PRELIMINARY FINDINGS

SPECIALTY CARE ACCESS SURVEY

A Joint Project of
KAISER PERMANENTE
CALIFORNIA PRIMARY CARE ASSOCIATION
CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS and HEALTH SYSTEMS

BACKGROUND

California's safety net institutions – both public hospital systems and community clinics and health centers (CCHCs) – have experienced an increase in demand for specialty care services from the uninsured and Medi-Cal populations over the past decade. This growth is a result of a myriad of factors, some of which include an increase in population; rising numbers of uninsured patients; a growing aging patient population with multiple chronic conditions; an increase in health needs for persons accessing care; and a greater reliance on the safety net for services. Given these factors and a simultaneous lack of additional funding for the safety net, patients in both CCHCs and public hospital systems have faced a decrease in specialty care access.

In an effort to better understand the current state of access to specialty care and to support movement within the safety net to ameliorate the problem, the California Association of Public Hospitals and Health Systems (CAPH), the California Primary Care Association (CPCA) and Kaiser Permanente (KP) have formed a partnership called the Specialty Care Access Initiative (SCAI), which is supported by KP Community Benefit. Started in 2006, SCAI seeks to: identify barriers to specialty care access and demand; establish solutions to increase specialty care access and demand; distribute knowledge about barriers and solutions; and create an advocacy strategy for needed change.

SCAI began its work towards accomplishing its goals through quantitative and qualitative data collection. To gain an initial understanding of the specialty care access issue in California, the Partnership hired Pacific Health Consulting Group to develop and gather data through a statewide baseline survey. The data were collected from public hospital systems and CCHCs and have helped SCAI begin to characterize the current state of specialty care access among California's major safety net providers. Concurrently, SCAI began to collect qualitative data by hosting statewide roundtable discussions. The roundtables are intended to provide a forum to spread knowledge, share promising practices and increase networking between CCHCs and public hospital system clinicians and administrators and other stakeholders. Having already facilitated two roundtables during 2007 that focused on E-health and E-referral, the Partnership plans to host additional roundtable discussions in 2008, building on the work of this past year.

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SCAI is also beginning work on the collection of additional qualitative and quantitative data through the development of three discussion papers that will focus on: (1) expanded scope of practice for primary care providers; (2) communication, coordination and collaboration between safety net provider systems to address specialty care access; and (3) financing and sustaining innovations in specialty care. The Partnership anticipates the completion of these discussion papers in the summer of 2008.

Presented below is a *preliminary* analysis of the baseline survey data that have been obtained thus far. The Preliminary Findings report is an internal document that is intended only for association members and not the general public. It should be noted that the presented data do not represent a full exploration of the issue of specialty care access by SCAI. Furthermore, SCAI intends to conduct additional analysis of the data in 2008. This supplementary analysis will be conducted through facilitation of discussions amongst CPCA and CAPH members regarding the implications of the data for safety net patients and institutions as well as for future advocacy strategies. The Preliminary Findings report is not meant to serve as a definitive stand-alone document. Further analysis of the data and the addition of information collected from SCAI's other activities are needed to complete SCAI's findings relevant to specialty care access in California. Through releasing this partial information, SCAI hopes to encourage discussions within the safety net institutions about increasing access to specialty care. A complete analysis of the survey data and its compilation with other qualitative and quantitative data collected from the roundtable discussions and case studies will be released in a final report towards the end of 2008. The final report will be provided to all members of CAPH and CPCA as well as other interested parties.

Survey Overview

As part of its project, SCAI decided to conduct a statewide survey to formulate a baseline understanding of the issues. A wide range of questions was developed and then reviewed by the SCAI staff group and consultants. Survey drafts were pre-tested by medical directors from two CCHCs and one public hospital system. The final set of questions was uploaded to an on-line survey site (www.surveymonkey.com) and were disseminated to all CCHCs and every public hospital system in California through CAPH and CPCA member outreach.

The final survey focused on four broad areas: on-site specialty care services, outside referrals and consultations, systems for organizing specialty referrals and consultations, and general issues regarding access to care and improvements to care. The survey focused on internal medicine sub-specialties and services to adult patients; mental health was excluded from the survey. The survey addressed three primary research questions:

- What are the demographics of specialty care for the underserved?
- What is the extent of the problem of specialty care access?
- What current and emerging practices are being used to improve access and manage demand for specialty care?

This document provides an overview of preliminary findings; it is not intended to be a review of all survey findings. Although the data were assessed for regional differences, for the most part, differences were not evident. Regional sub-groups comparing public hospital systems were too small to allow statistically valid comparisons. Relevant regional differences are noted below. In addition, the data have limitations based on the number and location of respondents and the validity of the answers provided, which have not been verified in any way.

Survey Respondents

Active outreach, encouragement and support by CAPH and CPCA staff facilitated respondent participation across the state. One response per community clinic or health center corporation and one response per public hospital system were solicited. The final survey reflects participation of a total of 115 CCHCs and 15 public hospital systems.

