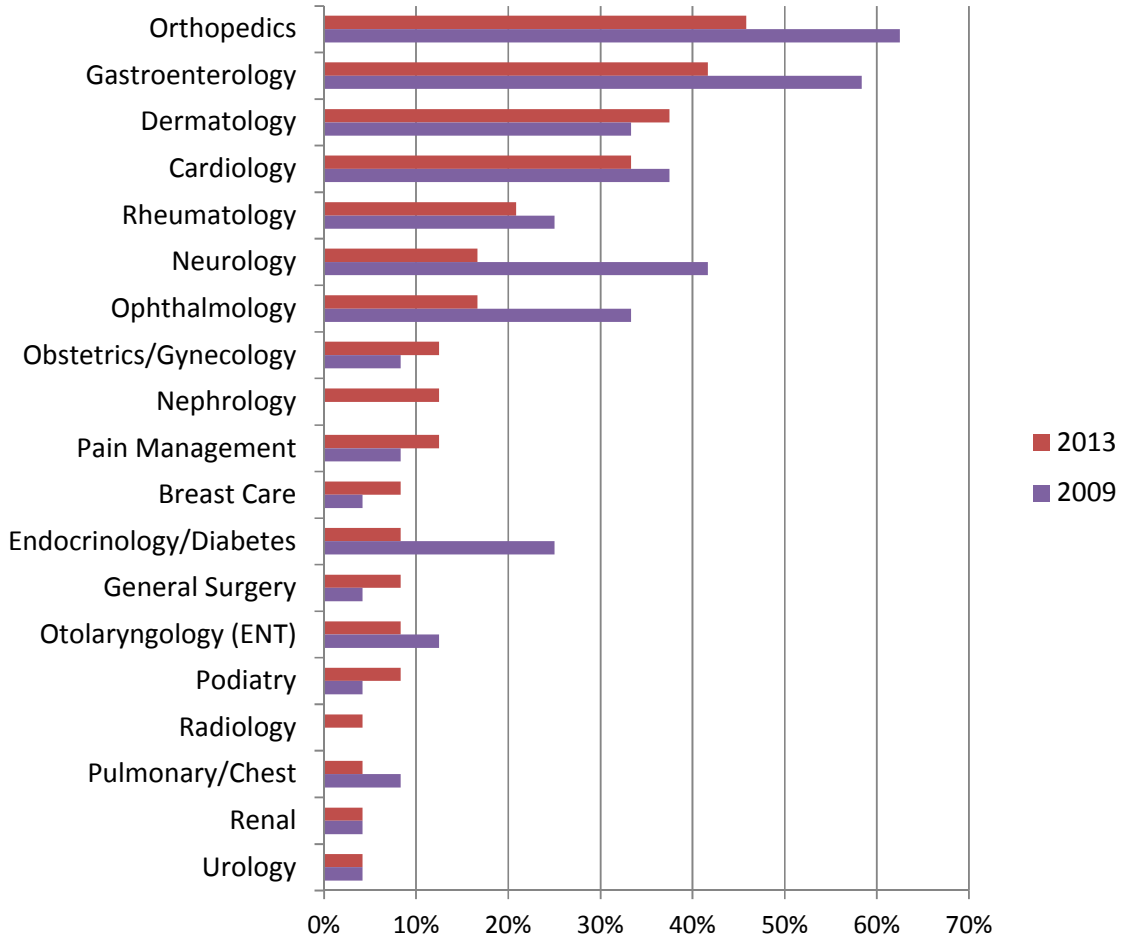
D. Target Population

Almost all coalitions' work within the initiative was aimed to influence all or the vast majority of safety net patients (both underinsured and uninsured patients) in their county or region. A few coalitions focused more narrowly on specific segments of the safety net that had more difficulty getting access to needed services (e.g., undocumented workers, only uninsured).

E. Specialty Areas of Focus

As part of the planning process, coalitions were required to identify the 3-5 most impacted specialty care areas (i.e., the largest gap between demand and capacity) to inform their implementation strategies. Generally, coalitions used those high need specialty areas to focus their work in the beginning of the initiative. However, over time, some coalitions struggled to get traction in specialties of high need and instead took a more opportunistic approach and focused on areas where there was a willing champion or a clear pathway for implementing a strategy (**Figure 1**). By 2013, the work did not always align with the 3-5 areas that were identified at the beginning of the initiative, however, orthopedics and gastroenterology (GI) were consistently the two most targeted specialty care areas during SCI. Fourteen coalitions addressed referral systems or processes that impacted all or most of their specialty clinics/referrals.

Figure 1: Specialty Areas of Focus



II. Evaluation Design & Data Collection

The evaluation was designed to answer three questions that the funders articulated for the initiative (see box). Based on these, CCHE collaboratively developed a logic model with Kaiser Permanente's Northern and Southern California Regions' Community Benefit Programs and CHCF to guide the evaluation. The logic model articulated intermediate outcomes to assess progress towards the long-term outcome of improving access to specialty care. Intermediate outcomes included:

- Increased access to timely specialty care
- Improved referral coordination
- Improved demand management for specialty care services
- Increased availability of specialty care appointments
- More appropriate referrals to specialty care
- Decreased no-show rates

Specialty Care Initiative (SCI) Evaluation Questions

- How successful has SCI been in stimulating the implementation of new strategies or models among coalitions? Which strategies or models appear to be the most successful and have the greatest potential for replication?
- How successful has SCI been in spurring new, stronger and more sustainable coalitions?
- How successful has SCI been in improving access to specialty care?

The logic model was reviewed annually to ensure that it was reflective of any changes in SCI; although no major changes were made. The final logic model is included as **Attachment A**. Based on the evaluation questions and logic model, a series of evaluation sub-questions and more specific indicators were developed. A summary of the evaluation plan is included as **Attachment B**.

To better assess progress for similar strategies being implemented across coalitions, proposed strategies were grouped into four "strategy clusters," which included: embedding guidelines into the referral process, building/expanding specialty care networks, increasing primary care provider (PCP) capacity/scope of practice, and integrating care coordination. These strategy clusters, discussed in detail later in this report, were used to guide peer learning opportunities, as well as evaluation activities.

Once this framework was established, a data collection plan was created. The evaluation design used a mixed methods approach to collect both quantitative and qualitative data to answer the evaluation questions. Routine data collection with SCI grantees included: semi-annual grantee progress report interviews, a survey of all coalition members, quarterly data reports on quantitative measures, and document review of progress and final reports. In addition, site visits, provider interviews, and coalition member interviews were conducted with a sample of case study sites that had demonstrated promise in 2011 (site visits and provider interviews) and 2013 (coalition member interviews). See **Attachment C** for more information on the data collection methods for the five-year evaluation.

During evaluation design, there was a desire to reach agreement on a set of quantitative indicators to assess progress toward improving access to specialty care. However, there were not industry standard indicators used to assess specialty care access. As a result, the SCI funders identified over 60 potential indicators that could be tracked to assess specialty care access. From that list, CCHE, in collaboration with the funders and grantees, identified and defined a smaller set of indicators to be used in the evaluation. To do this, CCHE facilitated four webinar discussions and conducted an assessment of coalitions' data collection capacity to inform the selection of four quantitative measures to assess progress on SCI strategies. The indicators identified as most useful and feasible to collect included: wait time for specialty appointments, referral volume, disposition of referral (i.e., referrals denied), and no-show rates. Coalitions were provided "recommended definitions" for these measures (see box), but the initial assessment indicated that funded coalitions were at different stages in their ability to collect these data. Some had access to electronic systems and could pull reports on most of these data, while others had not yet reached agreement about which measures to collect. Even those with existing systems were often defining the measures and collecting data differently than the recommended approach.

Recommended Definitions

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

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

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

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

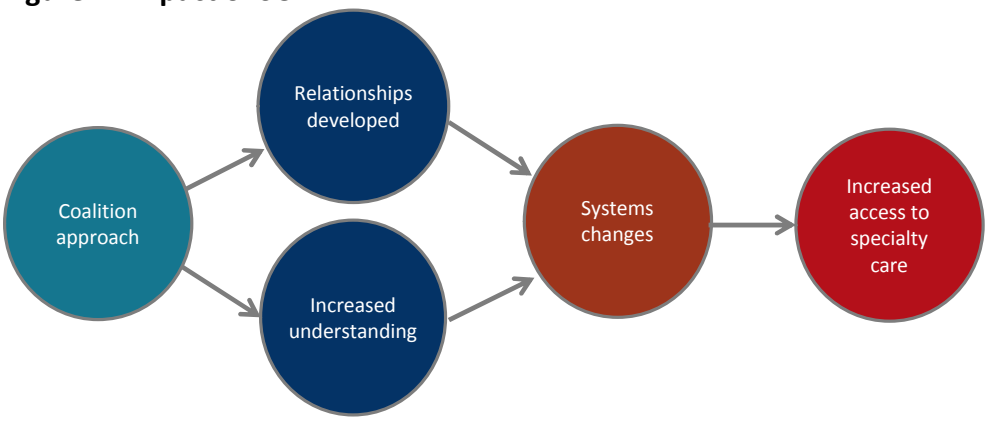
As a result of this variation across coalitions, in both capacity and approach, the SCI evaluation allowed coalitions to customize the definition so that it could be meaningfully operationalized. This focused on building capacity for data collection in a way that was meaningful for each coalition, but resulted in significant enough differences in how the measures were defined and how data was collected to make aggregating data across the initiative not feasible. As a result, the evaluation used a case study approach to assess the quantitative data—looking for trends within each coalition, rather than across coalitions.

Coalitions were required to collect and report on these measures quarterly during their first implementation grant. For coalitions that received additional SCI funding, they had the option of modifying their data reporting measures to be more closely aligned with their strategies.

III. Evaluation Findings

SCI required a coalition approach, which led to stronger relationships among safety net providers and helped raise awareness and increase understanding about the challenges related to specialty care access. As a result, coalitions were able to make changes in their local health systems that led to increased access to specialty care (**Figure 2**). By the end of SCI, more patients were able to receive the right care, at the right time, in the right place from the right provider.

Figure 2: Impact of SCI



The results of the SCI evaluation are structured in response to the three evaluation questions posed for the initiative, which correspond to the outcomes listed in **Figure 2** (**Table 3**).

Table 3: SCI Impact by Evaluation Question

Evaluation Question	SCI Impact
• How successful has SCI been in spurring new, stronger and more sustainable coalitions?	Relationships developed & increased understanding of the safety net delivery system as a whole
• How successful has SCI been in stimulating the implementation of new strategies or models among coalitions? Which strategies or models appear to be the most successful and have the greatest potential for replication?	Systems change & sustainable solutions to improving access
• How successful has SCI been in improving access to specialty care?	Increased access to specialty care

A. Building and Strengthening Coalitions

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

During planning, a key outcome identified for SCI was that coalitions of stakeholders would develop a community-based and coordinated response to increasing access to specialty care. To ensure a community-based and coordinated response, SCI funders required that the work be directed by a coalition, as a mechanism to actively involve multiple institutions and various roles in the safety net (e.g., providers, administrators, payors) in strategy development, implementation and oversight. The coalition was expected to select and drive implementation strategies that would benefit the entire safety net system rather than just one provider or institution.

Description of SCI coalitions

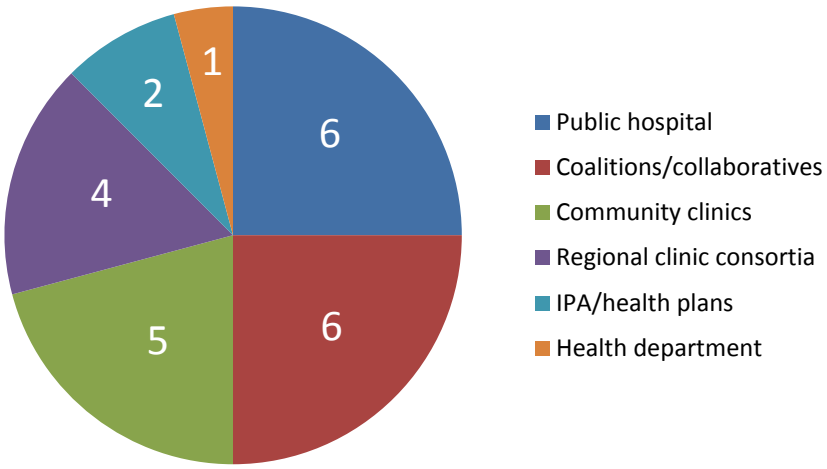
SCI coalitions:

- **Had a history of working together**. Half of the coalitions (n=12) were in existence prior to SCI. These coalitions typically had formed around broader health care access issues and SCI created a focus on specialty care access. Some existing coalitions formed a sub-committee to work on this initiative, while others incorporated SCI work into existing coalition structures. The remaining 12 coalitions formed in response to this initiative; although, in most cases, there were existing relationships in place and key partners had previously worked together.
- **Focused on specialty care access during SCI.** Over half of the coalitions (13/24) focused exclusively on improving specialty care access during SCI.
- **Consisted of a variety of different types of organizational partners.** All coalitions (24) had the participation of the primary care safety net providers in the area, including local community health centers. A majority of coalitions also included the local public hospital (15/24). (Not all coalitions had public hospitals in their county.) Other key coalition members included:
    - Private hospitals or specialty practices (11/24)
    - The local health department (11/24)
    - The local health plan or other insurer (9/24)
    - Kaiser Permanente (9/24)
    - Regional clinic consortia (8/24)
- **Included significant representation from administrative leadership (e.g., CEOs).** The vast majority of coalitions included administrative leaders. In 2009, half (109/220) of coalition survey respondents identified as administrative leadership. Clinical leadership and administrative or project staff were each about 15% of survey respondents.

Lead agencies

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

Figure 3: SCI Lead Agencies (n=24)



Benefits of a using coalition approach to improve specialty care access

Overall, SCI grantees considered a collaborative approach essential to improving specialty care access in a region. As one grantee explained: "*You have to [use a collaborative approach]. There's no other way to do it. There's no other way to have success in this unless you have everyone at the table and talking. Nobody can do it on their own*."

> *"We don't have enough clout to get movement [on our own as an individual clinic.] We speak with a bigger voice when we are grouped together. I think collaboration…is very important."*

In the 2013 coalition member survey, 74% (72/97) respondents indicated that their coalition was either an "*effective*" or "*very effective*" mechanism for addressing specialty care access in their community. Members cited a number of benefits to using a coalition approach and credited it for improving the relationships and communication between partners, which helped to ensure strategies were relevant to the safety net as a whole rather than just one organization (**Table 4**).

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

Table 4: Coalition members' reported benefits to using a coalition approach

Coalition benefit	% of coalition members identifying in top 3[4] (n=95)	Quote
Improving communication between key partners	65%	*"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. Keeps the lines of communication open. Without the coalition, this would not function properly. No way we could go out there and do the work without having the context to put it in."*
Establishing buy in and involvement from key partners	55%	*"[We] never would have gotten buy-in of specialists and office staff without [the coalition]."*
Leveraging existing resources and expertise in the community	52%	*"I think it made a difference in understanding the resources that we had within our own groups and ensuring those resources and it allowed us to refer among ourselves and we could get more benefit for example by having podiatry clinics at one site. Leveraging our resources so they can be utilized by more sites and we were able to get that done….we were able to really discuss other issues too where we saw abilities to do things together and get more out it."*
Prioritizing strategies appropriate to the local safety net as a whole	49%	*"Biggest benefit of [coalition] is that you have a broader group of stakeholders at the table. So it's not just viewed as clinic initiative or Kaiser Permanente initiative. But you can have discussions about how does this impact our system of care, with all perspectives represented. We get siloed at focusing internally at the clinics."*
Promoting collaborative decision making	37%	*"[Coalition] has allowed for rich collaboration, input from specialties, role of referral, and trying to seek better input. Better insight as to what specialists are thinking and how can we create efficiencies."*
Increasing understanding between partners of processes, resources, and constraints	33%	*"But we're a partnership, they [the community health center] rely on us [the public hospital] and their patients are ours. I think that goes back to our health care system, the people that are here have worked with different entities on different projects. We understand issues and constraints and we're all trying to solve the same problems."*
Providing an opportunity for new people to take leadership roles	16%	*"I think [the coalition] allowed a forum for providers who have leadership abilities to rise and have a voice. One of the biggest successes of SCI."*

[4] Quantitative results based on the 2013 coalition member survey, which included a sample of 14 SCI coalitions. Results are reflective of qualitative data collected throughout SCI.

Coalition benefit	% of coalition members identifying in top 3[4] (n=95)	Quote
Distributing funding and other resources to all partnering organizations	6%	*"One huge accomplishment is sharing data. That's happening in the collaborative. Historically, sharing data has been a big barrier, and we seem to have gotten over that."*

"It brings together people from the hospital and community partnership to work on specialty care, but we also can address other issues that come up. You can't replace the importance of these meetings with one-on-one meetings. None of us have all pieces of the puzzle. It helps develop relationships to develop further work that needs to happen. The individuals that I have met have offered me the ability to know who to go to when I need something done; had I not been part of that committee I wouldn't have been able to figure out how to get things resolved. The coalition's role is oversight, strategic planning and nuts and bolts of implementation. You have the key players there-we have people who go out to make the actual changes that need to happen."

