



## Breaking the Barriers to Specialty Care

*Practical Ideas to Improve Health Equity and Reduce Cost*

**BRIEF**

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## Increasing Specialty Care Availability



REIMAGINING SOCIAL CHANGE



Bristol-Myers Squibb Foundation

## About this series of briefs

This series aims to highlight the urgent need for the health care sector to make progress towards achieving equity in outcomes from diseases that require specialty care and to identify effective solutions for the payers, providers, policy makers, patient organizations, and community actors who will be critical to creating change.

The series was researched and written by FSG with the support and partnership of the Bristol-Myers Squibb Foundation. Findings were informed by an extensive review of clinical and field studies and more than 60 interviews with field experts, health care providers, and representatives from insurance companies. This work builds on the exceptional research in this field done by many others, referenced throughout this report. A full list of references and contributors can be found at the end of each brief. To access all the briefs in this series, please visit [www.fsg.org/publications/breaking-barriers-specialty-care](http://www.fsg.org/publications/breaking-barriers-specialty-care).

## About Bristol-Myers Squibb Foundation

The mission of the Bristol-Myers Squibb Foundation is to promote health equity and improve the health outcomes of populations disproportionately affected by serious diseases and conditions by strengthening community-based health care worker capacity, integrating medical care and community-based supportive services, and mobilizing communities in the fight against disease.

In 2015, the Bristol-Myers Squibb Foundation launched the Specialty Care for Vulnerable Populations Initiative, which aims to address inequities in access to and utilization of specialty care services in the United States. The goal of this national initiative is to catalyze sustainable improvement and expansion of specialty care service delivery to achieve more optimal and equitable outcomes for the people they serve who are living with cancer, cardio-vascular disease, or HIV/AIDS.

Learn more at [www.bms.com/foundation](http://www.bms.com/foundation).

## About FSG

FSG is a mission-driven consulting firm supporting leaders in creating large-scale, lasting social change. Through strategy, evaluation, and research, we help many types of actors—individually and collectively—make progress against the world's toughest problems.

FSG seeks to reimagine social change by identifying ways to maximize the impact of existing resources, amplifying the work of others to help advance knowledge and practice, and inspiring change agents around the world to achieve greater impact. With a deep commitment to health equity, FSG works with actors across sectors, including foundations, companies, governments, and nonprofits to accelerate and deepen population health improvements in the United States.

As part of its nonprofit mission, FSG also directly supports learning communities, such as the Collective Impact Forum, Shared Value Initiative, and 100,000 Opportunities Initiative, to provide the tools and relationships that change agents need to be successful.

Learn more about FSG at [www.fsg.org](http://www.fsg.org).

## About this brief

This brief illustrates how the health system can effectively increase timely access to high-quality specialty care services for low-income and rural populations by investing in three types of solutions: developing primary care capacity to deliver specialty care for select conditions, using telemedicine and telementoring to expand access to locally-based specialty care, and coordinating specialty care referral systems for underserved groups.

## About specialty care

Specialty care encompasses health care services dedicated to a specific branch of medicine—in other words, all health care services not considered primary care. Typically, patients are referred to a specialist by a primary care provider for disease-specific care that requires expert diagnosis and management. Specialty care encompasses many common and serious disease areas, including cardiology, oncology, rheumatology, immunology, psychiatry, and many others. Across disease areas, many patients face more challenges accessing and staying engaged in specialty care than in primary care.

## Relevant patient groups and disease areas

This brief will dedicate specific attention to the following groups and issues.

- **Uninsured and low-income patients** who face the challenge of limited availability and selection of providers due to low Medicaid reimbursement or lack of insurance, out-of-pocket costs, transportation costs and time costs.
- **Rural patients** who are particularly affected by a shortage of local specialists and are often required to travel long distances to seek care.

### Snapshot: Increasing Specialty Care Availability



#### Target Patient Populations

- Low-income patients
- Rural patients

#### Relevant Drivers of Inequity in Specialty Care

- Provider refusal of uninsured or Medicaid patients
- Limited availability of specialists in rural areas
- Complex or ad hoc referral processes between primary and specialty care

#### Health Equity Solutions

- Telemedicine services
- Development of primary care capacity to provide appropriate specialty care
- Coordinated specialist networks that streamline charity care



# The Equity Challenge: Unequal Access to Specialty Care

Accessing specialty care is inherently more difficult than accessing primary care. Although there are more specialists than primary care physicians in the United States, there are far fewer specialty care doctors for each type of specialty than primary care; this fact in turn limits the number of patients that can be seen.<sup>1</sup> This results in access challenges for low-income and rural patients, who regularly face delays and other hardships that contribute directly to disparities in health outcomes.