Approximately 58% of California's clinic corporations are represented in the survey and 80% of California's public hospital systems. Note that no CCHCs in Region 7 (Riverside and San Bernardino) participated and that there are no public hospital systems in Regions 1 (North Coast) and 2 (Far North).

Number of Organizations Completing the Survey by Region

	Region								Total
	1	2	3	4	5	6	7	8	
CCHCs	9	19	20	3	13	32	0	19	115
Public hospital systems	0	0	5	2	1	4	2	1	15

Locations of Survey Respondents by Region and County

Region 1, North Coast	Mendocino, Lake, Del Norte, Humboldt, Trinity
Region 2, Far North	Siskiyou, Modoc, Shasta, Lassen, Tehama, Plumas, Glenn, Butte, Colusa, Sutter, Yuba, Sierra, Nevada, Alpine, Mono, Inyo, Tuolumne
Region 3, Bay Area	Sonoma, Napa, Solano, Contra Costa, Marin, Alameda, Santa Clara, San Mateo, San Francisco
Region 4, Central Coast	Santa Cruz, San Benito, Monterey, San Luis Obispo, Santa Barbara, Ventura
Region 5, Central Valley	Placer, El Dorado, Yolo, Sacramento, Amador, San Joaquin, Calaveras, Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, Tulare, Kern
Region 6, Los Angeles	Los Angeles
Region 7, Riverside & San Bernardino	Riverside, San Bernardino
Region 8, Southern California	Orange, San Diego, Imperial

Survey Demographics

Many of the responding CCHCs and all of the public hospital system respondents provide specialty care services. There is considerable variety in specialty services provided onsite in CCHCs, the majority of which are not receiving special funding.

- Seventy (61%) of the responding CCHCs provide some specialty services onsite; 36% of them offer three or more different specialties.

- All of the responding public hospital systems provide a wide range and variety of onsite specialty care services.

- Generally, specialty services identified by respondents as those "most difficult" for patients to access are among those most often offered onsite in the CCHCs surveyed: gastroenterology and dermatology are offered in 14% of them; orthopedics, in 11%; and neurology, in 6%.

- Few of the CCHCs that provide onsite specialty care do so with special funding (16% of all 115 respondent CCHCs). The highest percentage of CCHCs (47%) with special funding for specialty care are located in Region 6 (Los Angeles), indicating that most have absorbed these services into their annual operating budget.

While most referrals to onsite care in both CCHCs and public hospital systems are inside referrals from the organizations' own primary care providers, a large number come from other CCHCs, and a surprising number from private providers in the community.

- In-house primary care providers serve as the greatest source of referrals for onsite specialty services, comprising 82% of total referrals to onsite CCHCs specialty care and 52% of the total referrals for onsite public hospital system specialty care.

- CCHCs are the second highest referral source to public hospital systems - 18% of the total referrals to public hospital system specialty care services come from CCHCs and 10% of the total referrals to onsite specialty care in CCHCs come from other CCHCs.

- Another 12% of the hospitals' total referrals come from *other specialist* providers within their own public hospital systems.

- More surprising is the number of referrals from private providers who are the third highest generator of referrals to specialty care services. Private providers refer 4% of the total referrals made to CCHCs specialty care services and 11% of the total number of referrals made to public hospital systems specialty care.

- In Regions 6 (Los Angeles) and 7 (Riverside and San Bernardino), more than half of the referrals for onsite hospital specialty care come from referrals sources outside of the public hospital systems.

There are very significant and apparent challenges in capturing information about the level of specialty care provided by CCHCs and public hospitals systems.

- Only 57 out of the 70 CCHCs providing specialty care responded to the question about annual unduplicated patients seen and only 10 of the 15 responding hospitals completed the question about annual number of specialty visits provided.

- There is no way to know whether the reporting problem is due to lack of tracking data or survey respondent knowledge.

- Of the respondents who completed the question, there were a number of responses that reflected probable entry errors.

Extent of the Problem of Specialty Care Access

Orthopedics, gastroenterology, neurology and dermatology are among the services perceived to be the most difficult for patients to access.

- Overall, orthopedic surgery and gastroenterology were reported to be the most difficult specialty services to access for both CCHCs and public hospital system patients. Neurology and dermatology also rank high in respondents' perception of access difficulty.

- There is some regional variability among CCHCs in terms of specialty access difficulties. For example, in Regions 1 (North Coast) and 2 (Far North), dermatology is more likely to be perceived as difficult to access than gastroenterology; in Region 5 (Central Valley), dermatology is second only to orthopedic surgery in assessment of difficulty to access.

- CCHCs respondents report that cardiology, high risk obstetrics and ophthalmology are the three specialties easiest for their patients to access. Easiest access for public hospital systems patients is in the area of infectious diseases including HIV/AIDS, followed by pulmonary disease and high risk obstetrics.

Respondents were queried about the extent to which they believe primary care providers limit referrals because they anticipate access difficulties for their patients. These concerns do appear to significantly impact primary care providers in both settings, with the result being that patient referrals are limited. Access concerns appear to have an even greater impact on CCHCs.

- About one-third of CCHCs respondents report that their primary care providers frequently limit referrals to orthopedic surgery, allergy/immunology, and dermatology because of perceived access difficulties.