SCI coalition engagement & functioning

SCI aimed to engage and empower community health coalitions in developing local solutions to specialty care access. To determine the effect of SCI on community coalitions, the evaluation assessed coalition engagement and functioning throughout the initiative. A primary source of data was a web-based survey administered to all coalition members in November 2009 and April 2011, and administered to a sample of 14 coalitions in May 2013. The following results are based on these survey data, as well as qualitative data collected throughout the initiative.

SCI coalitions evolved throughout SCI. Many coalitions evolved over the course of the initiative in terms of scope, structure, and membership based on **relationships needed** and **strategies of focus and how the work evolved**.

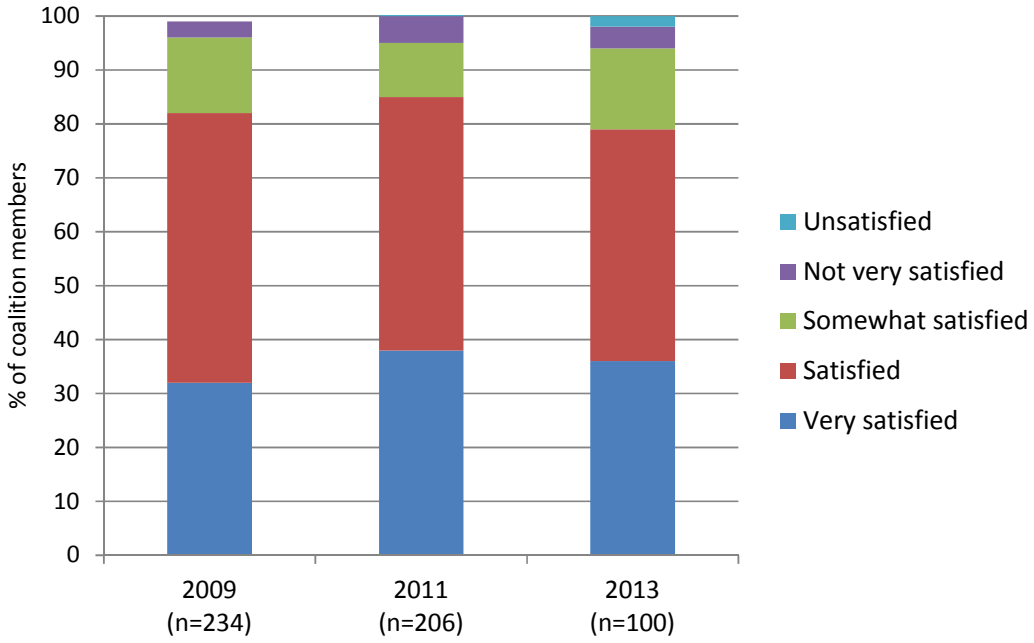
Relationships needed: Developing a community-wide response to specialty care access required the involvement of stakeholders from various organizations. At the beginning of SCI, most coalitions, both with and without existing structures, spent a significant amount of time making sure they had the right organizations and individuals engaged to accomplish their SCI objectives. They used the coalition as a mechanism for developing and expanding relationships to ensure they had representation from the safety net as a whole.

Strategies of focus/how the work evolved: At the beginning of SCI, it was important that coalitions had high engagement from leaders of various organizations as priorities were selected and strategies were developed. However, as implementation got underway, some coalitions found that their needs changed in terms of the perspectives that they needed to have at the

table and how frequently they needed to convene. As the work progressed, a number of coalitions adjusted their structure to include: (1) a group of leaders from the key partners for high level oversight and decision making, which could meet less frequently; and (2) work groups to focus on the day-to-day details of strategy implementation. These work groups often required the engagement of providers, clinical and front-line staff to ensure that strategies were grounded in the realities of existing practice and workflow. Mindful of the various demands on providers' time, some coalitions effectively engaged providers in an ad hoc way versus having them participate as standing coalition members.

Even as coalitions changed and adapted to support their work related to SCI, member perception of coalition functioning remained relatively high throughout the initiative—around 80% of survey respondents were either '*very satisfied'* or *'satisfied'* with the functioning of their coalition overall throughout SCI (**Figure 4**).

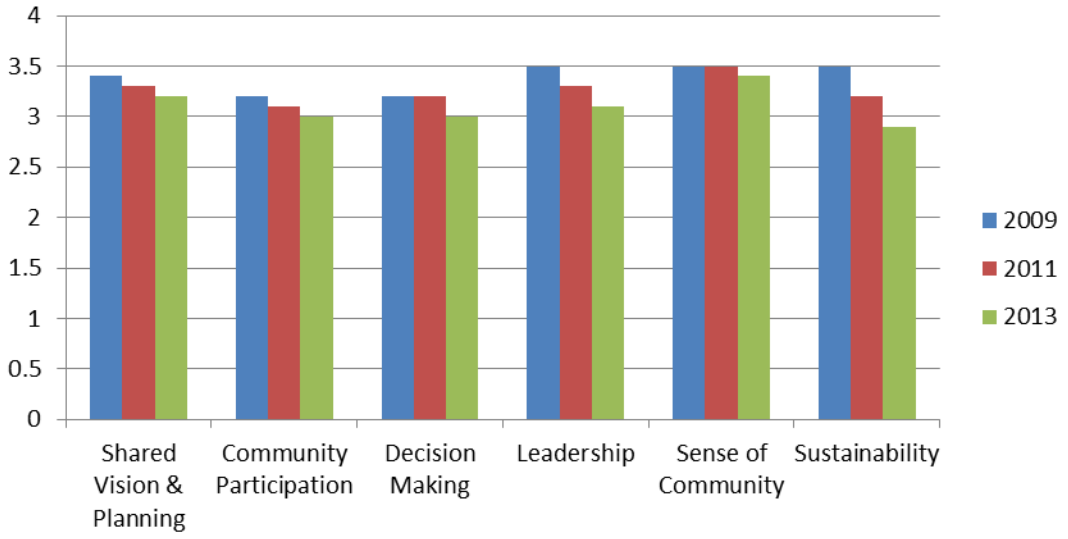
Figure 4: Coalition member satisfaction with coalition functioning



In addition to overall satisfaction, the coalition survey solicited coalition members' perception of their coalition functioning related to several domains: Shared Vision and Planning, Community Participation, Leadership, Decision Making, Sense of Community and Sustainability. SCI coalition members consistently indicated a high level of agreement with statements assessing coalition functioning related to each of these domains over the course of the initiative (**Figure 5**).

Figure 5: Coalition Functioning Summary

(average member level of agreement to statements assessing each domain; 4= *'strongly agree')*



A specific area, within the Community Participation domain, **where coalitions consistently reported relatively low agreement was related to specialist involvement**. Throughout SCI, about 30% of coalition members '*disagreed*' or '*strongly disagreed*' that the coalition had adequate involvement of specialists. Qualitatively, coalitions discussed the importance of a specialist champion in moving forward many of the strategies. In spite of this ongoing challenge, agreement in the Community Participation domain overall remained high.

While there were slight decreases in four domains over time, these were not significant changes (**Figure 5**). More notable decreases occurred in the areas of Leadership and Sustainability. In the Leadership domain, however, a vast majority of respondents (over 80%) continued to '*strongly agree*' or '*agree*' to all of the statements assessing coalition leadership. Qualitative data suggest that while most coalitions had high levels of organizational leadership involvement at the beginning of SCI, as the work and coalitions evolved there may have been less focus on engaging leaders, making sure roles were clear, and ensuring adequate communication throughout the coalition.

The only statistically significant decrease ($p<.05$) was in the area of Sustainability. Qualitative data suggest that **as SCI was wrapping up, coalitions were still figuring out how they would continue to support some of the work, as well as the coalition itself after funding ended.** (Sustaining specific SCI strategies is discussed further in the section: Establishing Effective Strategies/Models.)

"The coalition as an entity won't continue, but our collaborative efforts will still continue. Our relationship [with partner] has definitely expanded. We're always looking at how we can work together, not just with specialty care….I think of them more as a partner now, more than we did in the past. We know their capacity and how we can help them and how they can help us."

As for the coalition entities themselves, **over 60% of project leads indicated that the coalition does or is anticipated to continue to meet.** In some cases, coalitions were integrated into complementary groups working on health care access. However, even when the SCI coalition entity no longer convened, project leads said that the relationships developed through the coalitions remained and members continued to partner on efforts to improve health care for the safety net (**Table 5**).

Table 5: Status of SCI coalitions as of February 2013[5]

	SCI grantees (n=10)	**SCI alumni** (n=8)	**Combined** (n=18)
The coalition continues to meet regularly	**50% (5)**	38% (3)	**44% (8)**
Members continue to work together regularly, but the coalition as a whole meets infrequently	40% (4)	--	22% (4)
Members continue to work together regularly, but the coalition as a whole does not meet	10% (1)	**50% (4)**	28% (5)
Members no longer work together regularly and the coalition as a whole does not meet	--	13% (1)	1% (1)

Successful coalitions: what does it take?

There was not a cookie-cutter approach to coalition building within SCI. Every community had its own assets and challenges related to the health system and focused on implementing different strategies, so each SCI coalition was unique in terms of membership, structure and operations. **While it was important that each coalition be reflective of and responsive to the community it serves, effective coalitions consistently had high levels of agreement across all six of functioning domains discussed above** (i.e., shared vision and planning, community participation, leadership, etc)**.** This suggests that all of these things contribute to coalition strength. Qualitative data support the importance of these areas and add that members' regular participation in meetings also supports coalition effectiveness.

> **Member Engagement**: "*We have an active, attuned group of committed representatives from all the clinics and organizations and even patient advocates so when I was able to invite [other partners] to speak we had the audience ready and engaged. The forum was there so we could communicate effectively and help to improve the process."*
>
> **Shared Vision & Planning**: "*We all have a common purpose and we recognize the strengths of each organization."*
>
> **Community Participation**: "*We have always had equal representation from a variety of entities involved in the coalition. It involves public sector, private sector (community partners), schools,*

[5] At the time of the survey, SCI "grantees" were currently receiving SCI funding, while SCI "alumni" no longer had active SCI grants. Current status of the coalition for two SCI alumni and one current SCI grantee was unknown at that time.

and other community agencies. There is input and equal commitment from all of those sources to develop programs and projects. We all have a commitment to provide services and we provide [services] to the same patient population."

Leadership: *"I think our coalition is fortunate to have had a good coordinator. That definitely helps the organization. We have a bright and committed group that has different levels of experience and history. I think it is the quality of the people that makes our group work so well and over the years the people who have been organizing and keeping it going have made sure that a level of trust and open communication exists."*

Decision Making: "*All the goals and objectives were developed based on needs assessments and collaboration… it was group decision making that identified the goals and objectives, which also took into account what the group could have success with."*

Sense of Community: "*I think that as much as they can, [members] participate pretty actively and regularly. There's a willingness to share what's working, their concerns and issues. The group can then support them and help them address them. It's done in a spirit of cooperation rather than competition….They've been in the trenches together developing programs and have gained experience and been successful together."*

Sustainability: "*I think we work well together because we have taken baby steps. We had done work before the initiative funding, then we had the initiative, and now we are still addressing access to specialty care….We are at a point where we are looking at: 'how does the group work add to our structure?' We want to have a structure to deal even better with our goals in the future."*

While analysis of coalition member survey data did not show a statistically significant difference between the functioning of coalitions that existed prior to SCI versus those that formed for the grant, trends indicated that existing coalitions had consistently higher levels of agreement in all of the above domains, while most of the coalitions that had the lowest levels of agreement in the functioning domains were those that had formed for SCI. **This suggests that coalitions that form for a grant opportunity may not be as effective as coalitions that formed on their own to address a community need.**

SCI IMPACT: Building and Strengthening Relationships & Increasing Understanding

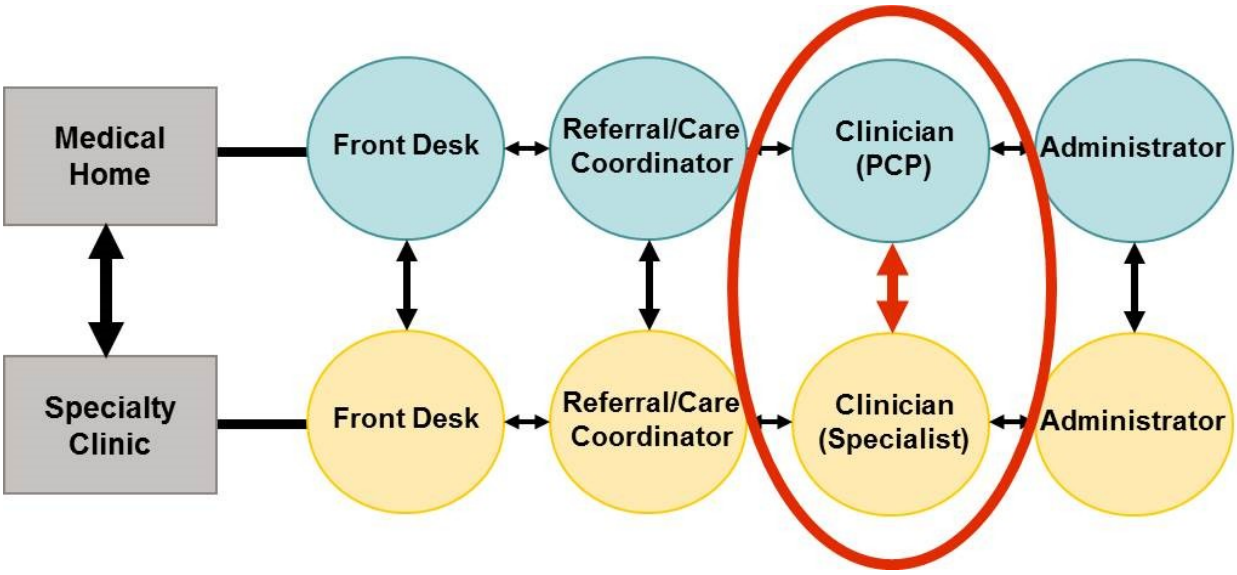
> *"It has really transformed our ability to take care of patients more appropriately. What a huge difference to have a relationship with somebody in the system. [It's] transformed our work."*

A key long-term outcome for SCI was "formalized relationships and collaborative decision making processes." The requirement that this be a coalition-driven effort drove progress toward this outcome. Over 80% (17/21) of coalition leads stated **that the relationships established through SCI were one of their coalition's most significant accomplishments**. Coalition leads and members highlighted the relationships developed between specialty and primary care at various levels (i.e., organizational partnerships, personal relationships between leaders and referral staff); particularly emphasizing the impact of SCI on relationships between primary care and specialty providers (**Figure 6**).

> *"We have a stronger safety net network.…People realize that no clinic or agency is really in competition, so working together we'll improve the health status of the community more effectively …. Working together has accomplished increased trust and collaboration that would not have happened if we had not come together to work on common goals and projects."*

> *"The overarching impact of [SCI] has been to solidify the relationships among the coalition members…through their collaboration in carrying out specific activities. The specialty trainings that have taken place for the PCPs, both the dinner sessions and the mini-fellowships, have also served as a relationship-building endeavor, as specialists have had the opportunity to interact with PCPs for an extended period of time."*

Figure 6. Relationships developed through SCI that helped improve access for the safety net



For many coalitions, achievement of this outcome was identified as the primary legacy of SCI. Prior to SCI, in many safety net systems across California, key players in the safety net were not effectively communicating and did not fully understand the delivery system within which they were working. As a result, it was difficult to provide comprehensive care for patients. Many primary care clinics were unsure what happened with a referral after they sent it and rarely received follow-up notes from the specialist. When referrals were sent back or denied, PCPs frequently didn't know if it was because it was clinically inappropriate or if they had not included necessary information. Specialists working in the safety net often did not understand how difficult it was to get a patient in to see them or how long their patients were waiting for an appointment, nor did they understand why primary care clinics were not providing some basic screening or diagnostic tests that they deemed necessary for a referral. Systems were running inefficiently and patients were being lost to follow-up. As one coalition member stated:

> *"We redesigned [the hospital's] referral process to facilitate open communication and build relationships with FQHC and community clinic partners. Having that communication open has been the biggest success for us. Prior to this, we had walls up around the hospital. This initiative has allowed us to gain the trust of our community clinic providers. When you have open communication about the struggles you are having,…it allows for a level of trust that is much different than when we had no communication or just written communication via the referral forms."*

> *"For me one of the biggest things is that four years ago there wasn't much going on in terms of getting PCPs and specialists in the room together. On the PCP side, we were making a lot of assumptions and thought we knew what the clinics did well. It was really eye opening at the roundtables. A lot came out in the discussions in terms of [what were] inappropriate referrals and [we learned that PCPs were] sending a bunch of unnecessary info and [specialists] did not really know what a referral was for."*

SCI did not solve all of these problems during its five-years of funding, but **it did make people more aware of the problems that existed and got people talking about and working together on potential solutions**. Even in areas where key organizations in the safety net had long histories of working together, coalition members indicated that SCI strengthened and deepened existing partnerships. Because of these improved relationships, coalitions reported increased confidence in their ability to tackle many of the problems facing the safety net and to better navigate the changing health care system.

