

Specialty access: creative solutions for Sonoma County

Kelly Pfeifer, MD

Medical Director for Access

Redwood Community Health Coalition

Medical Director, Petaluma Health Center

Background

- There is a serious mismatch between demand and supply for specialty access in Sonoma County.
 - We are 11 full time specialists away from being able to meet the needs of the Medi-Cal population in Sonoma County.*
 - The private sector does not have the capacity to “fold in” the MediCal population, even with improved reimbursement.
 - We must find creative solutions.

*Needs analysis done by RCHC in 2005.

Scarce specialty access = poor quality of care

- Poor access
 - Progression of preventable disease
 - Increased utilization of EDs and hospitals
- Difficulty recruiting PCPs
 - Fear about practicing outside of comfort zone
 - "I need my first job to be in a place where I can get help."
- Difficulty retaining PCPs
 - Exit interviews show high stress levels:
 - "I can't practice this way; I have to protect my license."

Who will take Medi-Cal in Sonoma County?

- Only one ENT, limited scope of practice (no throat surgery)
- No orthopedists, unless "special case," personally begged by PCP
- Two dermatologists, at two clinic sites (four hours/week)
- Rheumatology – four hours a month at Indian Health
- One volunteer neurologist, one day per month
- Gastroenterologists rotate through hub clinic at Southwest, long wait list
- Surgery, cardiology – depends on location

Most Sonoma County specialists are now cynical about Medi-Cal

- "Last month they sent me a check for twelve cents"
 - Local surgeon
- "50% of my surgeries are never paid for. The rest have to go through half a dozen claim rejections, for ridiculous reasons"
 - Local orthopedist
- "I tried to accept MediCal, and got flooded with patients; I couldn't afford it anymore."
 - Local orthopedist

Will managed Medi-Cal fix the problem?

- Partnership may woo some specialists back, who may take a limited number of patients, if the following is guaranteed:
 - Reasonable reimbursement
 - Eliminate hassle factor for credentialing, authorizations and payments.
- Given volume of currently unserved patients, they have a legitimate fear of being deluged if they open the door.
- Demand still will overwhelm supply, causing specialists to leave the Medi-Cal network, unless we make innovative changes in delivery system.

Now is the time to act

- Publicity around Sutter's potential closure has mobilized community interest in access to primary and specialty care
- Sonoma Health Access Coalition has signed on over 30 organizations, with specialty access one area of focus.
- Marin and Yolo Counties received large Kaiser planning grants to work on specialty access. They asked RCHC to coordinate communication and explore regional solutions.
- Kaiser is funding a major CPCA initiative to study specialty access on a statewide level.

Key factors for creating a successful system of care

- Increase supply
- Decrease demand
- Improve coordination to decrease waste
- Locally and regionally, supply and demand addressed in creative ways:
 - On-site clinics; hub clinics
 - Circuit riders
 - Telemedicine; E-referrals
 - Expanding networks
 - Referral coordination
 - Broaden PCP scope of practice

Models for expanded access: on-site specialty clinic

- Specialists rotate into half-day clinics at community clinic site; clinics bill Medi-Cal; specialists paid hourly rate.
- Examples:
 - Podiatry (available at most clinics)
 - Ophthalmology (Southwest Community Health Center)
 - Rheumatology (Indian Health)
- Advantages:
 - Eliminates language barrier
 - Fewer missed/late appointments due to transportation, logistic problems; care done at medical home
 - Brings more money into system, due to clinic's PPS rate

Local clinics are cost-efficient solution for many specialties

Easy access to specialists improves PCP knowledge base and scope of practice

- Less likely to refer simple cases if they can ask a direct question to a specialist on-site
- PCPs gradually expand their scope with good communication with specialists
- PCPs can do follow-up visits; unloading specialists' schedules
- Specialist has access to chart – fewer wasted referrals because of inadequate medical records
- Protocols and specialist-directed CME can prevent wasted consults due to inadequate work-ups.

Example of why referral numbers decrease with on-site specialists

Typical pattern for outside specialty referrals:

Patient sees specialist; specialists orders work-up.

Patient comes to follow-up appointment for results.

Specialist starts treatment.

Specialist sees patient in follow-up to assess outcome.

First-line treatment fails: second-line treatment started.

Follow-up visit.