- Thirty percent of CCHCs respondents wrote in specifics about other specialty areas to which referrals were *frequently* limited by providers, offering additional evidence that these kinds of limits are on the minds of these providers and impact their referral behavior. Of these "other" areas, rheumatology was most frequently indicated as a specialty to which referrals were frequently limited because of provider concerns about access.

- In a pattern similar to the CCHCs, one third of the public hospital systems respondents report that their primary care providers *frequently* limit referrals to allergy/immunology and dermatology because of perceived access difficulties. The third area of most frequently limited referrals for public hospital providers, however, is gastroenterology, as opposed to orthopedic surgery for CCHCs.

- Overall, twice as many CCHCs respondents as public hospital systems respondents report that their respective primary care providers *frequently* limit referrals to specialty care due to access concerns.

CCHCs primary care providers are more likely to encounter difficulties accessing consultation than are primary care providers in the public hospital systems.

- Overall, CCHCs report that their primary care providers are able to consult with a specialist less than half of the times that consultation is needed.

- On average, public hospital systems primary care providers are able to consult with specialists 50-75% of the times that they need consultation.

- Regional difference are evident in the CCHCs data, with primary care providers in Region 6 (Los Angeles) finding it more difficult to consult with specialists than primary care providers in other geographic areas.

Onsite care reduces patient wait time and improves primary care providers' ability to expedite its delivery. Where CCHCs have onsite specialties, patient wait time from referral is generally reduced.

- Typical wait time for specialty care offered onsite in CCHCs is less than four weeks; by contrast, for two-thirds of the types of specialty services referred out, CCHCs patients typically wait between one and three months to see specialists.

- Wait time for onsite public hospital systems specialty care is slightly longer than for onsite CCHCs specialty services; typical wait times for more than half of the onsite public hospital systems' specialty services are more than four weeks.

Current and Emerging Practices to Improve Access and Manage Care

The provision of onsite specialty care services does show promise in improving access. Providers in both CCHCs and public hospital systems are able to expedite care for patients with urgent need and generally receive consultation reports back for referred patients. There is modest evidence of expanded scope of practice by primary care providers to incorporate specialty care.

- Overall, 90% of all survey respondents (CCHCs and public hospital systems) report that primary care providers can expedite onsite care in their respective facilities for their patients with urgent need "*all of the time*" or "*most of the time*."

- By contrast, both groups of primary care providers have less ability to expedite urgently needed care for outside services: only about one-third are seen as able to expedite urgently needed care that is referred outside of their own facilities "*all or most*" of the time.

- Referring providers in CCHCs receive a higher number of consultation reports back from treating specialists when their patients are treated onsite than when referred out for specialty care. Interestingly, this trend is reversed for public hospital systems referrals, but the difference is not significant.

- There is modest evidence of expanded scope of practice to incorporate specialty care for primary care providers in CCHCs. Approximately 14% of CCHCs respondents indicated that they have primary care providers whose practice scope incorporates specialty care for dermatology, infectious diseases (including HIV/AIDS) and orthopedic surgery. In other specialty care areas, there is little evidence of specialty care expanded scope activities. This question was not asked of public health systems respondents.

A number of supportive services are provided to patients to facilitate follow- through and easier access specialty care. There is variation in the type and frequency of support services provided.

- Most CCHCs (75% of respondents) and public hospital systems (86%) report that they "*frequently*" have staff schedule specialty care appointments for their patients.

- Only 26% of CCHCs respondents report that staff "*frequently*" provide patient reminders for specialty visits, while 71% of public hospital system respondents report that patient reminders are "*frequently*" provided.

- 21% of public hospital systems report "*frequently*" providing non-emergency transportation; 9% of CCHCs do so.

- There is little evidence of CCHCs or public hospital systems regularly paying for outside specialty appointments (2% and 7%, respectively).

The impact of personal relationships to identify providers and obtain care is overarching.

- The most common mechanism used by primary care providers in CCHCs and public hospital systems to expedite the referral process is picking up the telephone and calling the specialist directly in advance of the referral.

- In all cases, CCHCs overwhelmingly report depending on personal relationships of providers to identify specialists for onsite services.

A number of emerging practices, including computer tracking, written referral guidelines, EMRs, and telemedicine, that have shown promise in other areas of health care, are not yet widely adopted.

- 27% of CCHCs and 29% of public hospital systems report that they do not track specialty referrals.

- The most common method for tracking referrals is a manual log used by 76 (68%) of the CCHCs and eight (53%) of the public hospital systems.

- Overall, few CCHCs and public hospital systems have or use written guidelines for referring patients for outside specialty care.

- Four CCHCs (3.5%) and three public hospital systems (20%) report use of electronic medical records.

- Less than 15% of CCHCs and public hospital systems use e-mail to communicate with specialists.

- Although nearly one-third of the CCHCs indicate they have telemedicine equipment available, it appears not to be used for many specialty areas.

- Regions 1 (North Coast) and 2 (Far North) reported the highest percentage of CCHCs telemedicine availability.

- Two public hospital systems responding to the survey report use of telemedicine.