> *"In the beginning [of SCI], it was pretty clear that the different sides [primary and specialty care] had clear differences in vision about problems and about what needed to be done about that…. We are seeing that strengthening these relationships and [engaging in] more big picture thinking will help take us to the next level where we can create a more regional network, collaborative network and have this be a foundation for an ACO [accountable care organization]."*

Long Beach Community Increased Access Specialty Care Coalition

Lead agency: The Children's Clinic

Westside/South Bay Specialty Care Coalition

Lead agency: Venice Family Clinic

Key relationships developed: For two coalitions in Los Angeles (LA) County, SCI provided an opportunity for community partner clinics' PCPs to meet in-person with the Director of the Cardiology Department (Dr. French) at their local county hospital—Harbor-UCLA Medical Center. These meetings facilitated a shared understanding of the current referral process and the resources and constraints at both the community clinics and the county Cardiology Department. As one coalition member said, "*It was a very eye opening experience."* Dr. French learned that there was a "*drawer of cardiology of referrals,"* a backlog of patients referred for cardiology services that were never seen. He worked with his staff to follow up with patients, determine who still needed to be seen and clear the backlog. Throughout SCI, Dr. French was accessible to PCPs of the two coalitions for consultation on challenging cases and was able to expedite urgent referrals.

> *"[The Cardiology Department] didn't know that there was a backlog until the coalition made them aware of the problem. Because of the coalition making the connection, those patients received the care they needed. So we feel that empty drawer in a concrete and metaphorical way. For providers, when you work in a silo and you send people to a black hole, you lose site of the bigger picture. Knowing that you can make the connections and get patients in, you feel the relief of that."*

Impact of SCI: For these coalitions, this relationship was a key outcome of their SCI work and the foundation of a partnership with LA County Department of Health Services (DHS) that has extended to other efforts to improve specialty care access. For example, clinics from both of these coalitions have been involved in the implementation of the LA County DHS's eConsult system.

> *"I've been here 20 years, prior to this grant, I'd never been to a Harbor specialist office. I'd been referring for 20 years without any face to face [interactions]. That's because it's hard to get faculty and private practitioners to have time to meet. That's what the grant did. It gave us the time and means to meet and form those relationships. That had yet to be done. Dr. French had been at Harbor for over 30 years but hadn't met anyone from the community clinics. The grant provided an ice breaker and nice way to meet people we should have met a long time ago.'*

B. Establishing Effective Strategies/Models

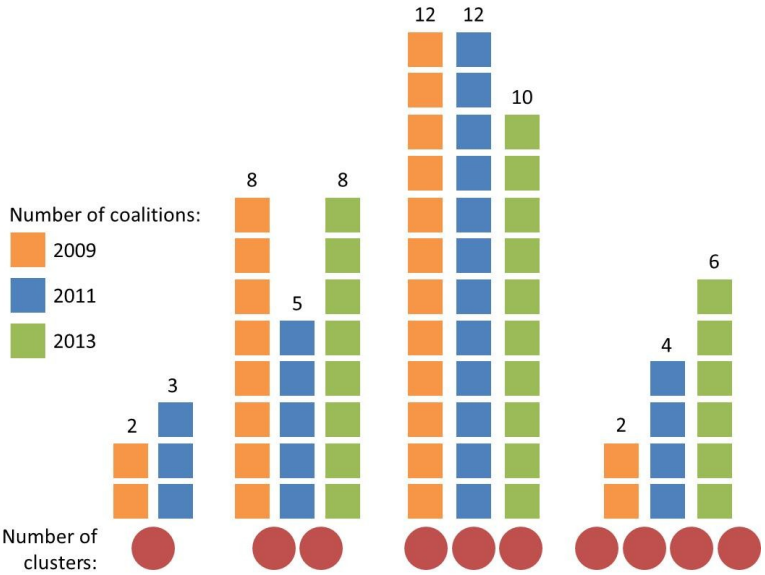
As previously mentioned, four "strategy clusters" were identified to group coalitions that were pursuing similar strategies. Clusters included: Embedding Guidelines into the Referral Process; Building/Expanding Specialty Care Networks; Increasing PCP Capacity/Scope of Practice; and Integrating Care Coordination. See **Table 6** for a summary of coalition participation by cluster.

Table 6: Description of Strategy Clusters

Cluster	Aim	Description of Strategies	# of Coalitions
Embedding Guidelines into the Referral Process	To better manage demand for existing appointments by ensuring more appropriate referrals.	Focused on improving the referral system(s) through: • Identifying, developing and customizing referral guidelines • Developing a system for embedding guidelines manually or electronically • Making improvements to existing referral systems • Implementing new electronic referral systems	18
Building/ Expanding Specialty Care Networks	To decrease wait time by increasing the number of available appointments for the safety net.	Focused on increasing the participation and/or availability of specialty care providers by: • Using volunteer models (e.g., recruiting specialists to provide uncompensated care, "Fair Share" model, and Kaiser Permanente Surgery Days/ Community Access Days) • Implementing telemedicine • Recruiting paid specialists at local hospitals based on demand • Training and using mid-level providers to increase capacity of specialty clinics	21
Increasing Primary Care Provider (PCP) Capacity/ Scope of Practice	To improve demand management by ensuring more appropriate referrals to specialists.	Focused on increasing PCP confidence and ability to manage common conditions without referral to a specialist through: • In-person training (e.g., didactic, "meet the specialist" events, case conferences, and hands-on procedural trainings) • Mini-fellowship programs (i.e., training PCPs in the specialty clinic) • Consultation between specialists and PCPs (e.g., "champion" model and eConsult)	18
Care Coordination	To reduce no-show rates and improve patient satisfaction.	Strategies focused on providing individualized support around referral to specialty care (e.g., ensuring patients have the information and resources (transportation, language services) they need for their specialty care appointment, and to make sure the appropriate information exchange and follow-up occurs after the appointment). This occurred through: • Coordinating care across health systems/clinics within a geographic area • Coordinating care within a large health care system by streamlining and improving operations, communication and information exchange	13

Most of the coalitions pursued work targeting more than one cluster as they recognized that **strategies were interrelated and there was need to work in several areas to improve specialty care access for the safety net population (Figure 7).** Over time, this often meant coalitions would add strategies they had not originally planned to support the work underway. For example, while referral guidelines and system improvements helped to eliminate some unnecessary referrals, several coalitions noted that the demand for specialty services continued to outweigh capacity, so additional work was needed to increase the availability of specialty services.

Figure 7: Coalitions participating in multiple clusters



Throughout the initiative, coalitions indicated that they were making at least satisfactory progress toward the goals established for their work—and their ultimate goal of increasing access to specialty care. In 2013, coalition survey respondents were asked to rate each of their goals separately and 83% of respondents rated progress on individual goals as at least satisfactory; 20% rated progress on individual goals as 10 (10 being "goal accomplished").

Lessons Learned about Strategy Clusters

The following tables describe each strategy cluster: how they evolved throughout SCI; tips for implementing similar strategies—distilled from successes, challenges and lessons learned from the SCI coalitions; and considerations for sustainability and spread.

Embedding Guidelines into the Referral Process

Evolution throughout SCI

Many coalitions made significant progress developing guidelines early in SCI, which was an effective mechanism for engaging and building relationships between specialty and primary care providers. As the initiative progressed, coalitions shifted their focus from guideline development to improvements in referral processes and systems.

Tips for Implementation

- Understand current referral practices—strengths and gaps—before developing new systems and tools, including:
  - Assessing the capacity of current tools and systems before adding a new system (e.g., EHRs, eReferral systems)
  - Paying attention to workflow within clinics and identifying what needs to change to effectively implement any new process or system; engaging those who will be impacted by changes in decisions about workflow changes in developing solutions
  - When possible, integrating a new process/system into a system that providers and clinical staff are already using
- Engage the people who will use the system/guidelines in the development process. Groups particularly important to engage in this work are providers and other users of the system/process (e.g., referral coordinators) from both primary and specialty care. Engaging key stakeholders can help to:
  - Create buy-in for the changes
  - Ensure the new system/process will meet the needs of different users
  - Facilitate conversations to reach agreement between specialists and PCPs about appropriate referrals and what information is needed to make a referral
  - Build relationships between key stakeholders (e.g., referral coordinators across clinics, specialists and PCPs)
- If your system is sharing health information across clinics/systems, address issues of protecting personal health information as part of developing the system.

Sustainability and Spread

While a large initial investment, referral process and system improvements generally do not require a lot of financial investment to sustain. However, they do require updating and maintenance to stay relevant. Overall, coalitions' efforts in this cluster created systems changes that continued beyond the grant period (or are likely to). In addition, establishing communication mechanisms and formalizing partnerships through referral system improvements better positioned safety net organizations to respond to additional needs related to specialty care access. However, while referral process changes can improve efficiency of the system, in many communities the demand for specialty services was greater than the safety net's ability to meet the need.

Replication and spread may be possible. Referral guidelines for many specialty areas were developed. Most coalitions have been willing to share their referral guidelines to help others get started; however, guidelines must be customized to the local health system and individual providers to be effective. Replicating the work with eReferral systems without grant funding would be difficult because of the large initial investment needed to build or customize a system. However, many coalitions were able to make improvements to existing systems—both electronic and manual—by engaging key stakeholders in discussions about current practice, making appropriate changes to workflow, and then developing tools to support those changes.

Building/Expanding Specialty Care Networks

Evolution throughout SCI

Coalitions' approaches to this strategy varied significantly depending on the lead agency and the presence of a public hospital in their county. Over half of the coalitions started out recruiting volunteer specialists to see their patients and much of this work continued throughout SCI, but several coalitions found the challenges of bringing volunteer specialists into primary care clinics too significant to overcome (i.e., contracts, liability coverage, space and needing to revise the clinic's approved scope of practice for FQHCs). Telemedicine strategies became more prevalent as the initiative progressed. Many coalitions that had success recruiting volunteer providers added a focus on care coordination to ensure effective and efficient use of these expanded networks.

Tips for Implementation

- Identify a physician champion to help with these efforts, whether that be recruiting volunteers or building support for other strategies (e.g., telemedicine, use of mid-levels).
- Plan for continuity of care for patients; a key challenge was ensuring that patients would have access to follow-up care after an initial consult or diagnostic test with a specialist.
- Establish systems for effective use of this expanded network—typically this happened through care coordination to ensure that referrals were appropriate, patients showed up to the appointment, patients and physicians had the necessary information, and that the consult report from the specialist was sent back to the PCP.
- If you need to share health information across clinics/systems to effectively implement the expanded network, address issues of protecting personal health information when developing the referral process/system.
- When recruiting specialists to participate in volunteer models or telemedicine, focus on relationship building first. Successful efforts emphasized relationship building over securing appointment slots in the short-term; once the relationship was established, physicians were more apt to volunteer to provide services.
- Institutionalize relationships; efforts were more sustainable when they were able to get institutional (as opposed to individual) support for participation.

Sustainability and Spread

Coalitions indicated that that developing relationships was the most important component of expanding networks. Sustainable relationships were developed through work associated with this cluster. The challenge was that many relationships were between individuals and needed to be institutionalized to be sustained and spread. Additional considerations for sustainability and spread varied by strategy:

- **Volunteer recruitment**: Managing a volunteer network requires ongoing resources and operational support to coordinate care and keep volunteers engaged. Work in this area was most successful when it leveraged existing programs or was successful at getting broader institutional support from the specialist partner.
- **Telemedicine:** Through the initiative, many clinics acquired the equipment they needed to provide telemedicine services. These strategies were particularly effective for teledermatology and digital retinal screening. The primary challenge for sustainability and spread is the current lack of adequate business and reimbursement models to maintain engagement of specialists and primary care providers.
- **Recruitment of paid specialists by public hospitals**: Coalitions employing this strategy used data to indicate demand and to drive their hiring decisions. There were no concerns about sustaining these added positions as long as they were in demand.
- **Use of mid-levels**: There were two approaches to using mid-levels to expand specialty care access, which were used by public hospitals during SCI. One model focused on training an individual mid-level provider to conduct basic specialty procedures. The sustainability of this model proved to be dependent on success retaining the individual who received additional training. The other model focused on expanding the use of mid-levels in specialty clinics. There were no concerns about sustaining this model.

Increasing Primary Care Provider Capacity/Scope of Practice

Evolution throughout SCI

Efforts to train PCPs continued throughout SCI both through in-person trainings, case conferences, and mini-fellowships (i.e., one-on-one interactions between specialists and PCPs that include training and shadowing). The development of eConsult systems garnered a lot of interest and support during the last half of SCI to formalize consultative relationships between PCPs and specialists.

Tips for Implementation

Trainings

- Use training as an opportunity to develop relationships between PCPs and specialists.
- Engage PCPs and specialists in prioritizing and designing training activities to ensure that content and format is appropriate and relevant.
- Set clear expectations around training objectives and anticipated outcomes; clear objectives are important for getting buy-in and assessing PCP competency after training is complete. Having data on the results can help to build organizational support to continue these programs.
- Focus trainings on practical advice and patient management guidance whenever possible. Hands-on procedural trainings were also well received.
- Recognize that these types of activities are asking PCPs to do more with limited resources; if PCPs are willing to participate in these activities, work to ensure that PCPs will have opportunities to use their new skills and reduce barriers by addressing financial disincentives and mitigating other operational barriers.
- Make trainings convenient and easy for physicians to attend. Coalitions had success integrating trainings into existing physician meetings and making remote access and/or archived versions of the training available.
- Consider incentivizing provider participation through physician release time, continuing medical education credits, or individual payments.

eConsult

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

Sustainability and Spread

When asked about sustainability of these activities, coalitions talked about the sustainability of the "learnings" that were gained from activities funded by SCI, as well as the sustainability of continuing to offer activities to expand PCP capacity. Generally, coalitions felt that the "learnings" were sustainable, but many reported having to scale back their ongoing activities in this area. Most activities in this cluster require some ongoing financial investment for coordinating the activities and providing incentives to providers. A number of coalitions reported they would be able to integrate training into one member's ongoing activities since it aligned with their mission and is a relatively inexpensive way to build relationships and increase communication within the health system. However, others had difficulty establishing buy-in for these strategies because they did not have data to show that training had a positive impact on access.

The potential sustainability and replication of eConsult systems depends on creating a mechanism for reimbursement for the physicians—PCPs and specialists—interacting with the system. The sites that were successful at implementing eConsult had institutional support for specialists to devote time to participate in eConsult. Barriers to reimbursing providers for time spent interacting via eConsult limits the potential spread of existing systems and the feasibility and usefulness of implementing such systems in other settings.

Integrating Care Coordination

Evolution throughout SCI

In the second half of SCI, coalitions recognized that care coordination was a key component to ensure the effectiveness of their work in other clusters (especially Guidelines and Networks). As one coalition explained, the work conducted in the initial years of SCI highlighted the importance of "connectors" between organizations.

There is considerable variation in how care coordination is defined in the literature and by the coalitions. Most of the care coordination that occurred in SCI involved logistics support—making referrals and ensuring effective information flow between PCPs and specialists. A few coalitions also used care/referral coordinators to do some clinical monitoring; one coalition implemented a more in-depth "case management" program.

Care coordination efforts took different shape depending on who was driving them. Within coalitions led by public hospitals, several worked on care coordination solutions through improved internal systems and processes to ensure that patients could effectively navigate within their system and appropriately discharge back to primary care. The community clinic and consortia-led coalitions often added positions to help navigate the referral process either at the community clinic or within a referral center at a public hospital.

Tips for Implementation

- Strategically determine the most appropriate approach for care coordination. The needs for care coordination and patient support differed by health care system. Within SCI, some coalitions focused on coordinating care from primary care, while others focused on having a referral coordinator at the specialty site.
- Build leadership support for care coordination activities; sustainability of these efforts requires it to be prioritized and funded by an organization.
- Identify and implement tools/systems to support effective coordination (e.g., systems that track referrals, facilitate follow-up and manage data).
- Standardize communication and processes across primary and specialty care clinics to reduce confusion for patients, staff and providers. To accomplish this, some coalitions convened referral coordinators across coalition clinics to discuss best practices and appropriate processes.
- Understand the specialty care environment and know where your patients can get access to care. The referral coordinator meetings helped to share information as the environment was constantly changing.
- Identify and implement changes to clinic workflow that are needed to ensure effective integration of care coordination; engaging the impacted staff in decisions about how this should be done may increase buy-in.
- If a position is needed, design a job description for this role that integrates it into clinic functions, provides adequate support and supervision, and assigns a reasonable scope of work (i.e., the more intensive the support provided to an individual patient, the fewer patients one person can manage). Coalitions were more successful when they made this a designated position, rather than tried to add these responsibilities into existing staff roles.

Sustainability and Spread

Sustainability and replication considerations for care coordination vary by approach. Strategies implemented by public hospitals—which were typically achieved through process improvements, revised workflows, and renegotiating job descriptions—were possible to integrate and sustain with leadership support and little ongoing financial investment. These changes can have a large impact when implemented at an organization that is the primary source of care for the safety net population in a community.