*“My Medicaid patients sometimes have to wait six months for a consult with a specialist. And six months matter when you’re talking about cancer.”*

—NURSE PRACTITIONER,  
COMMUNITY HEALTH CENTER, ALABAMA

In particular, the limited availability of specialists drives health disparities in three ways.

- **Inaccessible or delayed care due to insurance status:** Specialist practices often cap the number of Medicaid patients they are willing to see. In large part, this is due to differences in reimbursement rates between Medicaid and more well-resourced plans like Medicare or private insurance. A 2012 survey of reimbursement rates found that Medicaid reimburses 66 cents for each \$1 reimbursed by Medicare.<sup>2</sup> As a result of such differences, fewer than 50% of all medical practices in America accept Medicaid patients, and that rate is far lower for specialist practices.<sup>3,4</sup> **For example, studies suggest that only 27% of dermatology practices currently accept Medicaid patients.**<sup>5</sup> Even when they can see a specialist, Medicaid patients face delays. For example, Medicaid patients on average wait a full month more than Medicare patients to see a dermatologist, even for skin cancer consultations.<sup>6</sup> Examples from California show that Medicaid patients can wait as long as a year and a half to see a cardiologist.<sup>7</sup> Patients without insurance wait even longer.<sup>8</sup>
- **Transportation time and cost:** The supply of specialty care is not only inadequate, but it is also highly concentrated in urban areas. Estimates suggest, for example, that **97% of medical oncologists in the United States practice in urban areas.**<sup>9</sup> For the 20% of the U.S. population that lives in rural areas, this creates a significant challenge. Rural patients often need to travel hundreds of miles for care, a task that is particularly difficult when repeat visits are necessary to complete a course of treatment (e.g., for chemotherapy, radiation, or dialysis). According to the Community Transportation Association (CTA), approximately 3.6 million Americans miss or delay medical care for transportation reasons every year. This is borne out in health outcomes data: research shows that **rural cancer patients, regardless of income or insurance coverage, experience higher mortality rates than their urban peers** with access as one contributing factor. Although every state Medicaid program offers some form of reimbursement, subsidy, or service for non-emergency medical transportation, half require a formal request and prior approval, often a minimum of 72 hours in advance.<sup>10</sup>



- **Disparity in care environment and quality:** In this context of poor access to specialty care, low-income and rural patients are too often forced to settle for lower-quality care. Lacking the resources to travel to the highest-ranked specialty care centers or the insurance coverage and resources to access the best specialists, low-income and rural patients often seek care at charity care clinics attached to specialty institutions, safety-net facilities, or hospitals that lack extensive experience with their specific conditions and latest treatment guidelines and standards of care. In practice, this can include conducting a lower volume of specific surgeries per year, slower adoption of updated diagnostic and management protocols, and lower capacity for early recognition, prevention, and management of complications. These differences have direct and significant impacts on health outcomes. For example, a 2015 study by the California Healthcare Foundation found that patients who have cancer surgery at “low-volume” hospitals—hospitals that do not specialize or conduct significant numbers of a certain surgery—experience higher post-surgery mortality rates, higher rates of post-surgery complications, and longer hospital stays.<sup>11</sup> Similar trends were found in comparisons between public safety-net hospitals and private comprehensive cancer centers—a 2013 study of colorectal cancer patients in New York found that **three-year overall survival and relapse-free survival rates were significantly higher for patients at the private cancer center and that patients at the safety-net facility were less likely to complete full courses of chemotherapy and were more likely to experience delays and service defects.**<sup>12</sup>

*“One of the most common requests for assistance that we get is for transportation. Nearly 15% of our requests are for transportation, and almost all of those callers are low-income cancer patients who are traveling over 60 miles to receive specialty care. Nearly half of our rural patients travel over 100 miles for care—that’s a huge challenge.”*