Total visits: FOUR

With on-site clinics:

Protocols and access to specialists for questions allows PCP to do initial workup and start treatment.

Patient only sees specialist after above complete.

Total visits: ONE

Results:

- If the average patient requires one visit instead of four....
- Specialty capacity now expanded by 300%

On-site clinics: disadvantages

Grant funding often required:

- Hourly rate for specialist may not be affordable for clinic without subsidy
- Special equipment needs may require initial investment

Clinics need bricks and mortar to make this work

- All clinics are pushing capacity limits
- All clinics are currently working on a new building, or satellites
- Example: Petaluma Health Center has patient care rooms made from hallways and closets

Currently, most clinics are scrambling to find their own solutions, and most on-site specialty clinics are closed to outside referrals.

Model for expanded access: hub site

- On-site specialty clinic accepts outside referrals
- Typically use standardized referral forms and guidelines to decrease demand and waste
- Examples:
 - Derm Clinic, Alliance
 - GI Clinic, Southwest (long wait lists)
 - Hepatitis B/C Clinic, Petaluma
 - Neuro Clinic, Petaluma, West County (very limited availability)
- Most clinics would be willing to open their specialty clinics if they had space and funding

Why can't clinics hire their own?

- Concept: two or more clinics share full-time employment of a specialist "circuit rider"
- Examples:
 - GYN (Petaluma, Southwest)
 - Psychiatry (Petaluma, Marin Community Clinic)
 - Psychiatry (Sonoma County Mental Health Department)
 - Pain Management (Petaluma, Southwest)

Expanding access through circuit-riders

- Advantages:
 - A clinic may not be able to support a full-time specialist on their own
 - Clinics can share cost of benefits
 - Recruitment of specialists who otherwise wouldn't come to Sonoma County: specialists who are attracted to this model:
 - Close to retirement
 - Young children, seeking part-time work
 - Specialists tired of "running a business" and want employment
 - Interested in under-served population

Circuit-rider disadvantages

- Requires a tremendous amount of coordination and contracting (better managed by network such as RCHC)
- Unlikely to be affordable, or manageable, for surgical specialties due to income requirements and call demands.

Expanding access through E-referrals

- Excellent models available
 - Kaiser e-referral
 - Evidence-based protocols provide built-in prompts when PCP makes referral
 - Provides mechanism for PCP to learn initial work-up and first-line treatments (again, increasing capacity by decreasing number of specialty visits)
 - Provides secure communication between specialist and PCP.

E-referrals

- Santa Clara:
 - Proprietary system, built in protocols, has dramatically decreased number of referrals into system
- San Francisco General Hospital:
 - No protocols used. Specialists review referrals in advance, triage, and give management advice to PCP.
 - Appointments can be made on the spot (patients no longer “lost to followup”).
 - Cut waiting time to colonoscopy from one year to one month; other specialties equally successful.

E-referrals: future opportunity

Adoption of E Clinical Works (ECW) by the majority of RCHC clinics brings opportunity to have central four-county e-referral system.

Could Kaiser's protocols be adapted and incorporated into ECW?

Could ECW Health Information Exchange be expanded to include images, to allow derm and ophtho e-referrals?

ECW would allow improved tracking and case-management.

Model for expanded access: Telemedicine

- Links patients with specialists throughout the state
- State-wide network of hub and spoke sites currently in early development
- Currently state and federal funding available
- Academic centers are funded to supply access to rural sites
- Could dramatically increase specialist supply
- Requires initial capital investment, physician champions, and sophisticated coordination

Telemedicine Centers of Excellence

Northern California has several strong telemedicine networks in place:

Open Door Community Health Centers

Shasta Consortium

Del Norte Clinics

University of California, Davis

All specialties represented

Multiple clinic sites connected through central network

Davis hosts a Telemedicine Learning Center to train clinics and specialists how to start, grow, and maintain a telemedicine system.