Sustaining and replicating care coordinators, whose job is coordinating care between health care systems and clinics, is challenging because there is currently no reimbursement mechanism for these activities. Establishing leadership support is still crucial, but there is an ongoing question about how to sustain these types of positions during budget cuts. If an organization is committed to sustaining the position, attention must also be paid to retaining the individual(s) in the position by ensuring that they have support and a reasonable work load. Many hope that there will be opportunities for reimbursement for these activities through patient centered medical home initiatives and/or health care reform.

Cross-cutting success factors

Coalitions identified several factors that contributed to their success, regardless of the specific strategies implemented. Throughout SCI, coalitions talked about the need to understand the context in which this work was occurring—the demands on the safety net, the priorities of other partners, and how this work fit in. **Coalitions were more successful when they were able to strategically position the SCI work to be aligned with other priorities**. Similarly, it was important for coalitions to figure out how to integrate SCI priorities into existing systems and processes, and where changes were necessary, consider the workflow modifications that needed to occur in order to successfully implement these efforts.

Other factors that coalitions identified as critical to facilitating their success are outlined in **Table 7.** Leadership support, previously established relationships, and the involvement of key stakeholders were each identified the most frequently as one of the "top three" success factors influencing their progress.

Table 7: Success Factors Associated with SCI Progress[6]

Success Factor	Description	#/% of coalitions identifying it as one of the **"top 3 success factors"** (n=16)	
		#	%
Leadership support at the lead agency and/or key partner organizations	Leadership support was essential in the beginning of SCI to ensure that key organizations were involved in decision making and willing to invest staff time and resources in the collaborative effort. As work progressed, leadership support remained important—especially to make resource decisions and discuss issues related to sustainability and spread.	9	53%
Relationships between key stakeholders and/ or key organizational partnerships established prior to the grant	Coalitions that were able to leverage existing relationships were able to build momentum and make more rapid progress than those that had to develop new relationships. Existing relationships also established a collective knowledge, which helped coalitions apply lessons learned from previous efforts and avoid common pitfalls.	9	53%
Adequate involvement from key stakeholders	Coalitions benefitted from identifying and seeking input from key stakeholders in their safety net system throughout the planning and implementation processes. In addition to getting buy-in from leadership and decision makers, involving groups that were affected by or responsible for implementing the proposed changes was also important.	7	41%

[6] **Table 7** shows the results of a survey where project leads were asked to identify the "top 3" success factors that influenced their progress; this is combined with a narrative description from interviews.

Success Factor	Description	#/% of coalitions identifying it as one of the **"top 3 success factors"** (n=16)	
		#	%
Using a coalition to engage stakeholders	The coalition initially was an effective mechanism for grantees to plan and get buy-in for their efforts. During implementation, the coalition played an important role providing feedback and high level oversight. Having a coalition with representation from all of the key organizations in the safety net helped to develop community-based solutions that were appropriate for the local health care system, rather than just a few organizations. It also served as an effective communication mechanism to keep everyone updated on progress and issues as they arose.	6	35%
Shared vision for the project/alignment with organizational strategic plan	Shared vision for the project was important to keep key stakeholders around the table—they needed to have a unified goal as to why they were there and what they hoped to accomplish. Later in the initiative, it became more important that the work was well aligned with an organizations' mission/strategic work because that impacted the likelihood that the efforts would be sustained.	5	29%
Dedicated project management	Many grantees indicated that having a dedicated project manager for SCI helped to facilitate progress and drive efforts forward. This role was particularly important to: convene the coalition, serve as a liaison across various health care organizations, manage the work plan, and hold people accountable.	4	24%
Technology (pre-existing and newly implemented)	Technology was a critical piece of many efforts, especially related to eReferral, telemedicine, and eConsult. When implemented effectively, these systems were often sustainable solutions to improving the coordination of referrals and access to specialty care.	4	24%
Specialist champion	Engaging physicians, especially specialists, was essential for implementing and sustaining most coalitions' efforts. *(Note: While this was only identified by four coalitions as one of their top three success factors the lack of specialist involvement was often noted as a challenge that hindered progress.)*	4	24%
SCI funding	SCI funding provided the opportunity to devote attention and resources to addressing specialty care access in an intentional, strategic and collaborative way. SCI funder support, technical assistance and participation in a peer learning community provided coalitions with new ideas, best practices and an opportunity to problem solve.	4	24%

Challenges

While overall coalitions felt that they made satisfactory progress increasing access to specialty care services, there were challenges that impacted their work. When asked what deterred progress, **coalitions most frequently identified external factors, difficulties getting buy-in, and competing priorities within some of the coalition members' organizations**. Challenges related to external factors included negotiating changes in the environment and responding to a health system that was experiencing scarcity of resources and excess demand (**Table 8**).

Table 8: External/Environmental Challenges that Impacted SCI Progress

External/ Environmental Challenges	Example quotes	% of coalition members identifying the **challenge**		
		2013 n=98	2011 n=201	2009 n=231
Increasing demand on the safety net	• *"The biggest challenge is that it is really hard to take care of the demand of health care in the safety net. The disparity between demand and resource availability is huge."* • *"There are significant challenges at the [public hospital]…the specialists are overwhelmed. They don't have the capacity to take on more."*	58%	53%	54%
State budget/ funding environment	• *"The fact that we've gone through financial crisis is a huge challenge. The county is talking about cutting more positions, and I don't know how we'll be able to maintain the work that we're doing if we lose more staff."* • *"The economic crisis is putting financial pressure on the system. Developing new things is quite difficult when people are already overworked. Our resources are reduced, but there are more patients in need."*	44%	37%	43%
Reimbursement issues	• *"Reimbursement issues create disincentives. A lot of what we are doing is to improve the efficiency of specialty care, but we live in a world that is fee-for-service, which works against access to care. We actually cheat ourselves—if we keep someone out of clinic, we improve access and reduce our reimbursement."* • *"The issues aren't as simple as lack of training. In the community health center we get paid per visit, so if we see someone for a cold for 10 minutes or conduct a 45-minute biopsy, we're getting paid the same. So there are financial disincentives for doing some of these procedures [in primary care]."*	31%	36%	33%

External/ Environmental Challenges	Example quotes	% of coalition members identifying the **challenge**		
Changes in the health care delivery system	• *"Changes in the environment, new IT systems, new health plans coming to [the county], the health insurance exchange, meeting meaningful use, becoming a patient centered medical home…so many different things that the health centers are focused on. Access to specialty care fits into that, but other things have more pressing timelines."* • *"We may have to modify what we do depending on what the county decides to implement. The challenge for us is that there are a lot of unknowns at the county level [which will impact our work]."*	22%	Not asked	Not asked

Coalitions also identified challenges that were specific to their work. Many challenges related to the individual strategies they were pursuing, but there were also many challenges that were cited across the strategy clusters.

Throughout the initiative, **coalitions discussed how the work took longer than anticipated**—this was in a large part due to efforts to build and strengthen relationships that needed to occur before coalitions could make progress on specific strategies. As a result, many coalitions received no-cost extensions on their grants. In the words of one coalition member:

> *"Improving access is a lot harder than a three-year implementation plan. I'd really like [an investment] for five years. It's not even adding money to the pot, but extending the timeline. Even though you have a year of planning, you aren't thinking about implementation until when you have approval for implementation. Implementation the first year is really more planning to put those pieces in place. Here we are a year into it and we're really just now rolling."*

In interviews with coalition leads, the internal or project specific challenges that were discussed the most frequently included:

- **Technology** – coalitions struggled with both limitations of existing technology and difficulty implementing new technology.
- **Staff resistance to change/burn out** – project managers acknowledged that staff and providers were operating in an environment of constant change, which made it difficult to add additional initiatives and priorities. There were many changes that impacted clinic workflow, which were challenging to implement given people's resistance to changing practice.

- **Engaging coalition members/key partners** – coalition members and partners often had limited time and competing priorities that hampered the level of their engagement; often it was one key partner that the coalition had a difficult time bringing to the table. In the words of one coalition member*, "not everyone was equally at the table."*

- **Recruiting specialists to participate** – engaging specialists both in the coalition and to actively participate in the work was an ongoing challenge for many coalitions.

- **Logistics/scheduling** – there were often difficulties scheduling coalition meetings and engaging physicians (both primary care and specialists) due to busy schedules.

- **Negotiating contracts/MOUs** – coalitions struggled with the contractual and legal agreements to facilitate this work. This included things like contracting specialists to participate in telemedicine, negotiating changes in scope of practice for community clinics, ensuring liability coverage for specialists and PCPs operating at different facilities, etc.

- **Data collection** – collecting data for this grant was challenging due to inconsistencies in data collection systems and practices across coalition partners, data availability and quality issues, and changing data systems, which influenced the availability of consistent data over time (discussed further in the following section).

- **Staff/leadership turnover at key organizations** – for some coalitions, turnover resulted in loss of institutional memory and familiarity with referral processes or other project activities; this caused some coalitions to lose momentum until the position was filled and the new person was trained.

- **Hiring delays/hiring freezes** – because of budget cuts at many organizations during SCI, there were hiring freezes, which delayed some coalitions' ability to hire people for new positions. Additionally, some coalitions had difficulty recruiting and retaining the right person for the job, which resulted in delays and impacted progress.

Increasing Capacity to Track and Report Data on Specialty Care Access

In addition to implementing activities within the strategy clusters to improve specialty care access, SCI supported coalitions in improving their capacity to use data to inform and monitor efforts related to increasing access. As a result, a key outcome of SCI was to "increase coalitions' ability to track and report on data related to specialty care referrals." This outcome cut across all of the strategy clusters, and for many coalitions improving data systems and tracking within their health system was a significant area of work during the initiative.

As previously discussed, SCI required that coalitions track and report on specialty referral data and four common measures were identified for coalitions to track over time—referral volume, wait time, disposition of referral, and no-show rates. (See **Evaluation Methods** section for more details.) As a

result of the requirement and the effort that coalitions invested in data collection, improved capacity related to tracking and reporting on specialty referral data was reported as one of the major successes that occurred as a result of SCI, independent of the success of the strategies that they pursued.

Data Availability & Quality

"[SCI] resulted in a dramatic change in our philosophy around data. We now identify what we need to collect, make sure we're tracking it, and then report on it…the grant requirement led me to develop a data system [for this project]."

Collecting data on the four measures was challenging for many of the coalitions because of lack of access to complete data and quality issues with data that were available. The coalition approach required effective and consistent data systems both within and across organizations, which was a challenge in the safety net due to several factors:

- Implementation of new electronic systems;
- Clinics' internal systems not having the necessary interfaces (e.g., registries not interfacing with EHRs);
- Different EHR systems not being able to share data across institutions;
- No commonly agreed upon definitions for key data elements; and
- Increasing demands on safety net providers and staff, which made it difficult to make time for data collection, management and reporting.

As SCI progressed, many coalitions were able to resolve data quality issues related to specialty care referral data, while others were able to recognize the limitations of their data and begin to have conversations about improving data systems.

Towards the end of the SCI, there were slight increases in the number of coalitions that were collecting data on three of the common measures. The increase was most substantial for number of coalitions collecting data on outcome (disposition) of referral, which doubled from the beginning to the end of the initiative (**Table 9**). The increase in this measure was in part due to the low number of coalitions who were initially able to collect and report on it.

Table 9: Coalitions collecting data on key measures – pre/post (n=16)

	# of coalitions	Prior to SCI (Fall 2009)	As of January 2013
#/% collecting data on **wait time**	16	8 (50%)	10 (63%)
#/% collecting data on **referral volume**	16	11 (69%)	13 (81%)
#/% collecting data on **outcome of referral**	16	4 (25%)	8 (50%)

Additionally, SCI project managers reported that the data collected for the initiative were shared at coalition meetings and over 85% of coalition members (respondents to the 2011 and 2013 coalition survey) indicated they were at least *somewhat familiar* with the data. Of those, the vast majority

(97%) rated the data collected as at least *somewhat useful*, with 33% saying the data were *very useful*. The most common ways that coalition members reported using the data were:

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

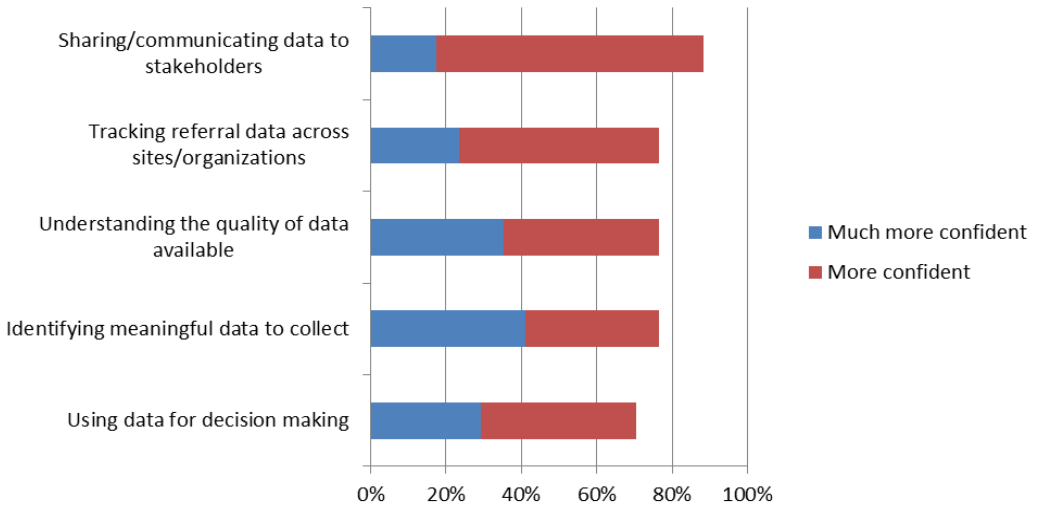
Furthermore, a few coalitions identified the willingness and ability to share data between coalition partners as a significant accomplishment. In the words of one project manager: *"Historically, sharing data has been a big barrier, and we seem to have gotten over that. I can send the county a request and they send a report. That wouldn't have happened five years ago."*

When data were not consistently being collected or were perceived to be only somewhat or not useful, coalition members indicated that this was because of ongoing challenges with data availability and quality. Coalition members said SCI data collection requirement forced conversations with organizations about data-related issues so they could begin to identify solutions.

Increased Capacity to Track and Use Data

Most coalitions reported SCI had a positive impact on their ability to track, use and report on data related to specialty care access**.** In 2013, the majority (at least 70%) of project managers (n=16) reported that participating in SCI had improved understanding of how and why data like these can be valuable and increased their confidence in several competencies related to collecting, using and sharing data (**Figure 8** on the next page). **Coalitions were able to improve data quality, use data to inform decision making (e.g., hiring decisions at the public hospitals), improve referral processes, and use their experience to inform the design of new electronic systems (e.g., development of fields and data reports).**

Figure 8: SCI project manager reported confidence related to data capacity (n=16)



Many coalitions reported increased understanding of which data they needed to assess their efforts—"we now know what to look at." Several coalitions reported that this helped to inform the design and implementation of data fields and reports built into new electronic systems. As one project lead explained:

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

> *"We started this project before implementing our EHR. The work we did around data collection and referral is helping to inform the EHR development and how we want to collect and report on data in it. It also helped us figure out what we needed to do to better manage the patients and to make sure they are getting follow up and appointments that they need. It definitely improved our referral processing system."*

Coalitions reported an increased awareness of the value of using data for monitoring progress and identifying areas for improvement. In interviews, 17 coalitions (n=21) discussed how the data collection efforts required by SCI had a positive impact on their work and one coalition stated "we never looked at these data before." The **most frequently cited benefit was that coalitions' partners have a better "*understanding of what's going on*."** Several coalitions used the data to look at variation between clinics or regions to identify strengths and potential areas for improvement. As one project lead stated:

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

> *"The most useful piece of [the data reporting] requirement was it forced everyone to identify and understand the process for referral. I think people were only seeing the piece where their individual role ended. No one knew what happened before or after they touched the referral."*

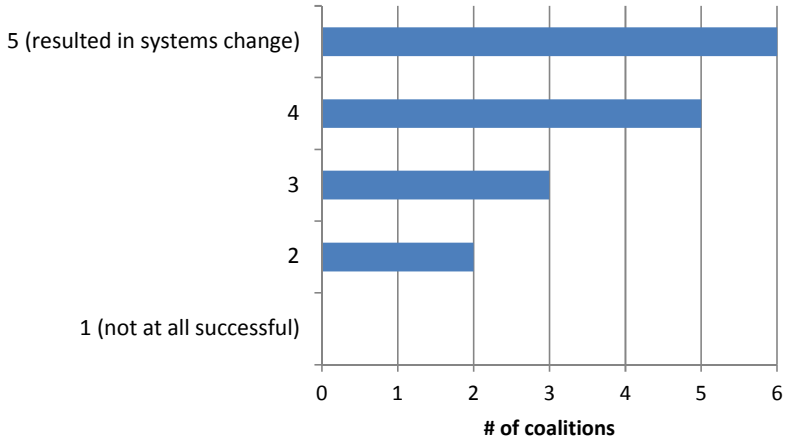
Many coalitions also reported that **being required to look at referral data and develop new data systems helped prepare them for many of the requirements of health care reform, which require more data accountability and reporting.**

> *"We [now] have a monthly dashboard that we use… That's one main issue around access—how quickly are patients able to get appointments. There is now a focus on that. There's a shift in the culture, from "well it's the county, what do you want us to do? You're going to have to wait" to that is no longer acceptable. [This work] was part of [what prompted that change]. With health care reform we are going to get evaluated on how quickly people get in… SCI complemented what was coming down the pike and we were better able to respond."*

SCI IMPACT: Sustainable Solutions & Systems Changes Leading to Improved Access to Specialty Care

Through SCI, coalitions were able to test many different strategies for improving access to specialty care with the goal being to change the way specialty care was delivered across an entire health system. "Systems changes" included changes in policies or processes that were integrated in the way specialty care was delivered in a community**. Nearly 70% of SCI project leads (n=16) rated their SCI efforts at least a 4 at facilitating systems changes that improved access to specialty care** (with 1=not successful and 5=resulted in systems change) (**Figure 9**). Coalitions cited various examples of systems changes including several of the specific strategies discussed above (e.g., referral process improvements, adding specialty services), as well as an increased use of data in monitoring and decision making and a more collaborative approach to improving specialty care access.