—ERIN SINGLETON,  
PATIENT ADVOCATE FOUNDATION

### Figure 1. Barriers along the Patient Pathway in the Traditional Referral Model

Even with a referral from a primary care provider (PCP), uninsured, underinsured, and Medicaid patients may be unable to find specialists willing or able to see them. Those able to be seen by a specialist face additional challenges:





These barriers not only drive poor health outcomes, but they also have implications for health systems costs. Without timely access to specialty care, many Medicaid and uninsured patients seek care in the emergency department (ED). In a 2015 survey of ED doctors, **75% of respondents noted that ED visits have risen because patients cannot otherwise get the specialty care they need.**<sup>13</sup> The ED is seen as more convenient (34% of ED visits are during regular doctors' office hours);<sup>14</sup> further, it is sometimes seen as a "back door" to specialty care for the uninsured, because patients can access care within days rather than months.<sup>15, 16, 17</sup> Studies and anecdotal evidence show that some specialists are more likely to see Medicaid patients when they are referred from the ED, and patients are aware of this. In some instances, patients who wait for months to see specialists are able to meet with one just four days after going to the emergency room.<sup>18</sup> Although convenient for patients, care provided in an ED is much more expensive than care provided in other settings, and the practice often perpetuates patient disengagement from more consistent and comprehensive primary and specialty care. Cumulatively, this has an enormous impact on the health system, as evidenced by a 2010 study, which found that over half of emergency room visits are avoidable and that ED overuse nationally costs more than \$38 billion in unnecessary healthcare spending.<sup>19</sup>

The example of specialty care for deep vein thrombosis, a condition that results in blood clots, illustrates this dual effect of poor outcomes and high costs. Research suggests that uninsured patients admitted to the hospital for deep vein thrombosis averaged a length of stay of 5.5 days, where insured patients averaged 3.7 days. Rates of return to the emergency department were 26.1% for uninsured patients compared to 11.3% for insured patients. This resulted in a significantly **higher average cost of care for uninsured patients than for insured patients—\$12,297 versus \$7,758.**<sup>20</sup>

In the worst-case scenario, some patients will never reach a specialist. Evidence from the Voices for Detroit Initiative, a network that coordinates care for the un- and under-insured population of Detroit (*see profile on page 14 for additional detail*), suggests that this is not uncommon—36% of the program's first-time enrollees were found to have pre-existing, untreated chronic conditions. Without the care provided through the program, these patients would have remained undiagnosed and untreated.<sup>21</sup> Poor access to care is a clear driver of both disparities in health outcomes for low-income and rural patients and health care system costs—as such, it should be a top priority for reform.



# Emerging Solutions

The health sector is increasingly recognizing this dual challenge of poor outcomes and high costs—and working to address it. New innovations to improve access to specialty care focus on the lack of specialists in rural areas, the need to increase access to specialists for low-income and uninsured patients in urban areas, and efforts to reduce administrative and financial costs for hospitals and patients alike. These solutions fall into three categories.

**Figure 2. Three Emerging Solutions for Increasing Specialty Care Availability**



### **PCP Provision of Specialty Care**

Building the capacity of primary care physicians (PCPs) to deliver some specialty care not only increases access, but also enables patients to access care from trusted providers in their communities

[Read more below](#)



### **Telemedicine**

Leveraging technology to enable physicians to treat patients remotely or from their PCP location helps reduce the travel, cost, and inconvenience burden on patients to see a specialist, especially in rural areas

[Read more on page 11](#)



### **Coordinated Specialist Networks**

Creating a central coordinator to streamline access to specialists for un- or under-insured patients increases access to care for patients and improves efficiency and reduces administrative burden for providers

[Read more on page 14](#)

## Primary Care Physician Provision of Specialty Care



Primary care providers are a highly valuable channel to reach a broad range of patients: they are often located in a patient's community, have trusted, long-term relationships with their patients, and have a comprehensive understanding not only of their patients' health status, but their social and economic status as well.

The health sector increasingly recognizes the potential of primary care physicians (PCPs) to deliver select specialty care services. Indeed, building the capacity of PCPs to deliver care for complex, chronic diseases, such as HIV and some cancers, is a new way to expand the reach of limited specialty care services to serve more patients. Delivering this care through PCPs has been found to drastically reduce delays and improve



access, reduce the travel and administrative burden on patients, and enable patients to receive specialist care in a comfortable and trusted environment—all while maintaining the same level of care quality that patients would have received from a medical specialist. Recent recommendations from the U.S. Department of Health on making the “medical neighborhood” more effective and efficient for patients focuses heavily on expanded roles for PCPs (along with the support of improved navigation for patients and better coordination across providers).<sup>22</sup> For specialty care providers, this type of “task-shifting” can greatly increase their own efficiency, enabling them to support many more patients through a network of PCPs or other allied health professional such as nurse practitioners.

