DRAFT 5

AURORA HEALTH ACCESS

PRELIMINARY REPORT OF THE ACCESS TO SPECIALTY CARE TASK FORCE

JUNE 2015

Background

In November, 2014, Aurora Health Access (AHA) appointed a task force to examine the issue of access to specialty care in Aurora. Denny O'Malley was appointed as the volunteer chair. Beginning in January, 2015, Denny (and in some cases AHA Executive Director, Denise Denton) met with various stakeholders to gain their perspective on the specialty care issue, the extent of the problem, potential solutions, and to gauge their interest in exploring community-wide approaches to improving access to specialty care within the city.

This report is a preliminary overview of the problem, the results of the discussions, and some potential approaches for consideration by the full task force, AHA board, and key stakeholders. Feedback will be solicited and modifications will be made with the objective of achieving consensus on a conceptual model. Once that is achieved, an implementation plan will be formulated to address the details of financing and timelines.

The Problem

All parties engaged in the assessment agree there is a problem of timely access to specialty care in Aurora. While the problem is greater in the Medicaid and uninsured populations, it extends to the commercially insured as well. The problem is more severe in some specialties, but virtually all specialties have challenges in meeting demand in a timely manner. The problem is not unique to Aurora, with similar projects to this one being undertaken by the health alliances in Boulder and Denver.

One of the unintended consequences of the Medicaid expansion is what appears to be an increasing trend by providers to place a cap on the number of new Medicaid patients they will accept. Limits of this kind were apparent before Medicaid expansion, but appear to be more prevalent today. Doctors Care, an Arapahoe County program that hosts a referral hub for specialty care providers, reports that they are finding it easier to arrange specialty care for uninsured clients today than for Medicaid clients because of new, or more stringent, Medicaid limitations adopted by providers.

Multiple factors contribute to this problem. Some of the factors discussed by the Task Force include:

- *Capacity.* In some specialties, there are simply not enough physicians to meet demand in a timely manner, regardless of payer source. The expansion of the Affordable Care Act has exacerbated a workforce shortage in some cases. In such cases, the time from scheduling a patient to the time the patient is seen can be six

months or more. While shortening this timeline would be a hoped for part of any proposed solution, that may not be feasible until capacity in some specialties is expanded.

- *Low Medicaid Reimbursement Rates*. Low rates paid by Medicaid discourage some physicians from accepting new or many Medicaid patients.

- *Uninsured and Medicaid Stigma*. Uninsured and Medicaid patients have historically been more challenging to care for due to co-morbidities, transportation challenges, and other social determinants of health that require more intense and varied services than many physician practices, whether primary care or specialty care, can provide. According to the Colorado Health Institute, Medicaid now insures one-fifth of all Coloradans. With this expansion, we might find that the broader base of enrollees has less complex needs. Still, the historical stigma about the complexity of the Medicaid and uninsured populations will take time to mitigate as the expanded Medicaid population moves towards a more normalized mix of beneficiaries.

An undeniable outcome of this situation is that delays in access to specialty care, regardless of payer, often lead to inefficient use of emergency services, and progression of medical complications, which result in preventable hospitalizations and generally higher costs than should be necessary if appropriate care had been delivered when first needed. Any proposed approaches aimed at improving access to specialty care must not only improve access, but should be directed toward cost reduction through delivering the right services at the right time.

Key Elements For Progress

The greatest chance for improvement in access to specialty care seems to point toward the inclusion of several key elements:

- **Common ground** - We must find that intersection where all parties to the healthcare transaction (patient, provider and payer) find benefit. To achieve meaningful collaboration, a win must be apparent to all the parties. The size of the win may vary, but there must be something in it for everyone.

- **Community based** - For essential buy-in and continued success, the approach must be owned by all, not just by a single party. Providers could attempt to improve access to their own resources for competitive advantage, but most of those approaches have minimized consideration of the real needs of the underserved. Caring for underserved people, in order to be effective and sustainable, must be a shared commitment by essentially all providers.

- **Incremental gains** - The problem of access to specialty care is very complex in origin, so to think it can be "solved" by this or any other initiative would be unrealistic. But progress should be possible, and that is AHA's goal.

- **Sustainable** - Any approach must be fiscally sustainable after a reasonable start-up period. If economic value can be clearly demonstrated, there will be an ongoing funding stream; if it can't be shown, it wasn't a very good idea to begin with.

Making Progress

Take Lessons from Existing Programs

Aurora should continue to support and build upon programs that are already making improvements in the healthcare delivery experience and healthcare delivery system. While these programs were not designed with a focus on improving access to specialty care services, they offer important lessons. Members of the ASC Task Force include representatives from these programs and models, which have been discussed during Task Force meetings:

Bridges to Care (B2C) This partnership with Metro Community Provider Network (MCPN), Together Colorado, and University of Colorado Hospital (UCHospital) provides better care for people with complex medical and behavioral health conditions. B2C is based on a program known as "Hotspotters" that focuses on getting patients and resources out of overcrowded emergency rooms and into quality primary care. In the "hot spot" model, care teams visit patients in high-need, high-cost neighborhoods to improve their access to healthcare and manage their chronic conditions. B2C connects patients to medical homes, gives them alternatives for care besides the ofte- visited Emergency Rooms, assistance with benefits, and other social services including access to behavioral health services. Significant success has been demonstrated during the funding period, but grant funds do not extend beyond summer, 2015.

