Stakeholder Meeting Report:

Building a Specialty Care Referral Network in Denver – What Will it Take?

December 4, 2014, 11:30 am – 2 pm - COPIC, Denver, Colorado

I. Introduction

The purpose of the meeting was to provide feedback to the Specialty Care Access Working Group of the Mile High Health Alliance on its draft plan to form a referral network to increase access to specialty care services for publically insured, under-insured, and uninsured persons in Denver. The meeting was supported by a grant to Denver Health from the National Partnership of the Health Care Safety Net, a collaboration between America's Essential Hospitals, the National Association of Community Health Centers, George Washington University, and Kaiser Permanente to support safety net providers in their collaborative efforts to implement the Affordable Care Act.

Forty-seven persons from 33 stakeholder organizations attended the meeting and gave their input to the draft plan. Participating organizations included safety net clinics, major hospitals and health care systems, specialty care practices, behavioral health care organizations, public health entities, foundations, universities, and key county- and state-level organizations. A list of attendees and the organizations they represented is included in Appendix A.

II. Background Information

1. The Mile High Health Alliance and its Specialty Care Access Group

The Mile High Health Alliance was formed in 2014, fulfilling one of the recommendations related to Access to Care in Denver's Community Health Improvement Plan, namely to create an alliance of important stakeholder organizations to increase access to care, better coordinate the health care services, and decrease health care costs.

The Alliance brings together stakeholders from medical care, behavioral health care, public health, and social and community services, to collaboratively address the city's most difficult health challenges and achieve better health for all Denver residents. Access to specialty care for publically insured, under-insured, and uninsured Denver residents is one of the three initial program areas identified for prioritization by the Alliance, along with "first access" to care (coverage, health and insurance literacy, and entry into care) and targeting high utilizers of the medical care system.

The Specialty Care Access Working Group was formed in April 2014 to make recommendations for increasing access to specialty care in Denver. The Working group contains representatives from safety net clinics, hospitals and health care systems, specialty care practices, behavioral health care organizations, public health entities, Colorado Access (the designated regional care collaborative organization for Denver), and the Colorado Regional Health Information Organization (COHRIO). The convening of this working group has been supported by the National Partnership Project's grant to Denver Health.

2. Draft Plan to Form a Specialty Care Referral Network in Denver

Access to specialty care for publically insured, under-insured, and uninsured persons a major challenge that cannot be solved merely by the expansion of coverage. Specialty care services, which include physical health, mental health, and ancillary services, could be better managed through a referral system that shares out the burden of providing care by connecting the supply and demand for care, and that includes both e-consults and face-to-face visits. Following are the principal elements of the draft plan proposed by the Specialty Care Access Working Group:

a. Create a central hub that connects publically insured, under-insured, and uninsured patients to specialty care providers, with an equitable distribution among participating specialists of the burden of providing this care. Patients will be referred by safety net clinics, and specialty care providers will be located both in large specialty care systems and in private practices .
b. Develop the hub with a hybrid model that includes both e-consults and face-to-face referrals, using e-consult whenever possible to be cost effective but also allowing for face-to-face visits.
c. Provide support for patients to keep their appointments, through reminders and assistance with transportation and interpretation.
d. Facilitate communication between the PCP and the specialist and retain the patient in his or her original medical home.
e. Include capacity in the hub for both physical and behavioral health care referrals.
f. When developing the hub, coordinate with related new developments such as HCPF's planned e-consult program and the future Colorado Project ECHO.
g. Include provisions for specialty care access for the remaining uninsured population in Denver.

3. The National Partnership Project with Denver Health

The National Partnership of the Health Care Safety Net Is assisting four communities – Denver, Cleveland, Richmond, and Atlanta - to bring together safety net providers to work together to address important policy and operational issues identified by each community. The Partnership extended funding and technical assistance starting early in 2014 to Denver Health, which has in turn partnered with the Specialty Care Access Group of the Mile High Health Alliance to focus on increasing access to specialty care for underserved populations in Denver.