*“Project ECHO is a multiplier for the amazing work that hospitals and doctors already do and are mandated to do—it is a scaling tool in and of itself. And while our doctors do Project ECHO to have greater impact, not to make more money, it does have a cost-saving element.”*

—ERIKA HARDING,  
PROJECT ECHO

Though there are several models for building the capacity of PCPs and other health professionals to deliver specialty care, most successful programs are grounded in a training curriculum on relevant treatments or procedures,<sup>23</sup> along with ongoing support and mentorship from specialists. These specialists help participating PCPs manage particularly complex cases through regular weekly or bi-weekly video conference calls between or among providers or teams of providers.<sup>24</sup> Some organizations supplement this training with on-site “champion PCPs” who focus on a particular disease or condition’s treatment through additional research and training, provide support to their institution’s PCPs, and consult on difficult cases.

These programs have long-existed in local pockets. For example, Project CICERO at Montefiore Medical Center in the Bronx, New York has used this practice to deliver HIV care to 1,000 patients in their community (see Case Example on the next page). This approach is now receiving renewed attention and interest through the emergence of Project ECHO—short for Extension for Community Healthcare Outcomes—which leverages videoconferencing technology to build collaborative care partnerships between specialist teams at academic medical centers and other centers of excellence and PCPs who provide care in rural and underserved communities. The Project ECHO platform operates through 39 “hubs,” which provide specialty care training and support for PCPs in 30 disease areas across 22 states. This model enables patients to access high-quality care more quickly and more easily, and also allows for smooth transitions to specialty care facilities when needed. While these projects continue to be funded largely by grants, there are signals that this could change: Medicaid managed care plans in the state of New Mexico, where Project ECHO is based, recently agreed to reimburse for the ECHO Care model on a fee-for-service basis in addition to the grant support that the state Medicaid agency already provides to support the Project ECHO hub at the University of New Mexico.<sup>25</sup>



## Project CICERO: Expansion of HIV Care through PCPs



Recognizing the challenges that many HIV/AIDS patients experience in seeking care from specialists, particularly as the number of HIV/AIDS specialists has decreased over the past several years, Project CICERO at Montefiore Medical Center in the Bronx, New York, provides patients with the opportunity to receive HIV treatment from their PCPs (in a patient-centered medical home model). Treatment provision by PCPs is not only more convenient for patients; it also mitigates stigma, one of the most common barriers to HIV testing and treatment adherence. Treatment by PCP enables HIV patients to be “anonymous” by avoiding HIV-specific clinics.

Established in the late 1980s, Project CICERO is made possible by leveraging a small cadre of HIV specialists at Montefiore, who support 100 primary care providers working in 10 community health centers throughout the Bronx to manage and treat more than 1,100 patients with HIV. These community-based physicians receive special training and ongoing support as needed from the specialists at Montefiore, as well as automatic reminders from the system about their HIV patients. Through the program, PCPs are supported by the program’s director, a medical director, an administrator, an HIV specialist pharmacist, a psychologist, a psychiatrist, a retention specialist, and 2 patient navigators. Drug and treatment costs are covered by Medicaid and insurance, and ancillary support services for the program are funded by the Ryan White HIV/AIDS Program and other government grants. Patients come to the program through a network of partnerships that Montefiore has established in the community, including partnerships with drug outreach, jail transition, homeless shelters, and community HIV/AIDS service organizations.

Project CICERO has created an environment of PCP empowerment and a community of practice within its participating clinics. This is achieved through several key components:

- Each clinic has a “specialty champion” PCP who acts as the HIV-specific medical director for that clinic, stays up-to-date on the latest advances in HIV treatment, and supports other PCPs to provide HIV care.
- Participating PCPs and specialists meet via videoconferencing to discuss challenging cases on a regular basis.
- PCPs are encouraged to reach out to specialists with questions, but they are required to consult with a specialist when changing a patient’s protocol. This policy makes collaboration an expectation and ensures that quality of care is maintained.