Triage – This is a collaborative project designed to address high utilization of 911 calls involving behavioral health and substance abuse issues. The original partners included the City of Aurora (including EMS, police), Aurora Mental Health (AuMHC), and Arapahoe House. The project is designed to review monthly the highest utilizers based on 911 calls and outreach to these clients and wrap them in needed services.

A group consisting of the City of Aurora (including EMS, police), University of Colorado Hospital, Medical Center of Aurora (MCA), MCPN, Aurora Mental Health (AuMHC) and Arapahoe House has begun discussing potential overlap on how the two projects can work together to meet both the overutilization of 911 and ER benefits, to maximize the effectiveness of both programs.

PACE - Program of All Inclusive Care for the Elderly (PACE) focuses on older people, who are frail enough to meet their State's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health

center, home, and/or inpatient facilities. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services, which are integrated into a complete healthcare plan. PACE offers and manages all of the medical, social and rehabilitative services their enrollees need to preserve or restore their independence, to remain in their homes and communities, and to maintain their quality of life. This includes such services as medical specialists, laboratory and other diagnostic services, hospital and nursing home care. Aurora's InnovAge/PACE Center at Chambers is involved in the ASC Task Force.

Accountable Care Collaboratives – Accountable Care Organizations (ACOs) are funded through the Colorado Department of Health Care Policy and Finance (HCPF) to coordinate care between members, medical, and non-medical service providers. Colorado Access has been awarded the contract for three regions, one of which is Region 3, servicing Medicaid members in Adams, Arapahoe, and Douglas Counties. Colorado Access (COA) Regional Care Collaborative Organization (RCCO) promotes medical homes by assisting members in selecting the best Primary Care Medical Provider (PCMP) to meet their individual needs. They also assist in coordinating care with other providers and help the member access support services in their area addressing the social determinants of health. RCCO staff report difficulties in specialty care access for RCCO members and are working with the ASC Task Force to explore solutions. Colorado Access RCCO has acknowledged the challenges surrounding access to specialty care services for the RCCO members and therefore has begun to implement several strategies to address the gaps in care. On a practical level, care managers work with individual members to address transportation barriers, pre-visit planning, coordinated communication between providers and supporting follow-up needs of the member. COA RCCO also has dedicated staff specifically working to address policy changes. For example, the progressive development of a specialty care access database assessing specialist acceptance of Medicaid; now encompassing barriers to acceptance and even time to next available appointment. COA RCCO has also implemented a clinical referral protocol tracking specialty care referrals through their care management staff. Providers have also joined the COA RCCO in guiding RCCO development of specialty care referrals through a RCCO Specialty Care Engagement Committee. By using the data COA RCCO is able to connect, they will influence perceptions, change attitudes and ultimately increase access to specialty care. This data-driven/supported policy-level change will be achieved by the collaborative RCCO approach.

Doctors Care - Doctors Care is a non-profit organization that has been helping connect low-income, uninsured individuals to affordable treatment for medical needs through a network of providers that bill on a sliding-fee-scale. They have been in operation since 1988, serving patients in the South Metro area, but currently, not Aurora. Doctors Care has built an extensive network of six hospitals and over 200 primary care and specialty practices. Specialty providers in the Doctors Care network can determine how many underserved patients they will accept; Doctors Care then provides patient health navigation services to help individuals identify and overcome barriers to accessing

healthcare. They also operate a primary care clinic, which also includes specialty care services on a very limited basis.

Support Statewide Improvements

Aurora can and should learn more about and support state-wide initiatives that are likely to improve access to specialty care services. For example:

Kaiser Permanente e-Consult Pilot – Kaiser has been piloting an e-consult program in the Denver metropolitan area since March 2013, with the goals of strengthening partnerships with healthcare safety net organizations and providing opportunities for Kaiser's specialty care providers to assist in the provision of care to underserved populations. The Program consists of e-consults, direct care, and medical education. A Kaiser representative reported that lessons to share from their experience include the importance of focusing on patient outcomes, being nimble to adapt to unforeseen challenges, having a neutral organizer of the network, and being patient - as it will take time to develop a referral system as envisioned.

Medicaid eConsults – The Division of Health Care Policy and Finance (HCPF) is working with the Colorado Regional Health Information Organization (COHRIO) to explore the development of an eConsult system that would enable primary care (PCs) and specialist providers to quickly and easily exchange clinical questions, messages and share patient medical records as part of a medical consultation process via a secure online HIPAA-compliant telemedicine system. Their studies estimate that 30 percent of referrals could be avoided if additional forms of communication between PCPs and specialists were available. The Department hopes to pilot an eConsult program later in 2015.