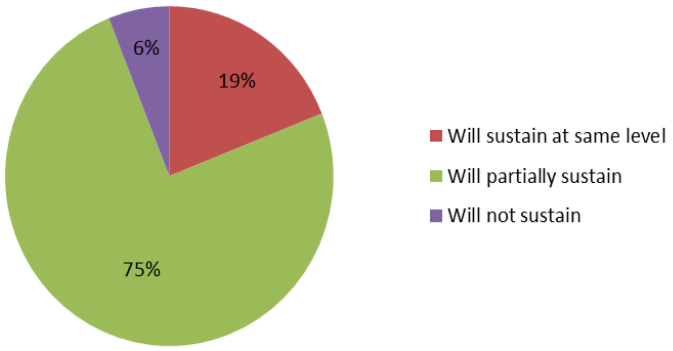
Figure 9: SCI Coalitions' Self-Ranking of Systems Change (n=16)



The extent to which systems change occurred was largely tied to the **extent of success in implementing specific strategies, as well as their scope and likelihood for sustainability.** The successful implementation of these strategies was heavily influenced by how well they aligned with other efforts and priorities among coalition members. All strategies benefitted from significant collaboration between partners, which generally occurred more easily in areas where coalitions or clinic consortia were driving SCI work. However, overall, strategies implemented by and within public hospitals were often broader in scope (i.e., addressed more specialties) and were more easily sustained by implementing systems changes.

Strategy-specific considerations for sustainability are discussed above for each cluster. In addition, project managers were asked to what extent their SCI efforts as a whole would be sustained after grant funding was completed. Only three (19%) indicated that efforts would be sustained at the same level as during SCI. More commonly they reported that their work would be partially sustained (75%)—meaning that only certain aspects of the work would be fully sustained or that the work (as a whole) would be scaled back (**Figure 10**).

Figure 10: Sustainability of SCI Efforts (n=16)



Looking across strategies, there were certain types of strategies that were more likely to sustain after SCI than others.

- ***Fully sustained:*** Efforts that were fully sustained tended to focus on three different strategies. (1) Internal systems change or "changing the way business is done." The internal systems change was often around the referral process or developing procedures that the clinics then integrated into their workflow. Typically these strategies did not require significant ongoing financial resources. (2) Adding new services or positions that could be sustained through reimbursement mechanisms. This included coalitions that used data on specialty care demand to influence hiring decisions for specialists and mid-levels at the safety net hospital. These positions could be sustained as long as demand continued. It also included adding new service offerings, like telemedicine, that once the equipment had been purchased and processes established could be sustained through reimbursement. (3) Having an organizational partner take responsibility for continuing the work, which generally occurred when it was well aligned with their mission. This happened with some PCP capacity building efforts and occasionally with strategies related to building networks (e.g., Kaiser Permanente Community Access/Surgery Days).

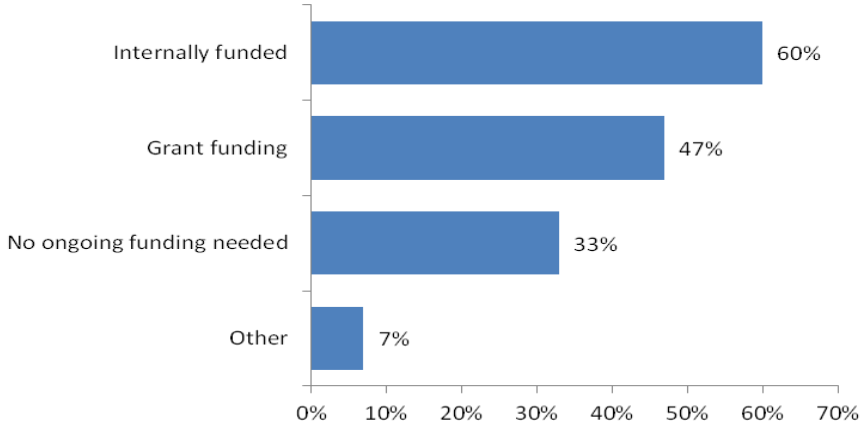
- ***Partially sustained:*** The partially sustained efforts were those that were scaled back at the end of funding. These included a lot of the PCP capacity building activities (e.g., trainings, mini-fellowships) and some referral coordination activities. Where possible, coalitions integrated these efforts into existing positions or meetings/structures, but that typically meant they were reduced in scope or scale. For example, they may happen less frequently or become internal activities rather than a broader coalition effort.

- ***Not sustained:*** Efforts that relied on grant funding for staffing the position or significantly managing the effort were more difficult to sustain. Generally, volunteer models were difficult to sustain unless they were embedded into existing programs or were successful at getting broader institutional support from the specialist partner (e.g., Kaiser Permanente Community Access/Surgery Days). Care coordination positions funded through grant funds

were generally not sustained or the focus of their work shifted to fit the role of an existing position.

Project managers were also asked to comment on *how* the work would be sustained. For about one-third of the efforts, project leads stated that no ongoing funding would be needed—these were strategies that resulted in systems changes and would not require additional funding to sustain. When additional funding was required, generally, it was a combination of internal funding and additional grant funding (**Figure 13**).

Figure 13: Method for Sustaining SCI Effort (n=15)



Changes in the health care environment and increasing demands on safety net institutions made it difficult for some coalitions to get traction on some of their strategies. As a result, not all of the work that occurred during SCI will continue. However, **regardless of the "success" and sustainability of the specific strategies implemented, coalitions indicated that, as a result of SCI, they are better positioned to meet the demands of the current health care environment.** Coalitions credited SCI with supporting changes to their systems that will provide the foundation for responding to both the complex needs of the safety net population and the emerging requirements related to health care reform and other national initiatives**. This is due to: 1) the strengthened relationships among key safety net providers; 2) the increased capacity to track and report on specialty care referral data; and 3) the experiences and lessons learned from the implementation of this work.** In addition to better positioning coalitions to be more effective in the future, SCI participation resulted in more immediate improved access to specialty care for the safety net.

C. Improving Access to Specialty Care

Increased access to specialty care

Overall, grantees agreed that their participation in SCI resulted in improvements in access for the safety net (19/21). Grantees defined "improved access" differently and the scope of improvement varied by community. However, they commented on impact in all seven of the intermediate outcomes identified in the SCI logic model intended to assess success in increasing access to specialty care (listed in order of frequency reported):

- Increased access to timely specialty care
- Improved referral coordination
- Improved demand management
- Increased availability of specialist appointments
- More appropriate referrals
- Decreased no-show rates

"[SCI] improved access to specialty curbside with [specialists]…and probably decreased unnecessary referrals to [the public hospital]. Capacity improved by understanding who can be managed in primary care."

All coalitions that completed participation in SCI reported improvement in at least one of the identified outcomes; on average, coalitions reported successfully impacting four of the outcome related to improved specialty care access. The evaluation captured quantitative and qualitative data to assess how coalitions made progress toward each outcome. Examples are provided below to illustrate progress made in each area.

Increased access to timely specialty care

"We've absolutely have increased access. We went from a 153-day neurology wait to usually a 7-day wait after the phone consult. That's been a huge increase in access."

Coalitions reporting improvement: 90% (19/21)

Description: A vast majority of coalitions reported increased access to timely specialty care. Fourteen coalitions reported **decreased wait times** resulting from their SCI work, even though for many the scope of improvement was difficult to quantify. Increasing efficiencies in the referral process (e.g., streamlining processes, establishing clear referral criteria), building relationships and increasing communication between specialty and primary care, and adding specialty resources were all strategies that improved wait time. Related to improving wait times, six coalitions credited SCI with helping them **reduce or eliminate backlogs** of patients waiting for a specialty referral. Typically this occurred through raising awareness of the problem, targeted referral coordination, or devoting resources to reviewing and following up with patients to clear it out. As one coalition explained:

> *"One unexpected benefit has been bringing to [the specialty clinic's] attention the wait time to get into cardiology. As a result of communication, they realized that they had hundreds of*

people on their waiting list and have been able to clean it up."

For many coalitions, timely access to specialty care went beyond wait time for specialty appointments. Nine coalitions cited improved access to timely specialty care when **patients benefited from specialty consult or resources in the primary care setting**. This included patients receiving basic specialty procedures (e.g., orthopedic joint injections) from trained PCPs, PCPs having opportunities to consult with specialists, and access to telemedicine. These resources allowed patients to be more effectively managed in their medical homes, without requiring a specialty visit.

> *"A lot more things are able to be handed at the PCP level. Before e-Consult, I would send a referral, a specialist would review—that would take a week to two weeks—and then the specialist would need to decide to see the patient or not. Now it's much faster! It's easier for the patient who knows what's going on more quickly and what the next steps are."*

Four coalitions credited SCI for **bringing a specific type of specialty service to a geographic area** that was not available to the safety net previously. The result was more timely access for patients that did not require substantial travel.

> *"Our population was not being served for things that weren't lethal in dermatology…. This grant allowed us to see indigent patients for conditions that weren't being seen before. It's exciting; patients with conditions that are not life threatening, but still negatively affect their lives are being seen, treated and resolved."*

The following vignettes provide two examples of how coalitions increased access to timely specialty care.

San Francisco Specialty Care Steering Committee's GI Workgroup

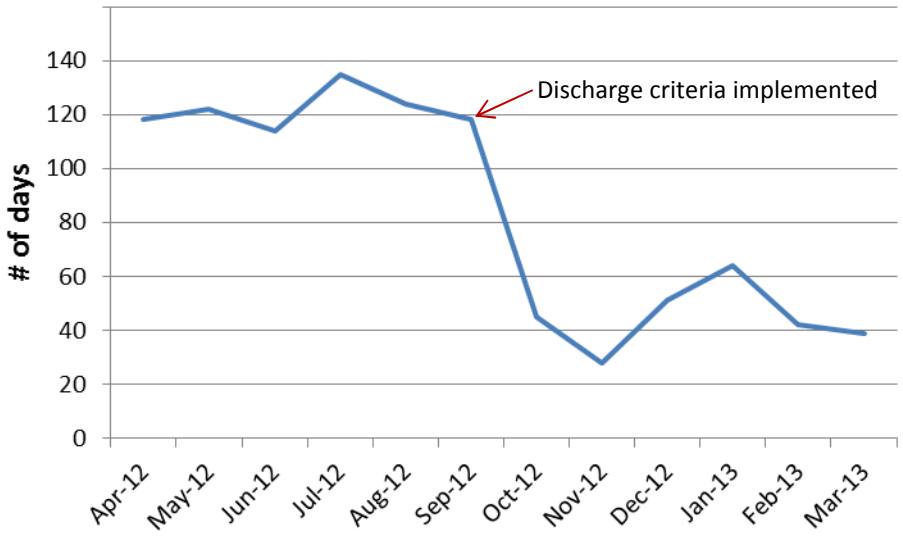
Lead agency: San Francisco General Hospital

Strategy: San Francisco's Gastroenterology (GI) workgroup consisted of representatives from all the major primary and specialty care safety net providers in the county. The workgroup engaged them in making system-wide improvements to ensure effective information exchange and support the transition of the patient back to primary care after a GI visit when follow-up with the specialist was not needed. They used a formal process to solicit feedback from primary care providers and specialists and then facilitate consensus around the type of patients eligible to return to primary care, criteria and process for discharging, and the information required in the specialist's dictated notes in the electronic medical record. As a result, **the workgroup developed specific discharge criteria and guidelines for co-management for post-colonoscopy patients where no biopsy was needed or biopsy results were normal and an in-person follow up visit was not needed**. Instead of a specialty appointment, those patients received a letter with their results. After implementation of the criteria, 400 appointments were cancelled because they could be more appropriately managed in primary care resulting in a decrease in wait time for GI specialty appointments.

"The model of getting together primary care and specialty has been so successful t come up with tangible things to improve patient care and delivery. Things like G discharge consensus criteria, decreased the wait time from 106 days to 40 days in a short period of time … There's a shared sense of ownership in the network, which is really important. Relationships and shared ownership of delivery system decisions i invaluable."

GI Wait Time (average # of days)

April 2012–March 2013



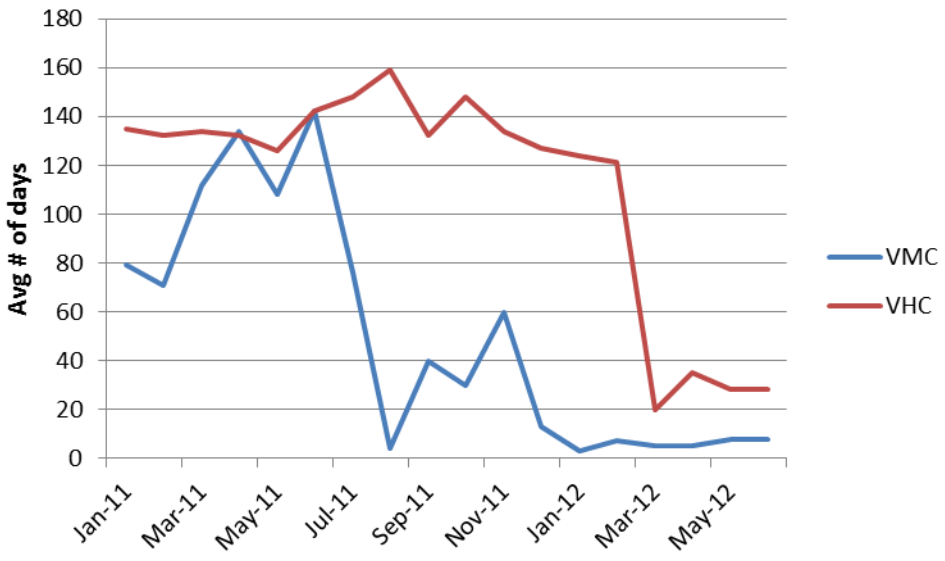
Santa Clara County Specialty Care Access Collaborative

Lead agency: Community Health Partnership (CHP)

Strategy: The Santa Clara Specialty Care Access Collaborative consisted of key primary and specialty care stakeholders in the county safety net system including the Director of Radiology at Valley Medical Center (VMC). CHP developed wait time run charts for mammography, abdominal, and pelvic ultrasounds to share with the Collaborative and inform the implementation of a sustainable solution. With this information, **the Director of Radiology was able to increase staffing and the number of appointments available for these tests**, resulting in a dramatic decrease in wait time for screening mammography at both Santa Clara Valley Medical Center and the Santa Clara Valley Health & Hospital System Ambulatory Care Clinics (VHC).

"[We] added mammography and radiology because we were hearing from clinics that thos were issues. We were able to collect data and present it back and it resulted in a change i wait time for mammography….We got the right people from radiology to the table and they now participate on a regular basis….[we've seen] measurable improvement we had wait times for mammography that were 5-6 months, that went down to 30 days."

Screening Mammography Wait Time
January 2011–June 2012



Improved referral coordination

Coalitions reporting improvement: 71% (15/21)

Description: A majority of coalitions reported **improved referral coordination through relationship development, increased communication and information sharing, and more efficient referral processes**.

> *"[The specialist] has made himself available for consultation and triage. He's helped with patients and we've been able to more effectively facilitate the referral process; because of conversations with [him] we can get urgent appointments in more quickly. Now in cardiology the wait time is down to 3 months for a routine visit, and we can get urgent appointments in more quickly."*

- 10 coalitions implemented referral process improvements, which targeted all specialties and benefitted the system as a whole. Four of these coalitions implemented centralized, electronic referral systems.
- The six coalitions that convened referral coordinators to discuss challenges and share best practices all reported improved referral coordination.