The program has achieved 87% viral suppression, compared with a city-wide average of 73%, and comparable treatment outcomes to those in hospital-based specialty centers, all while reducing delays in treatment initiation for low-income patients with HIV. Evidence suggests that it has been a good investment as well: few CICERO patients use the emergency room to access HIV care or other health needs, reducing capacity and cost strains on the city's healthcare system.

Program Director Paul Meissner notes, "Montefiore is developing a Medicaid Health Homes program for patients with high needs that result in high costs. I expected a lot of our Project CICERO patients to be on that list—but they're not. The fact that our patients don't meet that high need/high cost threshold means that we're doing something right." The program has been so successful that it will be replicated to treat patients with Hepatitis C.

*“The average wait time from learning you are HIV positive to being engaged by your treating doctor is about 6 seconds—because it's the same person.”*

—PAUL MEISSNER, PROJECT CICERO,  
MONTEFIORE MEDICAL CENTER, BRONX, NY

**Achieved 87% viral suppression in HIV patients**



## Telemedicine



Telemedicine provides the opportunity for patients to consult with specialists remotely via video technology, either by appointment or on call from emergency rooms. Telemedicine can be used in a range of different applications, including enabling more efficient reading of medical imaging, allowing providers to monitor patient's vitals and wellbeing while they are at home, and enabling direct patient-provider consultation and services in a range of specialties.

Telemedicine is a particularly helpful solution to improve access to specialty care for rural patients. The Indian Health Service, for example, has made Health Information Technology (HIT) and telemedicine a cornerstone of its efforts to reduce health disparities for the reservation-based Native American population. The IHS has established collaborations between tribes and academic medical centers to create a system for both “real-time” interactions between patients and remote providers and asynchronous services (also known as “store and forward” telemedicine), where doctors consult on patient cases outside of an immediate patient consultation (e.g., consulting on a scan or test). For example, the IHS’s tele-ophthalmology program enables patients on rural reservations to easily have their retinal images remotely analyzed by ophthalmologists. As a result of this service, screening rates for diabetic retinopathy increased from 50% to 75% and treatment rates increased from 19.6 to 29.5 per 1,000 patients between 1999 and 2003.<sup>26</sup> Telemedicine is also increasingly used for dermatology. Kaiser Permanente has one of the largest tele-dermatology programs, run in both urban and rural settings. The majority of users are in fact primary care physicians, who can send a photo of a questionable skin problem to a dermatologist via email and receive a quick response that they can then pass on to their patients. This model allows specialists to spend more of their time with patients who require more intensive, in-person assistance and reduces travel, wait time, and costs for patients.<sup>27</sup>

In order to further scale the use of telemedicine, more consistent practice guidelines and policy and reimbursement frameworks will need to be established. The Patient Protection and Affordable Care Act (ACA) expanded many provisions for telemedicine for Medicaid and Medicare.<sup>28</sup> Policies currently vary widely by state, but more consistent reimbursement frameworks and policies to enable use of telemedicine across state lines will be needed for telemedicine to flourish.<sup>29</sup> Several states are leading the charge—Maryland, for example, requires that private insurers reimburse for medically necessary use of telemedicine and has established a state-level task force dedicated to shaping telemedicine policy. Seven states currently receive an “A” rating from the American Telemedicine Association (ATA) for policies that support telemedicine, and the American

*“Transportation is a big barrier. I work on a Navajo reservation and the reservation is huge, some roads are unpaved. Patients have to travel long distances to come see us and they often don’t have money for gas or the roads are bad in the winter. I had one HIV patient who was enthusiastic about getting care but had no phone and no car. Once [a funder] covered those expenses, suddenly, he did great in care and now has an undetectable viral load. Addressing those challenges is critical.”*

—PRIMARY CARE PHYSICIAN, ARIZONA



Medical Association has also recently issued guiding principles of the use of telemedicine.<sup>30</sup> However, advocates note that Medicare reimbursement is lagging, as it only reimburses for telemedicine consultations conducted in health care facilities and does not allow for patients to have telemedicine consultations at home.

## Improving Access to Palliative Care: Balancing Access and Quality

Palliative care is a core component of treatment for many serious illnesses, including cancer, cardiac disease, and other chronic conditions such as organ failure. Palliative care is often provided simultaneously with curative care, but focuses on alleviating pain and distress, helping to coordinate care, and supporting patient care decision-making. The practice is supported by a strong evidence base of outcomes and cost efficiency—studies have found palliative care consultation to be associated with significant reductions in the overall cost of care.