4. Specialty Referral Systems Elsewhere

Part of the technical assistance provided by the National Partnership has been to research specialty care referral models in other cities that might inform the creation of a specialty care hub in Denver. A matrix summarizing this research was provided in advance of this meeting, with information on four e-consult programs and three face-to-face referral programs around the country.

These programs have sought to improve access to specialty care for underserved populations by distributing the burden of care among multiple specialty care providers, improving efficiency in the use of specialty care services, and increasing the scope of care provided by primary care providers. While none of the models is exactly like what is being proposed in Denver, elements of the various models might be put together to achieve the desired results.

5. Kaiser Permanente's Safety Net Specialty Care Program in the Denver Metro Area

Kaiser Permanente piloted an e-consult program in the Denver metropolitan area, not including Denver itself, since March 2013, with the goals of strengthening partnerships with health care safety net organizations and providing opportunities for Kaiser's specialty care providers to assist in the provision of care to underserved populations. The program was based on the results of a 2010 survey conducted by the Colorado Health Institute to assess the availability of specialty care services to these populations.

The Program consists of e-consults, direct care, and medical education. E-consults are conducted using a third-party clinical messaging portal that facilitates communication between safety net PCPs and Kaiser Permanente specialists. The direct care portion allows for face-to-face visits when needed between the safety net patient and the specialist. The medical education portion allows Kaiser Permanente clinicians to share information, new guidelines, and best practices with safety net providers. To date, the program has supported 552 e-consult and 78 direct care visits.

Kaiser had several lessons to share with the Specialty Care Access group from its experience with its own e-consult program: 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.

6. HCPF's Plans for a Stateside E-consult Program

HCPF is actively planning for a statewide e-consult and referral program that would improve access to specialty care services for publicly insured persons while demonstrating sound stewardship of public funds. It is estimated that 30% of in-person referrals could be avoided if additional forms of communication between PCPs and specialists were available. As such, HCPF is developing a system that would enable primary care and specialist providers to communicate and exchange information on the care of patients via a secure, online, HIPAA-compliant telemedicine system. Additional projected benefits include reduced wait times for access to specialty care and a reduction in unnecessary specialty care visits.

HCPF is developing the program based on a survey conducted in mid-2014 to assess needs and provider interest in an e-consult system. The survey found a high level of interest among providers. The Department is currently working with CORHIO on the technical requirements for hosting such a program, and anticipates an update in the second quarter of 2015 of a tool already in use by many safety net providers that could provide a platform for the new program. The Department is also awaiting confirmation from CMS on its authority to reimburse both the PCPs and the specialists engaging in e-consults. An e-consult program in Oklahoma that could be used for benchmarking rates of reimbursement currently pays $10 to PCPs and $20 to specialists participating in an e-consult.

III. Feedback from the Stakeholder Group on the Draft Plan

Stakeholders at the meeting were asked to review in smaller discussion groups the draft plan for creating a specialty care referral network in Denver, and to evaluate the plan according to the following criteria:

1. **Urgency of the need**
2. **Effectiveness of the model for both Medicaid/under-insured and uninsured**
3. **Ease and speed of implementation**
4. **Ensuring participation of specialists and specialty care systems in Denver**
5. **Cost of establishing the system and Sustainability**

Participants formed five discussion groups to consider these criteria. Following are the synthesized responses of all five groups.

1. **Urgency of the Need:**
   a. There was near-consensus that there is a great urgency for such a referral network, and for a pilot project as soon as possible.
   b. The urgency is more acute with Medicaid, where access to specialty care is actually shrinking with the expansion, with some specialists not wanting to see any Medicaid patients at all. E.g., at Doctors Care, some specialists who saw uninsured before the expansion are not willing to take Medicaid now, due to their expectations about difficulties with billing.
   c. There is urgency for a hub with multiple functions - e-consults, in-person visits, and capacity-building for PCPs. Some of these elements are already on the way, e.g., HCPF is preparing to make payments for e-consults and the CO ECHO program is launching soon.