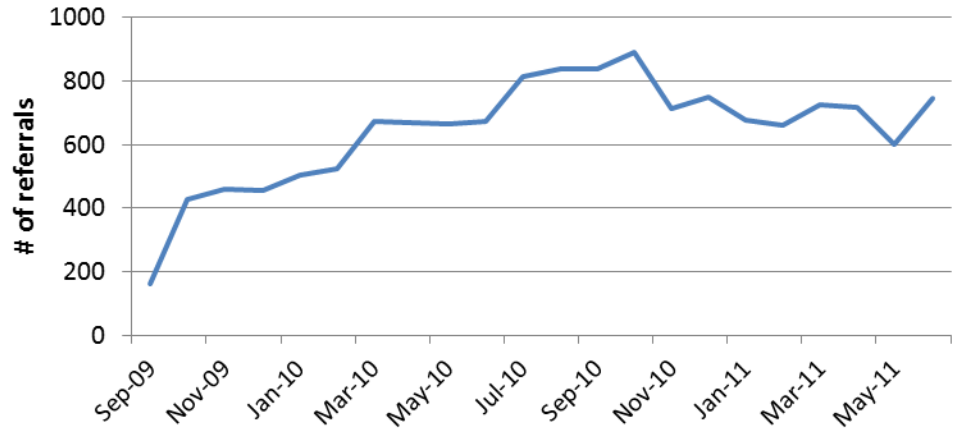
Humboldt County IRIS Steering Committee

Lead agency: Humboldt-Del Norte Independent Practices Association (IPA)

Strategy: Humboldt County is a large, isolated county in Northern California consisting of three large communities spread out across 30 miles along the coast. The system for primary and specialty care is decentralized; most physicians have private practices. Access for the safety net varies by community and specialist. With oversight from the Steering Committee, the IPA **implemented IRIS, an eReferral system, as a community-wide solution to improve health information exchange for all specialty referrals in the county.** IRIS is a HIPAA-compliant, web-based, electronic referral system that tracks and stores referral information.

IRIS was successfully implemented in 50 practices across Humboldt County for over 550 users, including 60 PCPs from 16 practices and 72 specialists from 34 practices. This increased communication between specialists and PCPs and improved the efficiency and transparency of the referral process for the **nearly 14,200 referrals** that were processed through IRIS during SCI.

Referrals Processed in IRIS
September 2009–June 2011



Improved demand management

"Two PCPs have done training in orthopedics [through a mini-fellowship] and now pretty much every day one of them is injecting joints. It's a win-win because it means fewer referrals to specialists."

Coalitions reporting improvement: 57% (12/21)

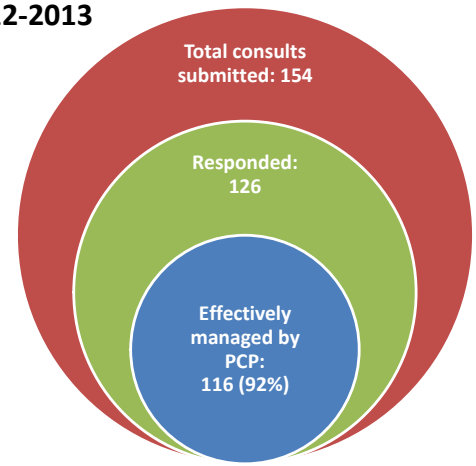
Description: Over half of the coalitions reported improved demand management for specialty referrals. **Typically demand management occurred when patients were able to be more appropriately managed in the primary care setting**. This was accomplished through strategies increasing the capacity of PCPs to manage basic specialty care needs. In most cases, coalitions reporting success in this area provided PCPs training in basic specialty procedures and opportunities to consult with specialists. A few coalitions implemented systems for triaging referrals or more accurate screening modalities.

San Diego Countywide Specialty Care Coalition

Lead agency: Council of Community Clinics in partnership with the San Diego County Medical Society Foundation

Strategy: San Diego focused on **improving specialty care access within the primary care setting, including the implementation of an electronic consultation system (eConsult)** in early 2011. The system allowed PCPs to obtain timely answers to clinical questions regarding patient care from volunteer specialists in 12 specialties. San Diego found that the vast majority of cases reviewed through eConsult can be effectively managed in the medical home. In addition, eConsult has provided a mechanism for PCPs to better meet the needs of their patients.

2012-2013



eConsult Success Story*: Patient Jack H*

Jack was a low-income, uninsured patient who presented at his community health center for what he thought was a thorn in his leg. His PCP explored the wound, found no foreign body, and sent a sample for biopsy. It was actually a skin cancer, which the PCP removed in two subsequent sessions.

Additional medical history uncovered that Jack had a history of hereditary hemochromotosis—a disorder that results in too much iron being absorbed from the gastrointestinal tract that requires therapeutic phlebotomy. He had not received treatment in some time due to the expense of the phlebotomy—$180 per week.

According to Jack's PCP: "*He realized that meant he was going to die, but he didn't have $180 per week. I ordered lab work to confirm the diagnosis. And packaged up his information for the hematologist to review via eConsult. I asked, 'Why can't we do the phlebotomy here in the office?' The Kaiser specialist confirmed diagnosis and provided recommendations and guidelines for treatment. I procured the equipment and we are doing the phlebotomy at the clinic. We have done a few rounds, and the patient is doing well. He is able to pay our sliding scale, which is about $35 per visit, for life saving treatment. This is an example of how eConsult may be low volume, but high impact.*"

Increased availability of specialty care appointments

Coalitions reporting improvement: 52% (11/21)

Description: Just over half of SCI coalitions reported **increased availability of specialty care appointments (i.e., increasing the number of specialty appointments available).** Successful coalitions in this area generally engaged in one or more of the following strategies: obtaining specialty services from volunteers, recruiting specialty organizations to provide services to safety net patients, using data to influence the recruitment of paid specialists, and expanding the use of mid-level providers in specialty clinics.

"The Community Surgery Day event with Kaiser Permanente…is another accomplishment that has expanded specialty care access for hernia and gallbladder surgeries for coalition clinic patients. Prior to [this] partnership….the wait time could be as long as one to two years. Surgery days allowed us to provide patients much needed hernia and gallbladder surgeries within a reasonable timeframe."

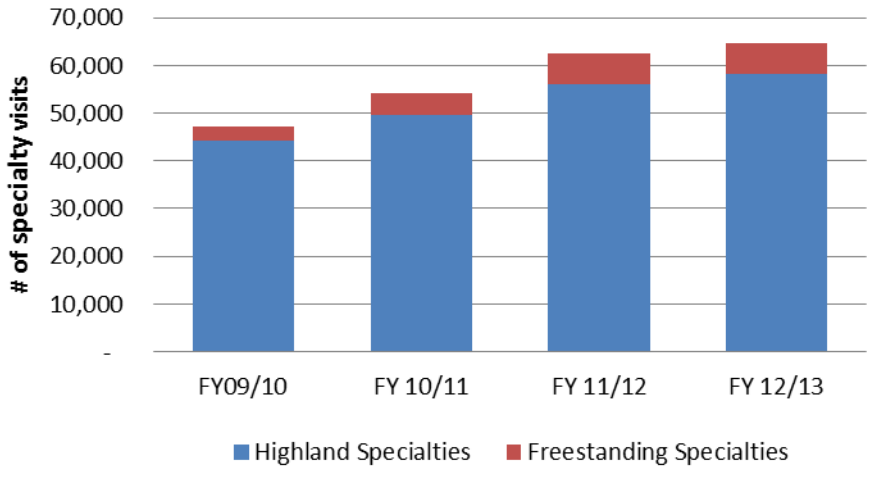
Alameda County Specialty Care Task Force

Lead agency: Alameda County Medical Center (ACMC)

Strategy: The Task Force extensively reviewed and discussed referral data in an effort to better understand the relationship between demand and capacity for specialty services at ACMC. As a result, **the quality of the data was improved to the point of being able to drive institutional decisions related to specialty expansion and recruitment**, which resulted in a 34% growth in specialty visits from fiscal year 2009-10 to fiscal year 2012-13. ACMC also increased its use of mid-level providers in specialty clinics to increase capacity and improve communication between the medical center and community clinic partners.

"SCI pushed us to really clean up our data and understand it and then we used tha in our strategic planning for the hospital and it really allowed us to advocate fo expansion of our specialty care clinics.'

Alameda County Medical Center Specialty Clinic Growth
FY 2010–2013
Overall 34% growth in specialty visits



More appropriate referrals

Coalitions reporting improvement: 38% (8/21)

> *"The referrals are more appropriate. With [the eReferral system], providers are more apt to try things because of the questions asked in the rules. We can see the difference things that they tried, and it looks like they are trying more before referring."*

Description: Over one-third of coalitions reported that **SCI improved the appropriateness of referrals**. SCI coalitions' definition of "appropriate" went beyond clinical requirements and included referrals that were complete in terms of health information provided (e.g., lab and other test results). Effective strategies included: implementation of and training on referral guidelines and process, providing PCPs opportunities for training and consultation with specialists, and improving screening practices to be more accurate.

Ventura County Safety-Net Specialty Care Access Coalition

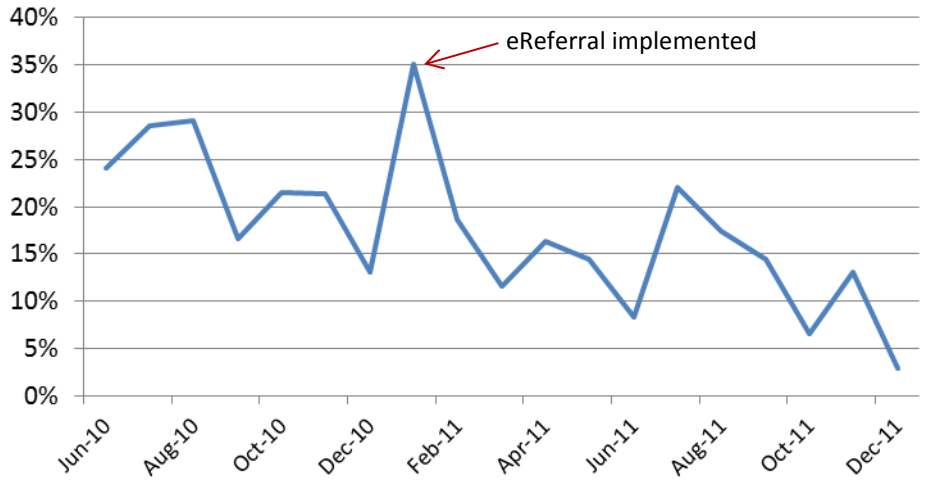
Lead agency: Health Care Agency of Ventura County

Strategy: The Health Care Agency—the public hospital in Ventura County—**developed a new, centralized eReferral system for Ventura County**, which went live in early 2011. All referrals went to the Referral Center where a nurse reviewed to ensure it met guidelines before approving it. The coalition also **developed and implemented guidelines in many specialty areas; guidelines were "living documents"** and presented as a tool to make more effective referrals rather than a mandate. They then conducted outreach and provided user trainings to all community clinics to increase understanding of the new referral process and guidelines. A survey of primary care referral providers indicated that "*satisfaction with the time it takes for a specialty referral to be processed*" increased from 24% pre-eReferral to 95% post-eReferral. In addition to improving the efficiency of the referral process, these efforts effectively strengthened the relationship between the Health Care Agency and community clinic partners.

> *"That is going to be the most lasting legacy: development of the centralized referral center—development of the guidelines, streamlining and standardizing the process. But from the spiritual side, having the community partners understand that everyone is on the same side of the table that is trying to get the patient high quality care. We're problem solving [and] working together. Longest term legacy from this grant is the relationships that have been built."*

Ventura GI Referral Denial Rates

June 2010–December 2011



Decreased no-show rates

Coalitions reporting improvement: 24% (5/21)

> *"[A key accomplishment] when it was really working was the case management. No-show rates are 30% average in many clinics. At [the lead agency], we've done a lot of work and it's 15%. With the specialty care case management, it was 5% or less, which I thought was incredible."*

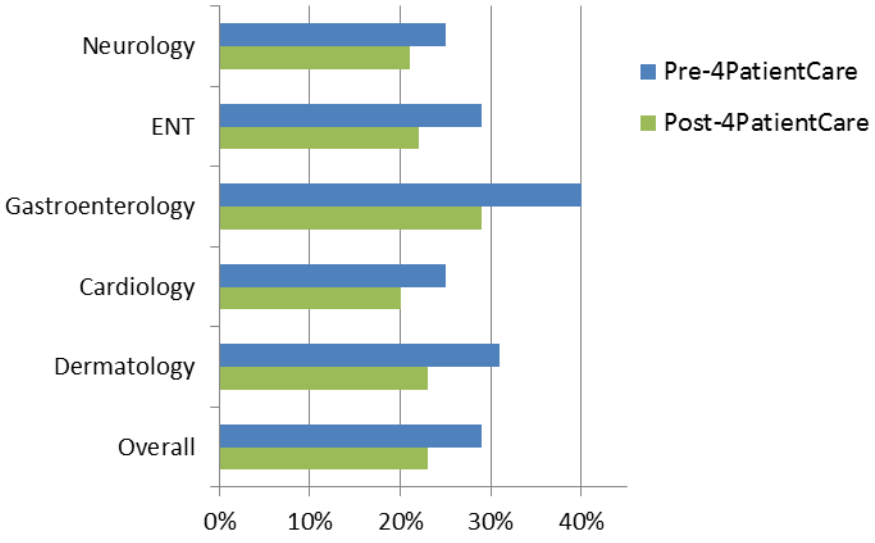
Description: **Nearly one quarter of SCI coalitions reported decreased no-show rates during SCI**. All of these coalitions implemented strategies to improve care coordination, ensuring patients had the information and resources needed to successfully complete their specialty visit. Effective strategies included: assigning patients a case manager, contacting patients prior to their specialty care appointment to remind and/or "pre-register" them, and intensive referral coordination.

Coalition of Safety Net Access Providers (C-SNAP)

Lead agency: Valley Care Community Consortium

Strategy: C-SNAP contracted 4PatientCare **to implement an automated patient-reminder system** at select specialty clinics at two Los Angeles County Department of Health Services (LA County DHS) sites—Olive View-UCLA Medical Center (OV-UCLA) and Mid-Valley Comprehensive Health Center. The system was initially implemented in five specialties—cardiology, dermatology, ENT, neurology, and gastroenterology. Patients received three telephonic appointment reminders—21 days prior to the appointment, 3-5 days prior, and the evening before the appointment. In the second reminder, patients could confirm, cancel or indicate they would like to reschedule their appointment. Call results were reported back to the clinics' scheduling desk to ensure that any available appointment could be filled. In January 2011, appointment-day text messages were added for patients who had a cell phone number. Eventually, based on the success of the program in cost-effectively reducing no-show rates, it was spread to all specialties at the two sites. Both sites committed to continuing to support the system after SCI.

No-Show Rates at OV-UCLA
Pre/post 4PatientCare



SCI Impact: More Integrated Delivery System & Improved Patient Outcomes

In addition to the improving access to specialty care, the intended impact of SCI was to create a more efficient, integrated delivery system and to ultimately improve patient health outcomes (see logic model in **Attachment A**). While these outcomes were not expected to be achieved in the five-year period of the initiative, coalitions sited progress toward both.

More efficient, integrated delivery system

As mentioned previously, coalitions discussed how SCI laid the foundation to better respond to emergent changes in the health care environment that reward more integrated systems (e.g., federal health care reform, patient-centered medial home recognition).

At the end of SCI, **88% of project managers (14/16) reported that their coalition was at least somewhat more effective in responding to changes in the health care environment as a result of the initiative.** Coalitions primarily discussed the contribution of SCI in preparing them for changes in the health care environment by: (1) helping them build relationships within their county's safety net system, and (2) helping them increase their capacity to collect, use and report on data.

- **Relationships:** As previously discussed, relationships were seen as a key factor in effectively co-managing patients across a system. Additionally, several coalitions reported that SCI laid the groundwork for conversations between partners related to becoming Accountable Care Organizations.
- **Data:** SCI's requirement that coalitions collect and report on referral data helped established data systems that coalitions stated would be leveraged as the health care environment becomes more data driven through initiatives like Meaningful Use and patient-centered medical home.

As one coalition member explained:

> *"We've been charged as a system to create an integrated system in the context of Medicaid expansion and health care reform and [SCI] had been invaluable in preparing us for that work….It's laid the foundation for future projects."*

Improved patient health outcomes

Overall, by the end of SCI, **coalitions reported more patients were getting the right care, at the right time, in the right place, from the right provider**. Five coalitions stated that the increased access achieved through SCI resulted in notable health benefits that improved the quality of patients' lives.

South Los Angeles Collaborative for Specialty Care Access

Lead agency: Southside Coalition of Community Health Centers

Description of strategies: Prior to SCI, there was no access to podiatry services for the safety net in South LA; the local public hospital (MLK-MACC) did not have a podiatrist on staff. Through an innovative public-private partnership between the coalition clinics and LA County DHS, Southside **implemented a podiatry program that included: 1) clinics for all coalition partners' diabetic patients located two community clinic sites; 2) outpatient surgical podiatry services at MLK-MACC; 3) a podiatry training curriculum for PCPs to increase their ability to handle basic podiatry needs.** The sustainability of the podiatry program was threatened early in SCI when podiatry was removed as an optional benefit for Medi-Cal beneficiaries. As a result, nearly all of the patients seen through the program had no payer source for the services. However, the program successfully demonstrated the need for podiatry services in South LA and MLK-MACC hired the podiatrist at 12 hours per week to continue providing podiatry access to diabetic patients in South LA.