There is a strong movement to expand access to palliative care through a variety of channels, including hospitals, nursing homes and assisted living facilities, in-home care services and telemedicine. These new initiatives are leveraging a broad range of health care workers, from physicians to nurse practitioners.

As this tremendous expansion occurs, however, access continues to vary greatly by state and by providers and payers. And there is a growing focus on ensuring that quality standards remain consistent as expansion occurs through alternative channels.

Organizations like the [Center to Advance Palliative Care \(CAPC\)](#) are leading this effort. CAPC advocates with public and private payers and policymakers to ensure equal access to palliative care for those in need, provides support to provider organizations to integrate palliative care into their services, and works with other palliative care organizations to establish consistent definitions and standards of practice for palliative care across states.



## Center for Connected Health Policy: Specialty Care Safety Net Initiative



The Specialty Care Safety Net Initiative was launched in 2010 by the Center for Connected Health Policy with support from the California Health Care Foundation. The three-year pilot program aimed to expand the state's safety net to include specialty care, with a focus on the use of telemedicine. This effort was particularly relevant in California, where some patients were travelling as much as 600 miles to see a specialist. Over three years, the program connected five University of California medical centers with patients at 43 safety-net facilities around the state. Through this system, 2,301 consultations were provided to patients in the areas of dermatology, endocrinology, hepatology, neurology, orthopedics, and psychiatry. Lasting relationships were built between CHCs and academic hospitals, allowing hospital employees to feel as though they were contributing to healthcare to those who would otherwise be unable to access it, and CHC patients received care that would have taken months or been impossible to reach due to distance.

Despite enthusiasm expressed by participating providers about the success of the pilot and the progress that was made toward fostering acceptance of telemedicine within participating clinics, payment and reimbursement are the biggest barriers to continuing the established partnerships. In its concluding report, the Center for Connected Health Policy outlined potential options for covering the costs of providing telemedicine-based specialty services at safety net clinics, including purchasing a portion of a specialist's time from an academic medical center (rather than paying on a fee-for-service basis), partnering with other community health centers to hire a central cadre of specialists that could consult with patients at all of the participating providers via telemedicine, and advocating for greater reimbursement of telemedicine services.<sup>31</sup>

**Three-year pilot provided 2,300 telemedicine consultations**



## Coordinated Specialist Networks to Streamline Charity Care



Specialists have traditionally seen uninsured patients on an ad hoc basis. Even to get these appointments is a struggle—primary care providers are often required to rely on personal relationships and favors rather than an established system. These informal referral networks are vulnerable to uncertainty in terms of specialist availability, inconsistent communication, unclear policies and protocols, and mixed patient follow through.

Some community health centers and hospitals, however, are establishing more formal partnerships. These collaborations operate under unified policies and systems, share electronic medical records, and often provide patient navigation services to more efficiently and effectively manage specialty care for uninsured patients.

These networks can form either directly between provider organizations or can be facilitated by an intermediary organization that coordinates donated care across a number of local providers. Project Access for example, which is independently administered in a number of metropolitan areas, coordinates donated care between specialists and safety net providers in its communities. The organization works with specialist providers to understand and coordinate their availability, and works with patients to minimize missed appointments and ensure that patients are well-prepared for their visits. To do so, Project Access provides a number of additional services to its patients such as transportation, information about providers, and counselling. This service is generally funded through grants from government agencies and local providers, who realize cost savings and efficiencies from these initiatives. The history of the Cuyahoga Health Access Partnership (see *Case Example on the next page*) illustrates how local actors can come together to establish and maintain these collaborations.

*“We have a deep knowledge of the local underserved population and we’re neutral among all of the different local providers. These are unique assets that can be leveraged for a lot of different purposes to help improve access and efficiency in the local health care system.”*

—SALLIE NEILLIE,  
PROJECT ACCESS NORTHWEST

The Voices of Detroit Initiative (VODI), a collaboration between several Detroit-based health systems and local FQHCs, provides strong evidence of the opportunity these networks offer for cost savings. Similar to CHAP, VODI works to strengthen the continuum of care in the safety-net through shared policies and referral protocols for primary and specialty care in Detroit. Over a five-year period, the program produced cost savings of \$23 million for the local health care system, including \$8.2 million in revenue enhancements from helping patients enroll in insurance and \$13.3 million in cost savings associated with reduced ED utilization.<sup>32</sup> Despite the value these efforts bring to patients and the healthcare community, similar organizations elsewhere have had to cease operations due to a lack of consistent funding.