Telemedicine advantages

- Increases supply through remote site access
 - University settings
 - Retired physicians not ready to quit completely
 - Physicians wishing to work from home:
 - Disabled
 - Family leave
 - Wishing avoid office overhead
- Decreases demand:
 - Increases physician scope of practice
 - Video collaboration allows PCP to become comfortable managing conditions that previously required referral
- Decreases waste:
 - Patients receive care in own language, at medical home, decreasing missed visits or poor care coordination

Telemedicine disadvantages

- Complexity
 - Several clinics abandoned effort due to bad experiences:
 - Decreased productivity
 - Technical difficulties and failures
 - Loss of physician champion
 - Logistical barriers
- Cost
 - Equipment: start-up and maintenance
 - IT: connection fees
 - Staff:
 - Coordinator
 - Physician champion

Store and Forward: good place to start

Ophthalmology and Dermatology are ideal "starter specialties"

- Digital photos with standardized referral template sent through secure email.
 - Specialist can bill MediCal for consult.
 - Alliance and Petaluma collaborating on telederm pilot; plan to spread to other clinics.

Store and forward

- Diabetic retinal screening:
 - Retinoscope takes good quality retinal images
 - Currently UC Berkeley optometry setting up rural sites and reading images for \$15 each.
 - Petaluma/Marin/Sonoma clinics collaborating with a shared scope.

Expanded access through expanded scope of practice

Train primary care doctors and midlevels to assume specialty expertise

- Napa piloting year-long project to expand psychiatric prescribing skills
- Southwest has monthly case management reviews with psychiatrist
 - Eliminates all but complicated cases
- Procedural courses available to learn skin biopsies, flex sigs or colonoscopy, colposcopy, joint injections, casting and splinting, etc.
- Develop “local expert” at each clinic site.

Expanding access through centralized referral coordination

- RCHC could coordinate recruitment, contracting, credentialing, referrals, and case management
- Successful example in a volunteer setting: KidsNet
 - Large network of volunteer specialists agree to see a set number of patients per month in their office.
 - Number of referrals strictly controlled to prevent specialists from feeling “if I give an inch, they will take a mile.”
 - Developed data base system to case manage each referral; they boast a 3% no show rate.

Centralized referral coordination

- Advantages:
 - Increases supply through centralized recruitment of new specialists
 - Decreases waste through effective case management
 - Allows counties to share resources (one county's feast may be another county's famine)
 - Centralized training of referral coordinators improves coordination and case management.

Centralized referral coordination

- Disadvantages:
 - Cost:
 - Major IT investment
 - Staff:
 - Project Coordinator
 - Medical Director

Expanding access through the private sector

- Create network of specialists seeing people in their office:
 - Centralized coordination of referrals
 - Define fixed contribution:
 - Patients per month?
 - E-consults per month?
 - Allows specialists to open the door without fearing a deluge

Example: Kaiser volunteer program

- Individual departments agree to see a set number of patients per month
- Currently in operation in Marin and Petaluma
- Advantages:
 - Increases access to difficult-to-find specialties
 - Access to expensive in-office procedures (cystoscopy, in-office surgery)
- Disadvantages:
 - MOUs difficult to negotiate
 - Benefits very small number of patients, compared to demand
 - Does not allow access to surgery
 - Communication with PCP challenging due to incompatible EHR

Next steps: Approach access in a coordinated, comprehensive way

RCHC specialty access project:

- Organize county-wide creative approaches to increase supply and decrease demand
- Coordinate efforts with other regional coalitions

Pick the low-hanging fruit

- Expand local and hub clinics
- Formalize and spread telederm project
- Formalize and spread Kaiser volunteer specialty project
- Spread concept of circuit-riding retinoscope
 - Three months on each site can “capture” most diabetics once a year

Then move on to comprehensive projects

- Create E-referral system through E Clinical Works
 - Embed protocols and guidelines in electronic health record
 - Facilitate PCP/specialist communication
- Centralize recruitment, credentialing, referral coordination

Comprehensive projects

- Join state-wide telemedicine network; expand telemedicine access to local clinics
- Hire circuit riders for high-demand specialties.
- Build multi-specialty medical building as hub for entire county

Conclusions

- Specialty access for Medi-Cal patients is a major barrier to high quality care, locally and state-wide
- Lack of access leads to poor quality, high health care costs, and primary care physician shortages

Conclusions

- Other communities have developed comprehensive, successful programs; we do not need to re-invent the wheel.
- Specialty access is a problem that transcends managed care – improved reimbursement will help, but will not possibly meet the demand.

Conclusions

- The time is right: we are in the midst of a perfect storm of community interest, stakeholder collaboration, and funding opportunities.
- Let's create a comprehensive solution; not just build more patches on a broken system.