ECHO - The University of Colorado Anschutz Medical Campus was just awarded a grant from The Colorado Health Foundation to launch ECHO Colorado (Extension for Community Health Care Outcomes). ECHO Colorado will be a statewide system of training and practice support to increase the capacity to manage complex healthcare problems in primary care settings and to prevent disease in communities, using telehealth as a medium of delivery. The inspiration for this project comes from the University of New Mexico, which has developed a successful program for using bi-directional video to connect health care providers across New Mexico to the Health Sciences Center in Albuquerque.

Medicaid Reimbursement – The Colorado Department of Health Care Policy and Financing (HCPF) proposed and received budgetary approval for a series of targeted rate increases (TRIs) for FY14-15 that were implemented on July 1, 2014. Rates were increased for a wide variety of procedure codes in the areas of: audiometry and hearing assessments, OT/PT assessments, digital mammography, chemotherapy, cardiac scans, assistive technology assessment and training, eye exams, EENT procedures, long-acting contraceptives, EEGs, and developmental screening. Medicaid participation increased for some of these specialty areas (e.g. optometry) within a few months of the

rate increase. This year the Joint Budget Committee approved another set of TRIs for implementation in FY15-16, focused on improving reimbursement for high value specialty services. Reimbursement will be increased for certain procedure codes related to the following areas: retinal procedures, children's glasses, substance use treatment for pregnant women, OT/PT, prostate biopsies, dental services, diabetic self-management education, and pre-natal and post-partum services. Legislation was also passed in the 2015 session to create an independent Medicaid Provider Rate Advisory Committee to systematically review all Medicaid rates over a five-year period.

Create a Community-Based, Community-Wide Hub

Aurora could be bold, and explore the feasibility of creating its own specialty care referral hub.

What we envisioned is an independent, non-profit organization (hereafter referred to as NEWCO) with a board of directors selected from the Aurora community who can bring a broad-based, objective perspective about how to best improve access to specialty care in the city. All board members would represent the community at large, not any specific organization with which they may be affiliated. Independence and objectivity are the primary criteria. NEWCO would employ some staff, recruit volunteers, and may subcontract for some services with existing provider organizations. NEWCO is not to be confused with AHA, which is not recommended to be a provider of services. The envisioned role of AHA is to support the project and serve as a neutral convener until NEWCO is formed.

The foundation of the NEWCO model will be case management, similar to what Doctors Care offers. (In fact, they have offered to be at the table to help design such a system.) Referrals of patients in need of specialty care can be made by any and all providers in Aurora, when comprehensive case management is desired. It is not anticipated that NEWCO will be a direct provider of service (different from MCPN, Doctors Care and others in this way). NEWCO will provide "wraparound" services to include problem solving for identification of appropriate specialists on a case by case basis, transportation, acquisition of essential patient information for treatment and billing within related privacy regulations, patient reminders to minimize cancellations, follow up with patients to promote the highest possible patient compliance with care plans, and appropriate data sharing with the referring party. Billing for services rendered will remain the responsibility of the treating provider. Participating providers must agree that all patients they treat will be returned to the provider who made the referral to NEWCO. While it is anticipated that most referrals to NEWCO will either be uninsured or Medicaid recipients, referrals will be accepted from commercial insurers and Medicare.

Staffing NEWCO will require some employed staff, but could use the services of volunteers, especially students in various health professions tracks, who could work under the supervision of highly qualified case managers as part of clinical rotations. The University of Colorado and other educational institutions could be ready sources

for student placements. Other community volunteers could also be recruited to assist with staffing necessary functions (Doctors Care has used a high proportion of volunteers in their successful model).

NEWCO might be a good home for the Bridges to Care program, if the program is not sustained within its current setting. This program could also be housed within NEWCO if continuation funding can be found. In fact, the Bridges to Care moniker might be an appropriate name for NEWCO, with the expanded mission of improving access to specialty care.

Funding good ideas is always a challenge, and NEWCO will be no exception. If Aurora's community providers would collaboratively support grant applications to foundations, corporations and individual philanthropists, pledging their commitment to the NEWCO project, charitable funding could provide start up working capital. But if NEWCO is to survive, a sustainable model must be developed quickly before charitable funds run out to assure its survival. If effective case management can demonstrate cost savings, there will be value added which should be saleable in some form to payers and providers. If the model works, some continued charitable funding might also be possible to generate, but hopefully, as a small proportion of required sustainable funds. Data would need to be collected to allow objective evaluation of the success or failure of the NEWCO model, both financially and clinically.

Conclusion

The above approach is merely a starting point for continued discussion with community stakeholders. If this, or some other approach can be embraced by a wide range of providers, an implementation plan with timelines will be developed.

The possibilities are intriguing. An independent, community based organization that serves all referral sources, and more importantly patients in need, could become a highly valued service in Aurora. All could benefit-patients, payers of all varieties, providers and educational institutions. There are many challenges ahead, but it must start with a vision, which this proposal offers as a starting point for further collaboration.

Next Steps

Collect Baseline Data – Task Force members from MCPN, ClinicNet, and Colorado Access have agreed to share information regarding where specialty care referral seems to be most problematic. This would allow better understanding of where the problem might related to workforce shortages versus client payer source.

Other?