2. **Effectiveness of the Model:**
   a. E-consults work well for certain types of care that can be managed by a cognitive approach between physicians, but not when direct intervention with the patient is needed. However, in-person referrals are more challenging to provide.
   b. Consider whether to do only e-consults first or roll out both at once. Both would be preferred, but would be more difficult to start up.
   c. Combining e-consults, direct referrals, and capacity-building for PCPs into a single hub may be much more effective than conducting any of the activities on its own.
   d. An advantage of a hub such as this is that it can serve both uninsured and Medicaid. Screening patients will be important.
   e. Have a single process for patients, regardless of the insurance status.
   f. Beware of the potential problem of the hub's non-medical staff being put in a position to triage patients. E.g., CCHN was in this situation with a previous referral program 13 years ago and had to close the program due to liability issues. In addition to the liability issues related to triaging, patients must get actual care through the program and not only triaging.
   g. The effectiveness of the model is uncertain, but will be better than what we have now, which is nothing.

3. **Ease and Speed of Implementation:**
    a. This project would have neither ease nor speed of implementation.
    b. Don't focus too much on the tool and the platform when there are other fundamental issues that need to be addressed earlier on, e.g., participation of hospitals to garner the level of support needed to create a provider network where none exists now.
    c. Select carefully a small number of initiatives to pilot and don't try to build the whole referral network at the start. E.g., start with a small set of specialties or with referrals for a specific procedure. Psychiatric services may be highest need. Dermatology may be a good place to start, as it is not likely to generate many in-person referrals, which will help with recruitment.
    d. Start with giving access to a single sub-population, e.g., Medicaid, uninsured, or privately insured. Take advantage of the changes in Medicaid and start there, where there are some resources. Don't try to serve all patients at the start.
    e. Start with the clinics and specialists that are most ready and willing to participate.
    f. Keep track of and align the creation of the new referral hub with existing efforts, e.g. Project ECHO, C-PACK, and developments at HCPF and the RCCO.
    g. HIPPA issues have been a barrier for CORHIO connectivity at Denver Health and need to be overcome.

4. **Participation of Specialists and Systems:**
    a. Equitably distribute the work among specialists.
    b. There was some skepticism about whether volunteer participation will work, but the Doctors Care model has had success in recruiting many volunteers.
    c. Have both an earnings component and a charity component for specialists participating.
    d. Involve COPIC, in order not to put providers at legal risk.
    e. Ensuring the participation of hospital systems is important, especially to get the hub up and running. Reach out to hospitals themselves as well as to the specialists within them because the system must be ready to support the work of individual specialists.
    f. The community of specialists beyond hospitals is also important, but don't focus there first.
    h. Generate a list of all the available specialty care providers in the area. There is no directory for this purpose now to assist with this process. Assess capacity by service line.
    g. Help manage change in the organizations participating. Work with the CO Hospital Association to create a sub-hub to assist hospital systems/institutions as well as the specialists within them to ensure that they are ready and able to participate.
    h. Care coordination and management are very important for ensuring specialist participation. Identify who is already doing care coordination (RCCOs, PCPs, Behavioral Health organizations) and what the hub's role would be. No-shows are second only to reimbursement in doctors' reasons for not wanting to see Medicaid patients.
    i. Designate a lead care manager/referral coordinator, positioned at least within the hub and possibly an additional one in the PCP/medical home.

5. **Cost and Sustainability:**
    a. The cost of startup could be substantial, but foundations may be interested to provide start-up funding if we put together a good plan.
    b. The hub will be initially Denver-based but could be scaled up if it works well.
    c. Look at the potential impact of cost savings, especially via the ACCO, to support funding requests. If there is evidence of cost-savings, it may be possible to divert funds from other areas to support the hub infrastructure.

d. Investigate possible contributions from for-profit entities.
e. This stakeholder group will be important for the sustainability of the hub. It can help to create a shared mission and vision, implement the program, and periodically review progress.
f. HCPF and the RCCO are important supporters for these efforts – they will realize large savings through the program, and as such may support its costs.