## The Cuyahoga Health Access Partnership: Streamlining Referral Networks for the Uninsured



Cuyahoga Health Access Partnership (CHAP) is an organization in the Cleveland area that coordinates donated specialty care among community health centers, free clinics, and hospitals, including the Cleveland Clinic. At the core of the program is CHAP's "Access Plan," which confirms a patient's eligibility for donated services at participating provider institutions. Uninsured patients are screened for eligibility and entered into the system by their PCP, at which point they receive a "network card" that allows them access to free or discounted care within the network. All participating hospitals are connected to the same eligibility system, making it much easier for uninsured patients to receive the same care as commercially insured patients.

The streamlining of administrative paperwork and processing has major advantages for participating hospitals, as well as for patients. Prior to CHAP, an uninsured patient would be required to receive financial counseling and screening at each hospital separately. Each site required different documentation and had different standards to determine eligibility for charity care. Because CHAP centralizes the application, patients can be processed at a single location with eligibility that applies to the entire system. This not only makes things easier for the patient, but it also reduces the administrative burden for hospitals. Moreover, CHAP complements this system by supporting patients with navigation services. This ease of use increases the patient's retention in care, and decreases his/her likelihood of resorting to emergency treatment.

Building such a collaborative system required vision, cooperation and financial support on the part of hospitals and MCOs, as well as strong support from local officials. CHAP was conceived in 2008 at the county level, when a local report shone a light on Cuyahoga County's high uninsured rate and attendant health disparities. The report noted that the populations of two neighboring towns, which were situated just a few miles from one another, had life expectancies that differed by a full decade. County and city officials met with hospital administrators and federally qualified health centers (FQHCs) to determine the best way to ensure equitable health for all county residents,<sup>33</sup> and that meeting eventually led to the creation of CHAP. Today, CHAP's operational expenses are covered by grants from participating hospitals, managed care organizations, state initiatives, and other sources.



# Wrapping Things Up: Taking Action

## The Value of Investing In Equity

These three solutions—building the specialty care capacity of primary care providers, leveraging telemedicine and telementoring, and establishing coordinated local networks—are showing tremendous promise to both address health disparities for low-income and rural patients and strengthen systems of care.

### How patients benefit

Access to timely specialty care can be the difference between life and death. These models and initiatives not only enable improved access to specialty care services, but also deliver an improved health care experience. Patients treated via telemedicine, for example, have been found to have reduced travel time and cost—an assessment of a telehealth program at the University of Arkansas found that **94% of patients that used the services would have travelled more than 70 miles for medical care, 84% would have missed a day of work, and 74% would have spent \$75 to \$150 for additional expenses**.<sup>34</sup> Studies suggest that impact is achieved without reducing the quality of care provided. Several studies of telemedicine have found that patient satisfaction is more than 98% when telemedicine from home was utilized instead of hospital-based treatment and have shown telemedicine to result in comparable health outcomes to hospital-based care.<sup>35</sup> Patients who receive specialty care from their PCPs also experience comparable quality, as the outcomes of Project CICERO demonstrate. Similar trends hold for the other solutions discussed in this brief, each of which increases patients' access to specialty care services.

### How providers and provider institutions benefit

- Telemedicine, particularly when employed by a hospital in a capitated setting, has been consistently shown to provide cost savings, in some cases up to 19% of health care delivery costs. For example, one study on remote monitoring of elderly patients with conditions requiring specialty care found the use of telemedicine provided “comparable or better outcomes compared with similar inpatients and [with] higher satisfaction levels,” and reduced re-admissions and emergency room visits for high utilization patients.”<sup>36, 37</sup>



