

# Alameda County Board of Supervisors Health Committee's Community Dialogue on Preparing for Health Reform

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Session 11: November 5, 2012

This session examined health reform's impact on efforts to coordinate patient services along the continuum of care from prevention to specialty to care to acute care. This was part of a [13-month series](#) on how the Patient Protection and Affordable Care Act (ACA) could impact Alameda County. This session examined new models of care delivery promoted by the ACA and how they're being developed in Alameda County. The speakers for this session included:

- National and state perspectives on specialty care by **Kathleen Clanon, MD**, Medical Director, HealthPAC and Interim Chief Medical Officer, Alameda County Medical Center (ACMC)
- Improving specialty care and primary care coordination in LA County with eConsult, **Charlene Chen**, Director of Clinical Integration and Translational Research, COPE Health Solutions
- Challenges and opportunities in building strong linkages to specialty care, **Evan Seevak**, MD, Chair of Ambulatory Preventive Medicine at ACMC
- Connecting specialty care with the community clinics, **Melissa Marshall**, MD, Chief Medical Officer of the Community Health Center Network
- Health plan perspective on improving linkages to specialty care, **Lily Boris**, MD, Chief Medical Officer at Alameda Alliance for Health

## California's Health Benefit Exchange

This is one of the most turbulent times for health care in the past 50 years, said Dr. Kathleen Clanon. Alameda County Medical Center has set the following key priority planning areas:

1. Preparing for an influx of new patients, particularly in ambulatory care. Learning from the experience in Massachusetts after its coverage expansion provides lessons that patient demand will increase substantially as the number of uninsured decreases. An interesting model in New Haven, CT uses community partnerships and patient navigators to increase specialty access for the uninsured.
2. Emphasizing core differences – recognizing that ACMC can't be all things to all people. This is a major shift in thinking and not always a comfortable one.

However, the market demands require the hospital to differentiate itself from competitors.

3. Linking with other providers along the safety-net continuum to coordinate care. The hospital must develop new financial relationships that it never thought of before in order to meet patient needs along that continuum of care.

Clanon summarized the following findings about health care reform's local impact:

1. The population is growing more slowly, but it's aging and there's more medical need. APMC needs to think about how it can integrate care for Medicare patients.
2. The local provider landscape is consolidating into just a few organizations. This consolidation will create benefits for patients but change the competition.
3. The lack of access to primary and specialty care will remain major barriers for a long time. There are opportunities for providers who can offer convenience, access, and coordinated care.
4. Payors will continue testing new payment models and narrow their provider networks. In response, providers will need to more effectively manage the total cost of a patient's episode of care.
5. The payor mix will change significantly with the launch of the California Health Benefits Exchange. Patients who historically had no choice now will have a better ability to choose where to access care. APMC needs to become a provider of choice.

## **Innovating in LA County's Safety Net: Using eConsult to connect primary care and specialists**

Camino de Salud Network is a public-private partnership launched in 2004 to address fragmentation in the safety net health care system in Los Angeles. It includes LA County USC hospital, 14 community health centers and a network manager: COPE Health Solutions. The network focuses on building relationships between primary care providers and specialists. One tool that has emerged is using eConsult to connect the specialists and primary care providers for the purposes of co-managing patients, building primary care capacity, increasing timely access to specialty care and reducing inappropriate referrals to the specialists.

The system has had its challenges in terms of gaining buy-in among providers, but steadily they are overcoming technology barriers and concerns about liability. They learned that as relationships and trust build, use of the system increases. They are now exploring how support staff can help facilitate the consultations. Additional next steps include expanding implementation of eConsult to a total of 60 sites by May 2013.

## ACMC's Efforts to Improve Linkages to Specialty Care

ACMC is working on several initiatives to build relationships between subspecialists and community primary care providers, said Dr. Evan Seevak. These include monthly dinners, mini-fellowships and a new electronic referral tracking system. Additionally, they are all in the midst of implementing electronic health records systems that are compatible with each other.

Generally, however, there are very long waits for access to specialty care and this is a basic problem of both supply and demand, Seevak said. There are more patients who need care from specialists than there are specialists to see them. The solutions have to address both the supply and the demand. For the demand side, the hospital is focused on reducing readmissions and unnecessary referrals to specialty care.

Increasing the supply is extremely challenging due to limited clinic and operating room space. They currently use all the space available and are constrained to expand. Working to expand specialty services in primary care clinics near to where patients live is a top priority, he said. Another project is using telemedicine dermatology consultations from UCSF. The Delivery System Reform Incentive Payments (DSRIP) program helps fund much of ACMC's work around expanding primary and specialty care services.

## Community Clinics Connecting to Specialists

Increasing access to specialty care is a major focus issue of the Community Health Center Network, which serves about 70,000 Medi-Cal and Medicare patients with primary care, labs, pharmacy and behavioral health care. Generally, patients are referred outside for specialty care. Insurance status plays a major role in a patient's access to care. Patients with Medi-Cal have a broader provider network than patients in HealthPAC. The clinics are working on increasing the co-location of some specialty services at the primary care clinics. They also have partnered with Highland Hospital to provide "mini-fellowships" that pair primary care doctors with specialists for half a day a week for six weeks so they can become more proficient in things like dermatology, rheumatology and orthopedics. This helps reduce the need to refer to specialists and improves communication. These innovations can help reduce the wait times for specialty care.

## The Health Plan's Role in Providing Access to Specialists

The Alameda Alliance currently provides health care coverage for about 150,000 Alameda County residents. The vast majority of them receive Medi-Cal managed care through the Alliance. The Alliance, like other Medi-Cal health plans in California, is undergoing a major transition in its member demographics. Traditionally, children and their mothers have been the primary members. That is changing to many more adults

with chronic health needs, as California moves nearly all of its Medi-Cal beneficiaries into managed care. Additionally, the Alliance is applying to participate as a health plan option under the California Health Benefits Exchange. Accompanying this transformation, the Alliance is seeking accreditation from the National Committee on Quality Assurance (NCQA) by the end of 2013.

As a managed care organization, we have access standards around distance, time and mileage for our patients, said Dr. Lily Boris. The Alliance is contractually obligated to provide access to at least two primary care physicians within 10 miles or 30 minutes drive and at least 1 specialist within 15 miles or 30 minutes. Additionally, there are timeliness standards the health plan must meet, including scheduling specialty appointments.

Access to specialty care will only worsen as the population ages and chronic disease prevalence increases. The Alliance works with all of the safety net providers, as well as private providers. Finding ways to improve care quality by organizing care around the patient with the primary care provider as the foundation is the Alliance's chief goal for the future. This will require ongoing collaboration with providers across the continuum of primary care, specialty care, long-term care and behavioral health.