Impact of the program: *"The primary impact of our SCI work has been the development of collaborative relationships between the community health centers in South LA and the MLK-MACC. Prior to the SCI work, there were only a few informal relationships and there was no collaboration in existence."*

In addition to increased organizational collaboration, the podiatry program had significant impact on its patients. Internal evaluation showed patients were overwhelmingly satisfied with the care they received through the podiatry program, both the outcome and the process. When asked about the program, "*one of the doctors said the difference between now and how it was before this program is 'the difference between heaven and hell.' They are seeing positive outcomes. They are seeing saved limbs."*

Podiatry program success story: *Patient Rocinda C*

Rocinda C. is a 48-year-old diabetic and single mother of five and the sole provider for her family. She was referred to the Southside podiatry program at St. John's Well Child and Family Center for non-healing bilateral ulcers on both of her ankles. Rocinda worked at a tamale stand which required her to stand for twelve hour shifts and was experiencing significant pain. Since she did not have health insurance, [she] had been seen at a County health facility for the condition and was told that she would require a double amputation of both lower extremities. With this fear, she delayed seeking any care for six years. Upon examination, Dr. Glover [the podiatrist] found that the infection was so severe that her bones were also infected. Dr. Glover, whom we often refer to as the Robin Hood of podiatrists, had developed a relationship with a research-based organization who provided him access to stem-cell plasma rich platelet grafts which healed Rocinda's ulcers within a two month period. In order to get Rocinda the comprehensive care she needed, Dr. Glover had to piece together her care which spanned his relationships at St. John's for her outpatient care and follow up, diagnostic studies and imaging at MLK-MACC and then inpatient surgical care needs at a local hospital under a charity care program. Rocinda is now back and work, and able to provide for her family without suffering through her long work days. She is also able to exercise and play with her children.

IV. Conclusion

The evaluation found that overall, during the five-year initiative, SCI coalitions were successful in improving access to specialty care and indicated that they were better positioned to effectively respond to changes in the health care environment that aim to establish more efficient, integrated delivery systems (e.g., implementing health care reform, patient-centered medical home).

Most participating coalitions identified the **building and strengthening of relationships** among safety net providers in their county—particularly between primary and specialty care providers—as a primary outcome of SCI. These new and strengthened relationships resulted in increased access to specialty care for the safety net by improving communication, establishing more efficient processes, and building partnerships that helped to establish a more integrated system of care. Coalitions attributed their success in relationship development both to the funded opportunity to work collaboratively toward a common goal (i.e., to improve the system of delivering specialty care) and the requirement that they use or establish a coalition to drive the work.

Many coalitions reported that the individual strategies implemented through SCI resulted in sustainable solutions and **systems changes that improved access to specialty care**. Additionally, most coalitions reported an **increased ability to track and report on specialty referral data**, which included improved data quality and more frequent use of data for decision making.

In the face of a struggling economy and major changes in the health care system—e.g., health care reform implementation, Medicaid expansion—demands on the safety net are larger than ever. However, coalitions stated that SCI, particularly its requirements related to using collaborative approaches and ongoing data reporting, has **positioned them to effectively respond to the various changes in the health care environment**.

A number of coalitions reported that they had obtained additional funding that built on their SCI efforts and partnerships; for example, implementing patient-centered medical home or a community-wide health information exchange. In addition, in Los Angeles (LA) County, the Kaiser Permanente Southern California Community Benefit Program has made a significant investment to support collaboration between five of the SCI coalitions in the county and other key stakeholders to spread promising SCI strategies across LA County.

Overall, coalitions appreciated the opportunity that SCI offered to engage stakeholders in problem solving and implement solutions to improve specialty care access. They reported that they will be able to leverage the work and relationships that resulted from SCI to continue to work towards more coordinated, higher quality care for patients.

V. Next Steps: Recommendations for Kaiser Permanente

Coalitions saw Kaiser Permanente as not only a funder, but also a key partner in strengthening safety net health care system in California. The following were areas that SCI grantees indicated Kaiser could make significant contributions to the safety net going forward.

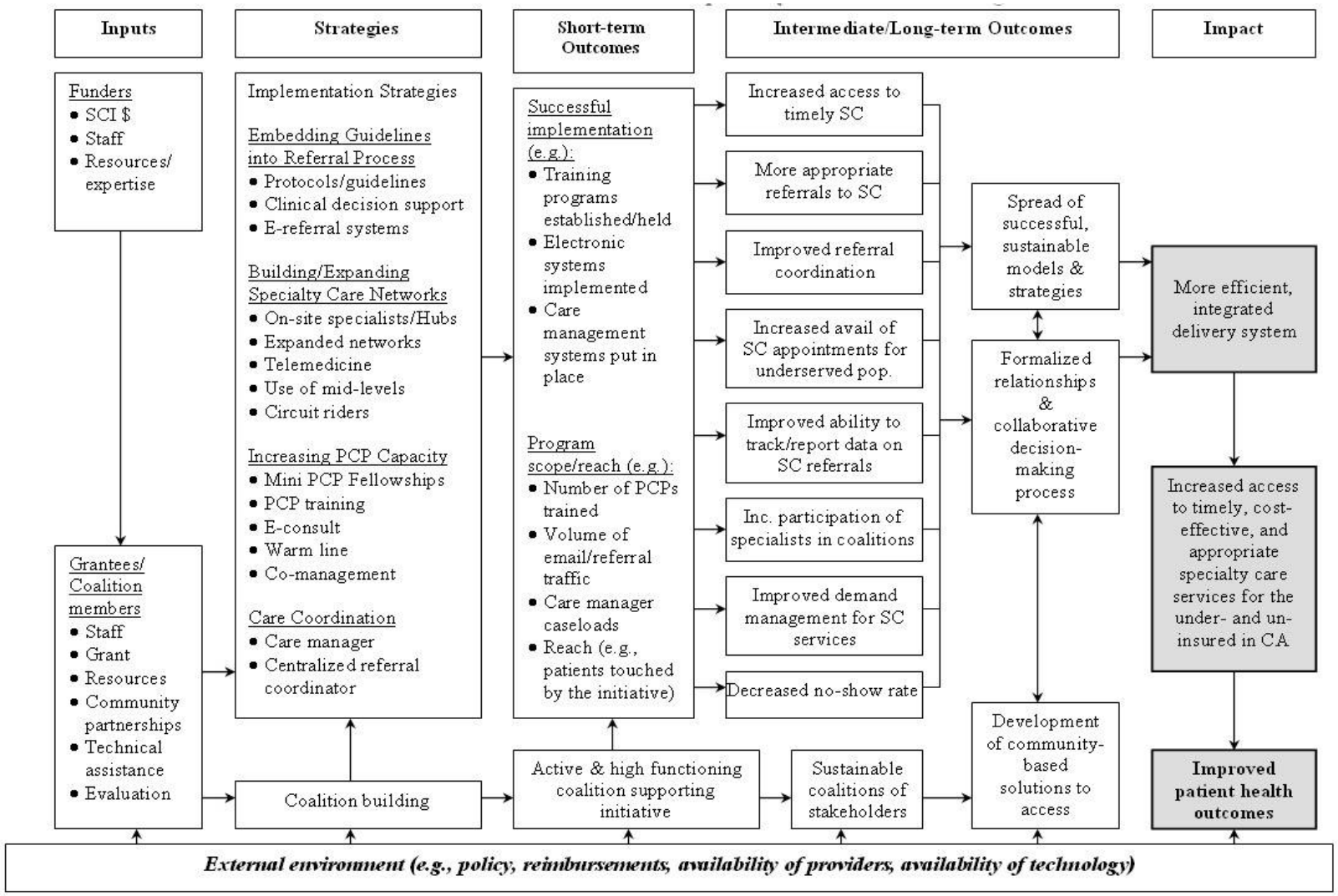
1. *Continue and expand efforts to share Kaiser's expertise and lesson learned to support the development of integrated health systems in the safety net.* Given Kaiser's experience as an integrated health system, coalitions saw Kaiser as an "expert" in many of the changes safety net systems are being asked to make in the current health care environment—population management, team-based care, using technology and data. There was a perception that Kaiser has "figured a lot of these things out" and the safety net could benefit from Kaiser sharing what it has learned and "promising practices." This included things like specialty referral guidelines, approaches for specialty care capacity planning (i.e., provider to patient population ratios), and workforce development and career ladders that support team-based care.

   > *"Anything [Kaiser] can do to improve integration of safety net systems, with a focus on population management, that would be very helpful. And Kaiser is positioned as an industry leader, which puts them in a unique position to support this work in areas where that is not their current approach….We have such issues with fragmentation in the safety net, [Kaiser] pushing integrated systems and a population approach would be very beneficial."*

2. *Continue to play a role as a high-level partner, using position and reputation to influence policy and convene decision makers.* Coalitions acknowledged that while it is important to support local efforts to improve health systems, there are larger forces influencing the ability to successfully implement and sustain effective strategies (e.g., policy, reimbursement structures). Coalitions believed that Kaiser could continue to play an important role in convening decision makers and translating lessons, from initiatives like SCI as well as its own experience, to influence policy.

3. *Continue to provide funding and support to community health centers in California to help them effectively respond to current changes in the health care environment.* This included:
   - Making internal (Kaiser) resources and personnel available to the safety net to share subject matter expertise, lessons learned and other materials (as mentioned above).
   - Supporting patient-centered medical home implementation and other clinical quality improvement efforts.
   - Providing targeted funding to support innovation within the safety net system in areas where policies and reimbursement structure do not yet support essential practices (e.g., care coordination).
   - Awarding capital grants for infrastructure expansion to allow community health centers to see more patients.

Attachment A: SCI Logic Model



Attachment B: Specialty Care Initiative Evaluation Overview

Goals of the Initiative

- Increase access to specialty care for vulnerable populations
- Decrease and improve demand for specialty care
- Improve the health care delivery system for the safety net

Evaluation Questions

1. **How successful is the overall initiative in:**
   - Stimulating the implementation of new strategies/models by grantees?
   - Improving access to specialty care services?
   - Funders' contribution to success of the initiative?

2. **Which strategies/models appear to be the most successful and have the greatest potential for replication in other settings or disciplines?**
   - Essential elements of successful programs
   - Challenges in implementation and achieving sustainability
   - Lessons for sustainability and spread to other health care delivery systems
   - Role/value of cross-organizational coalitions in implementing strategies

3. **How successful has the initiative been in spurring new, stronger and sustainable coalitions?**
   - Characteristic/factors that lead to successful partnerships and sustainable coalitions
   - Coalition or environmental characteristics associated with success/failure
   - Lessons for future initiatives and collaborations

Data Collection Approaches

- Grantee "oral progress reports" (every 6 months)
- Web-based coalition member survey (every other year)
- Grantee quantitative data report (quarterly)
- Funder/grant manager interviews (once per year)
- Case studies with a sample of grantees (including site visits and provider interviews)
- Document review of grantee progress reports and other relevant documents

Attachment C: SCI Evaluation Data Collection, 2009-2013

Source	Method	Purpose	2009-2010	2010-2011	2011-2012	2012-2013
SCI Grantees	Introductory call	To understand grantees' strategies and goals	N=24	--	--	--
	Oral progress reports (biannual)	To understand grantee strategies, progress and outcomes related to SCI, specifically: • Status of coalition functioning • Accomplishments • Successful models for improving specialty care access • Impact of SCI work on patients, coalition partners and partner organizations • Capacity for tracking and using data • Benefits and challenges to participating in the initiative	N=24	N=21	N=16	N=12
	Document review	To assess key accomplishments and progress on work plan and activities	N=24	N=14	N=10	N=15
	Quantitative data reports (quarterly)	To assess changes in: • Grantee data collection capacity • Specialty care access in four metrics: referral volume, referral disposition (i.e., denial rates), wait time, and no-show rates	N=24	N=21	N=16	N=9
	Quantitative data discussions	To assess quality of quantitative data and grantee perception of the usefulness of data collected	--	--	N=8	N=7
	Exit interviews (occurred post-funding)	To understand grantee experience and progress, specifically: • Accomplishments since funding ended • Sustainability of strategies • Impact of SCI work on patients, coalition partners and partner organizations • Status of coalition • Benefits and challenges to participating in the initiative	--	--	N=5	N=10
	Project lead survey	To assess grantee perception of: • Status of coalition functioning • Accomplishments • Successful models for improving specialty care access • Impact of SCI work • Likelihood of sustainability (coalition and strategy) • Capacity for tracking and using data • Benefits and challenges to participating in the initiative	--	--	--	N=16
	Site visits (sample of 6 grantees)	To understand in depth how strategies were implemented. Site visits included interviews with key project staff, tours of facilities, and demonstrations of electronic systems.	--	--	N=6	--

SCI coalition members	Coalition Survey	To assess coalition members' satisfaction and perceptions of: • Coalition functioning • Progress on SCI strategies • Use and effectiveness of technical assistance provided	N=239	--	N=228	N=114
	Interviews (sample of 3 grantees)	To assess perception of impact and understand success factors related to coalition functioning	--	--	--	N=8
Specialty and primary care providers	Interviews (sample of 6 grantees)	To better understand the impact of SCI activities on access.	--	--	N=31	--
Funders & Technical Assistance Providers	Interviews	To assess funder and technical assistance provider perceptions of grantee progress, promising models to improve access to specialty care, and benefits and challenges of the coalition process	--	N=3	--	--

Attachment D: Summary of SCI Coalitions' Work

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
AccessOC Coalition	Building Networks Increasing PCP Capacity	ENT Gastroenterology General Surgery Orthopedics	<1	**eConsult:** Purchased and developed an eConsult system, which enables PCPs to access to guidelines that have been uploaded by specialists and communicate with specialists via secure email. Initial challenges recruiting PCPs and specialists to participate hindered the uptake of the system.
San Bernardino Specialty Care Coalition	Building Networks Care Coordination	Cardiology Orthopedics	<1	**Volunteer specialists:** Planned to recruit volunteer specialists to provide specialty care at a centralized Specialty Care Hub.
Solano County Specialty Care Committee	Building Networks Care Coordination	Breast Care Cardiology Gastroenterology	1	**Volunteer specialists:** Developed physician recruitment materials. Built relationships directly with local hospitals and with private specialists through the medical association.
Marin Specialty Access Coalition	Embedding Guidelines Building Networks Care Coordination	Referral process improvements included **all specialties**. Volunteer recruitment efforts focused on: Gastroenterology (GI) Orthopedic Surgery Neurology	2	**Referral:** Developed an in-house electronic referral system at Marin Community Clinic (MCC) to process internal and external referrals. Database allowed them to track data and improve the process. Convened referral coordinators to share best practices, challenges and lessons learned. To support this, MMC added referral coordinators to manage referrals from other coalition clinics. Although MMC did not sustain the external referral process, improvements to the internal process continued after SCI. **Volunteer specialists:** MMC had early success expanding their volunteer network and opened up excess capacity of its volunteer network to coalition clinics. These expanded efforts did not continue after SCI.