IV. Closing Thoughts

Stakeholders at the meeting were in agreement that there is sufficient need for specialty care access for publically insured, under-insured, and uninsured persons in Denver to warrant proceeding with the plan to form a referral network.

They agreed that e-consults alone would not be sufficient to meet the needs, and that the system must also accommodate in-person referrals. They advised that the creation of the referral network should be coordinated with related, ongoing efforts such as HCPF's development of a statewide e-consult system and the launching of the Colorado ECHO program. They noted that case management will be a key component for the network to be successful, and that it must be coordinated with existing case management resources located with health care providers, the RCCO, and behavioral health organizations.

The group suggested several areas in which the Specialty Care Access should be cautious as it proceeds to further plan for and establish the referral network. They were asked to remain available for further consultation and to offer their support as the plan is further refined and implemented.

Appendix A: Meeting Attendees

No.	First Name	Last Name	Organization
1	Sneha	Rangaroo	America's Essential Hospitals
2	Janelle	Schrag	America's Essential Hospitals
3	Art	Schut	Arapahoe House
4	Laura	Warner, MD	Centura Health
5	Jim	Garcia	Clinica Tepeyac
6	Brooke	Powers	ClinicNet
7	Webster	Hendricks	CO Division of Behavioral Health and the Far Northeast Alliance
8	April	Abrahamson	Colorado Access
9	Drew	Kasper	Colorado Access
10	Charlie	Lippolis	Colorado Access, C-PACK
11	Suegie	Park	Colorado Alliance for Health Equity and Practice (CAHEP)
12	Aubrey	Hill	Colorado Coalition for the Medically Underserved (CCMU)
13	Gary	VanderArk, MD	Colorado Coalition for the Medically Underserved (CCMU)
14	Polly	Anderson	Colorado Community Health Network (CCHN)
15	Jessica	Sanchez	Colorado Community Health Network (CCHN)
16	Amy	Latham	Colorado Health Foundation
17	Chet	Seward	Colorado Medical Society
18	Mark	Carlson	Colorado Regional Health Information Organization (CORHIO)
19	Morgan	Honea	Colorado Regional Health Information Organization (CORHIO)
20	Alan	Kimura, MD	Colorado Retina Associates
21	Summer	Gathercole	Denver Foundation
22	Melinda	Estep	Denver Health
23	Simon	Hambidge, MD	Denver Health
24	Paul	Melinkovich, MD	Denver Health (retired)
25	Aimee	Truesdale, MD	Denver Health
26	Jennifer	Solano	Denver Health
27	Adrianne	Maddux	Denver Indian Health and Family Services, Inc.
28	Kelly	Rankin	Denver Indian Health and Family Services, Inc.
29	Bill	Burman, MD	Denver Public Health
30	Bebe	Kleinman	Doctors Care
31	Mary Ann	Littler	Doctors Care
32	Erin	Brantley	George Washington University
33	JD	Belshe	HCPF
34	Kraig	Burleson	Inner City Health Center
35	Christopher	Fellenz, MD	Kaiser Permanente
36	Meredith	Fort	Kaiser Permanente
37	Lynnette	Namba	Kaiser Permanente
38	Lisa	McCann, PhD	Mile High Health Alliance
39	Scott	Joy, MD	Presbyterian St. Luke's Medical Center, High Street Clinic
40	Sr. Melissa	Camardo	Saint Joseph Hospital
41	Alwin	Steinmenn, MD	Saint Joseph Hospital
42	Barbara	Rosario	Sisters of Charity Leavenworth Physicians
43	Susan	Schubert	Sisters of Charity Leavenworth Physicians
44	Ben	Honigman	University of Colorado Hospital and University Physicians
45	Jeff	Thompson	University of Colorado Hospital and University Physicians
46	Meredith	Niess, MD	University of Colorado School of Medicine
47	Tim	Byers, MD	University of Colorado School of Public Health