[7] "Years funded" is implementation funding only, including any no-cost extensions awarded.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
ACCEL (Access El Dorado)	Embedding Guidelines Building Networks Increasing PCP Capacity Care Coordination	Orthopedics Pain Management	2 ½	**Specialty care pathways:** Designed and implemented two countywide care pathways including specialist recruitment, referral guidelines & tracking templates, and integrated referral and care coordination. Partnered with a local orthopedic group for the orthopedic pathway. Implemented telemedicine to support the pain management pathway in partnership with the University of California (UC), Davis Pain Management Department. By 2011, ACCEL had served over 600 patients through the pathways. However, ACCEL later hosted several pain management educational sessions via telehealth with UC Davis after the grant ended. The orthopedic pathway is still in place; however, the orthopedic group is now managed by the local community health system as a result of a recent acquisition.
Alameda County Specialty Care Task Force	Embedding Guidelines Building Networks Increasing PCP Capacity	Reviewed and acted on data as appropriate for **all specialty clinics**. Teledermatology Conducted training activities for a variety of specialties including: Cardiology Dermatology, Eye clinic, Hepatitis C, Gastroenterology, Neurology, Orthopedics, Pain management, Podiatry, Urology, Rheumatology	5	**Specialty expansion:** Improved the quality of referral data to drive medical center decisions related to expanding specialty care clinics and recruiting specialty providers. Decentralized some specialty clinics. Expanded the role of mid-level providers to improve communication between the specialty and primary care clinics. Number of specialty appointments increased from 47,186 in 2010 to 64,155 in 2012. **Telemedicine:** Implemented store and forward teledermatology in partnership with UC San Francisco (UCSF). UCSF providers come to Alameda County weekly to follow up with patients with abnormal results. This program is expected to continue after SCI. **PCP training:** Dinner series with community clinic PCPs and ACMC specialists on various specialty topics. Included discussion on updated referral guidelines. Nine events held annually with 30-40 PCPs attending. Implemented a mini-fellowship program for all of the specialties listed. 28 fellowships anticipated to be complete by the end of 2013. ACMC is committed to continuing to provide opportunities for PCP training after SCI.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
Contra Costa's Specialty Care Stakeholder Committee	Embedding Guidelines Building Networks Increasing PCP Capacity Care Coordination	Referral process improvements included **all specialties**. Volunteer recruitment efforts focused on: Breast Care Gastroenterology OB/GYN	2 ½	**Referral:** Developed a standardized, in-house tracking system for specialty referrals. Convened community clinic referral coordinators to facilitate peer learning and sharing of best practices. Developed a provider database to aid referral coordinators in linking patients to specialty care. The lead agency (Community Clinic Consortium of Contra Costa) integrated both of these efforts into its operations. **Volunteer specialists:** Recruited volunteer specialists to provide services to the uninsured through outreach to local hospitals and formalizing partnership with Operation Access, which continued after SCI.
Coalition of Safety Net Access Providers (C-SNAP)	Building Networks Increasing PCP Capacity Care Coordination	All (4PatientCare) Telemedicine activities targeted: Dermatology Ophthalmology PCP training activities focused on: Cardiology Dermatology Neurology	4	**Care coordination:** Implemented 4PatientCare, an automated patient reminder system (includes both phone and text messages) at two LA County Department of Health Services (DHS) sites—Olive View-UCLA Medical Center and Mid-Valley Comprehensive Health Center. Although initially established in five specialty clinics with high no-show rates, it was determined to be a cost-effective strategy in reducing no-show rates and eventually was implemented in all specialties. Commitment from LA DHS to continue supporting the system after SCI. **Telemedicine:** Implemented a store and forward teledermatology program with a specialist in partnership with a private dermatologist champion. In its first year, over 800 scans were received and reviewed; 80% could be handled appropriately in primary care. Conducted a video ethnography project to assess how teledermatology was working for patients and medical staff at two health centers. The project determined "*patients were very satisfied with the improved wait time, treatment received and the quality of care provided.*" Although this program did not continue, it informed the way dermatology referrals occur through LA County DHS's new eConsult system.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
				PCP Capacity: Held case conferences with PCPs and specialists to discuss referral process and guidelines, including some practice management recommendations. In neurology, conducted a chart audit to identify common issues in referral and develop a training approach.
Fresno Access to Care Task Force	Embedding Guidelines Building Networks	Dermatology	4	**Specialty expansion:** Provided specialty data from the planning process to the local hospital to inform specialist recruiting efforts. **Telemedicine:** Analyzed specialty referral and demand data to identify areas of high telemedicine applicability and high need clinics. Assessed and "staged" community clinics for telemedicine spread; included technical screening, IT coordination, workflow mapping and sustainability planning. Implemented teledermatology program at one community clinic, which continued after SCI.
IRIS Steering Committee (Humboldt County)	Embedding Guidelines Building Networks	All specialty clinics	2 ½	**Referral:** Purchased new eReferral system (IRIS). Enrolled 553 users in IRIS including 60 PCPs from 16 practices and 72 specialists from 34 practices. Worked with specialists to build "rules" for referral to their practice. Nearly 14,200 referrals occurred September 2009 – June 2011. Effort successfully engaged a community of independent practices around a common health information technology initiative and provided the first step towards a health information exchange (HIE) in the county.
Kern Medical Center Specialty Care Coalition	Embedding Guidelines Increasing PCP Capacity	All specialty clinics	3	**Referral:** Redesigned the referral process "*to open communication and build relationships*" between Kern Medical Center (KMC) and community clinic partners. Integrated an eReferral system including referral forms and guidelines into the new EMR at KMC. Guidelines were adapted and standardized for Kern County from existing guidelines. Process was informed by a countywide referral workgroup. Conducted community round tables, facilitated trainings and discussions on referrals at community clinics' provider meetings. All referral improvements sustained after SCI.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
LAC+USC Camino del Salud Network Specialty Care Access Project	Embedding Guidelines Building Networks Increasing PCP Capacity	Cardiology Gastroenterology OB/GYN Orthopedics Rheumatology	4	**PCP training:** Formalized a PCP champion program that included ***mini-fellowships*** in cardiology, rheumatology and OB/GYN. Identified and finalized training outcomes for all three areas, and had them approved by the LA Department of Health Services to help assess competency of champions. Held monthly ***community grand rounds*** consisting of either a CME session with Q&A or a facilitated dialogue between PCPs and specialists. Future of training activities unclear due to changing priorities and resources at LA County Department of Health Services (DHS). **eConsult:** Piloted an eConsult system to support communication between champions and specialists. Experience with the pilot helped coalition providers to be early adopters in the new county-wide eConsult system in LA County. **Care coordination:** Early success in establishing access for PCs to Affinity, LA County DHS's electronic information and billing system, so they could see the status of their patients' referrals. Later, Affinity access became a county-wide effort of LA County DHS.
LMSS (Lassen, Modoc Siskiyou, Shasta) Specialty Care Coalition	Embedding Guidelines Building Networks Increasing PCP Capacity	All specialty clinics	2 ½	**Referral:** Researched & purchased a new eReferral system (IRIS). Recruited and trained providers and staff on the system. Worked with specialists to build and embed "rules" for referral to their practice into the system. Over 1750 referrals in various specialties occurred November 2010 – June 2011. The system continued to operate after SCI; although recruitment efforts were scaled back.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
Long Beach Community Increased Access Specialty Care Coalition	Embedding Guidelines Building Networks Increasing PCP Capacity	Cardiology Dermatology OB/GYN Rheumatology	3	**PCP Training:** Partnered with Harbor-UCLA's cardiology clinic to implement a cardiology champion program; have cardiology champions in each of the participating primary care clinics. Recruited a private sector cardiologist to provide additional support to champions. Explored expanding model to OB/GYN and rheumatology. Consulted with a dermatology specialist on potential roles for PCPs related to dermatology. Expanded relationships with LA County DHS specialists continued after SCI and positioned them to be involved in implementation of the county-wide eConsult system.
San Diego Countywide Specialty Care Initiative Coalition	Embedding Guidelines Building Networks Increasing PCP Capacity Care Coordination	Guideline development and eConsult included **various specialties.** PCP training driven by PCP demand and focused on **various specialties.** Basic procedural trainings on: Dermatology, Hepatitis C, Orthopedics, Pain Management	4½	**eConsult:** Developed and implemented an eConsult system where volunteer specialists provide case review and consultation in various specialties. In two years (2011-12), PCPs submitted 154 consults, 92% of which were successfully managed in primary care. Most common specialties consulted on included: endocrinology, GI, dermatology, and rheumatology. The Medical Society Foundation committed to continue supporting eConsult after SCI. **PCP training:** Implemented a number of programs to improve PCP knowledge including physician roundtables, didactic lectures and webinars, and in-person training on performing two procedures: orthopedic joint injections and punch and shave biopsies. The Council of Community Clinics committed to continuing to provide PCP training as needed. **Referral:** Created over 90 guidelines that are posted online so that PCPs and referral coordinators can easily access. Provided training for participating clinics to integrate guidelines and referral tracking into standard workflow. Coordinated referral managers to share best practices on tracking referrals. In addition, referral guidelines are used by Project Access San Diego, a program in which volunteer specialists provide certain types of consult and procedures to uninsured residents San Diego.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
San Francisco Specialty Care Steering Committee	Embedding Guidelines Increasing PCP Capacity Care Coordination	Endocrinology Gastroenterology (GI) Orthopedics (2011-13) Pulmonary (2009-11)	4	**Workgroups:** Established workgroups for each targeted specialty that included leadership from the four main safety net providers in the county (both specialty & primary care). Initially, each workgroup selected its own project(s) including: implementing a colonoscopy class and expanding direct colonoscopy by changing the screening modality; adding a diabetes portal in eReferral that houses both clinical and patient education resources; development of a primary care clinic-based spirometry network. In the last half of SCI, workgroups focused on transitioning patients back to primary care from specialty. The workgroup model continues to be used, but these specific workgroups discontinued after the work was institutionalized. **Referral:** Embedded a rating tool into eReferral to evaluate physicians' experience. Focused on primary care providers' ratings of specialty reviewers. Used ratings to give formal feedback to the individual specialty reviewers, discuss best practices, and identify opportunities for improvement. Intervention resulted in an improvement in specialists' ratings. **Care coordination:** Got consensus on criteria for discharging patients from specialty back to primary care in GI, endocrinology. Implementing the criteria in GI resulted in 400 cancelled referrals and a decrease in GI wait time. Implemented an intervention in orthopedics that increased the number of consult notes uploaded in the EHR to over 80%.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
San Joaquin County Specialty Care Access Coalition	Building Networks Increasing PCP Capacity	Primary focus: Dermatology Orthopedics Secondary: Cardiology ENT Nephrology i2i Tracks used in **various specialties.**	3	**Specialty expansion:** ***Dermatology:*** Created a dermatology clinic at San Joaquin General Hospital (SJGH), which is staffed by trained family medicine physicians. Clinic is open daily serves approximately 100 patients per month. Established a website for teledermatology consult from UC Davis. Included development of a curriculum and training of PCPs in basic dermatologic procedures. ***Orthopedics*****:** Initially trained an orthopedic physician assistant to handle basic consults and procedures, but lost that resource due to turn-over. Identified a PCP with a sports medicine background to work in the orthopedic clinic. ***Other***: Added capacity through mid-level providers in cardiology, ENT, and nephrology. **i2i Tracks:** Purchased i2i Tracks to support the dermatology program and was expanded to support the SJGH's PCMH effort; obtained NCQA diabetes care recognition, currently working on obtaining full PCMH accreditation.
San Mateo County Specialty Healthcare Improvement Project (S.S.H.I.P.)	Embedding Guidelines Building Networks Increasing PCP Capacity Care Coordination	Referral and care coordination strategies targeted **all specialties.** Specialty expansion focused on: Dermatology Orthopedics	2	**Referral:** Developed and implemented a Smart Referral system that integrated with the existing EHR. Identified guidelines in the public domain and San Mateo Medical Center (SMMC) specialists adapted. Work was ongoing to integrate guidelines into the Smart Referral system after SCI. **Care coordination:** SMMC implemented specialty care redesign with support from Coleman Associates. Redesign process had six strategies: 1) Quick start (all staff showing up on time); 2) Clinic prep (getting ready for the next day); 3) pre-registration (calling patients to remind them of appointment, etc.); 4) central registration in the lobby; 5) implementing guidelines; 6) rational scheduling determined by specialists. Pre-registration and central registration were the strategies that got the most traction during and sustained after SCI. To support redesign, SMMC implemented a centralized call center.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
				Specialty expansion: Trained a physician's assistant (PA) to support the orthopedic clinic. His role included direct patient care, as well as referral review and providing additional care coordination for patients. Services provided by the PA were reimbursable and the position sustained after SCI.
Santa Clara County Specialty Care Access Collaborative	Embedding Guidelines Increasing PCP Capacity	Initial efforts targeted referrals across **all specialties**. Focused on **Radiology** & **Mammography** in 2011-13.	4	**Referral:** Improved and streamlined the specialty referral process into Valley Medical Center (VMC). Established systems to facilitate and expedite PCP access to their patients' specialty consult notes. Created a secure website to post guidelines and referral information so that all referring providers have access. **Radiology & mammography:** Collected data and conducted referral process mapping resulting in a decrease in wait time for mammography. *"We got the right people from radiology to the table….We had wait times for mammography that were 5-6 months that went down to 30 days."*

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
South Los Angeles Collaborative for Specialty Care Access	Building Networks Increasing PCP Capacity Care Coordination	Podiatry Ophthalmology Referral navigation targeted referrals for **all specialties**.	4	**Specialty expansion:** Implemented a podiatry program in South LA—two podiatrists provided basic services at two coalition clinics and one podiatrist performed procedures at space provided in-kind by LA County DHS's ambulatory care facility in South LA (MLK). Providers reported this increased access improved outcomes and "*saved limbs*." High patient satisfaction with the quality of care. The program demonstrated the need for podiatry services in South LA and MLK hired the podiatrist part time to provide services after the SCI grant ended. **PCP training**: Implemented a podiatry curriculum (10 training sessions) for PCPs. Included opportunities for didactic, hands-on training, and case consultation. **Telemedicine:** Implemented telemedicine retinal screening program in four clinics, which provided several thousand visits in 2009. Program was integrated into a National Institute of Health research project and expanded to two additional clinics. Established process to expedite urgent referrals at MLK. **Care coordination:** Hired patient navigator to work at MLK referral center; navigator is able to fast track urgent referrals and get patients into open slots with a retinal specialist. Navigator also provided interpretation services as needed. MLK committed resources to sustain the referral navigator for the year following SCI. In addition, convened referral coordinators at all the clinics with the referral navigator and MLK referral manager to discuss the referral process and troubleshoot issues.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
SPA 3 Specialty Care Planning Coalition	Embedding Guidelines Building Networks Care Coordination	Dermatology Gastroenterology Referral navigation targeted **all specialties.**	5[8]	**Colorectal cancer screening:** Implemented the immunological fecal occult blood testing (iFOBT) modality for colorectal cancer screening. Developed a guide for diagnostic colonoscopies that explains program guidelines, eligibility, identifying patients, and referral process. Participating clinics were trained on the new screening modality and integrated it into clinic practice. It is anticipated to continue after SCI. **Volunteer specialists:** Established a surgery day with Kaiser Permanente Baldwin Park to obtain colonoscopies for patients with positive iFOBT test results (5 patients/ month). This program is expected to continue after SCI. **Telemedicine:** Implemented teledermatology at six clinics. Supplied equipment to four clinics. Provided training to 1) PCPs on teledermatology consults and biopsy procedures, and 2) care coordinators on program guidelines, workflow and capturing images. This program is expected to continue after SCI for uninsured patients; for other patients, clinics will use LA County's new eConsult system. **Care coordination:** Early success convening care coordinators from SPA3 clinics to discuss referral practices and troubleshoot issues. Placed a central referral navigator at the referral center of the local LA County DHS facility (LAC+USC) to facilitate appointments for coalition clinic referrals. From January-August 2013, the navigator assisted in scheduling 681 pending appointments. This position did not sustain after SCI. **Specialty care hub**: Developed an implementation plan and business plan for a specialty care hub at the two largest coalition clinics. Awarded an additional year of SCI funding to implement (October 2013).

[8] Excludes the one-year continuation grant awarded in October 2013.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
Ventura County Safety-Net Specialty Care Access Coalition	Embedding Guidelines Building Networks Increasing PCP Capacity	Referral center efforts included **all specialty clinics** Telemedicine targeted: Dermatology Retinal screening	4½	**Referral:** Developed a new eReferral system for Ventura County, which went live early in 2011. All referrals go to the Referral Center where a nurse reviews to ensure it meets guidelines before approving it. Developed and implemented guidelines in many specialty areas; guidelines were "living documents" and presented as a tool to make more effective referrals rather than a mandate. Referral system improvements continued after SCI. **Specialty expansion:** Used data from the Referral Center to inform the Health Care Agency's recruiting efforts. **Telemedicine:** Implemented telemedicine for retinal screening; medical assistants were trained to do the scans; four specialists were trained to read the scans by ophthalmologists at UC Berkeley. This program continued after SCI. Established the infrastructure for a teledermatology program.
Westside/South Bay Specialty Care Coalition	Building Networks Increasing PCP Capacity Care Coordination	Cardiology General Surgery Gastroenterology Ophthalmology Rheumatology	4	**Volunteer specialists:** Built on Venice Family Clinic's volunteer network; focused on expanding to the number of specialist volunteers. Opened up capacity in cardiology for a coalition partner clinic. Partnered with Kaiser Permanente West LA and Kaiser Permanente Harbor City to implement two Community Access Days (CAD) per year. CAD included: colonoscopy, cataract, hernia, and gall bladder procedures. **PCP training:** Identified cardiology and rheumatology PCP champions at each clinic; these providers had access to consultation from specialists at Harbor-UCLA. Quarterly calls held with cardiologist and provider champions to discuss challenging cases. Specialists at Harbor-UCLA continued to be available for consult after SCI. **Care coordination:** Specialty Care Coordinators for CAD helped to identify patients, make sure patients had what they need for the surgery/procedure and ensured that they show up at the event; for the volunteer model, referral coordinators tracked referrals and ensured that patients are able to make it to their appointments.

Coalition	Clusters participated in	Specialties targeted	Years funded[7]	Highlights of SCI work
Yolo County Future of the Safety Net	Embedding Guidelines Building Networks Increasing PCP Capacity Care Coordination	Orthopedics Rheumatology Neurology Gastroenterology Endocrinology	4½	**Fair Share:** Implemented a "Fair Share Model" with four local health systems (Kaiser Permanente, Sutter, Woodland and University of California, Davis); each agreed to take certain referrals from the participating clinics. Services were tracked and assigned a dollar value by the Specialty Care Project Manager to ensure fairness. Established referral guidelines and process; all referrals for Fair Share participants were reviewed for appropriateness. Although the Fair Share model did not sustain, the process established with Kaiser Permanente for rheumatology, neurology, and endocrinology continues. **Care coordination:** All referrals for Fair Share patients went through a central specialty care case manager who tracked the referral and worked with patients one-on-one to make sure they have what they need to complete the appointments (e.g., transportation, interpretation services). Case management for new and follow up appointments. Also assisted with patients' transition back to primary care. No-show rates for these patients were below 5%. Although the specialty care case manager position did not sustain after SCI, integrated many of the systems and best practices into the role of the referral coordinators.