- PCPs who receive training to provide specialty services, especially in rural areas, feel there is an opportunity to grow professionally that wouldn't otherwise be afforded to them. By staying connected to specialists for support, they have access to the latest advances in their field, and it may even help retain physicians where they are located and enhance their job satisfaction.<sup>38, 39</sup> The model also helps provider institutions use their resources effectively, employing "task shifting" to ensure that each cadre of health care workers is operating at the highest levels of their capabilities. Project CICERO provides a strong example, leveraging just a handful of specialists to effectively reach thousands of patients.
- Effective implementation of formally coordinated networks for the uninsured also results in cost savings for health providers. In North Carolina, the Carolina Health Net program calculated that "20% of patients [accounted] for 86% of costs." By streamlining these patients' care in the system and utilizing a medical home model as a "home base" for those also under specialty care, emergency room visits by the targeted cohort "declined by 47% and [emergency room] charges decreased by 41%."<sup>40</sup> Similarly, the VODI initiative in Detroit delivered **\$23M in cost savings for local health systems** by helping patients get access to insurance and by reducing ED usage and readmission rates.

## How payers benefit

By investing in services and technology that improve patients' ability to access specialty care, payers can also benefit from reduced use and cost of hospital-based services. The Veterans Health Administration, for example, has instituted telemedicine as a core component of its care model to coordinate the care of veteran patients with chronic conditions. Ongoing analysis of a cohort of 17,025 telehealth users found a **25% reduction in numbers of bed days of care, a 19% reduction in numbers of hospital admissions, and a mean satisfaction score rating of 86% for patients enrolled in the program.**<sup>41</sup> Recognizing the opportunity for similar savings, insurers Aetna, Wellpoint, UnitedHealth Group, and Blue Cross Blue Shield are all developing partnerships to provide telehealth services to members. In 2015, for example, UnitedHealth began offering one million of its self-funded members the ability to connect with medical services via smartphone, tablet, or computer and the program is set to expand to 20 million fully-insured members in 2016.<sup>42, 43</sup> These programs are currently focused on primary care, but they will set the stage for future consideration of specialty care services.



# What's Needed to Scale These Solutions?

**W**hile it can be daunting for one doctor or one hospital to improve the system alone, these models demonstrate the mutual value that can be created when safety net providers, PCPs, and specialists work together to increase the availability of specialty services. Institutions interested in supporting or implementing these approaches can learn from the best practices of existing implementers, outlined in the tables below.

For additional recommendations on what's needed to scale these solutions, please see [Brief 5: A Call to Action for a System-wide Focus on Equity](#).



## PCP Capacity Building

### State of Adoption

In-person PCP training and support has been used in isolated instances around the country for various specialties, but the advent of virtual training and support models heralds the promise of further scale.

### Opportunities for Further Implementation and Scale

#### Where to start

- For institutions interested in building PCP **capacity, selection of disease areas** should be driven by the local burden of disease and relevant disparities, as well as considerations about the complexity of managing a given disease relative to provider capacity.
- Potential adopters should **consider the relative trade-offs of in-person vs. virtual models**. In-person support may offer greater personalization and a clearer channel for referring complex cases, though it may not be feasible in rural or low-resource areas.

#### Success factors

- **Data capture on clinical outcomes and cost effectiveness** as a platform for greater advocacy for reimbursement coverage.
- **Ample support for the specialists who are providing PCP training** (e.g., through communities of practice that foster the development and sharing of best practices).
- **Ongoing engagement and mentorship** between specialists and PCPs beyond a one-off training.

#### Examples include

- Project ECHO
- Project Cicero, Montefiore Medical Center



## Telemedicine

### State of Adoption

Telemedicine is gaining prominence in the broader U.S. healthcare marketplace, but adoption among safety net institutions remains low and systems are ad hoc.

### Opportunities for Further Implementation and Scale

#### Where to start

- **Detailed pre-implementation assessment and planning** is a crucial first step; often providers are attracted by the technology but do not fully assess whether it is the right solution for their context or do not fully develop staffing and workflow plans, leading to underutilized implementations.
- **Healthcare systems can partner with safety net providers** to identify high-need disease areas in which telemedicine might offer greater efficiency in care and to make remote specialty services available.

#### Success factors

- **Policy advocacy to increase the standardization of telemedicine regulations** (e.g., to enable more cross-state care, lower barriers to entry).
- **Full engagement of primary care staff during telemedicine implementation** to reduce potential resentment of the technology and to collaboratively develop workflows.
- **Consortiums of safety net providers** can pool resources to secure needed specialist capacity that can be shared virtually and reduce cost.

#### Examples include

- Indian Health Service
- Center for Connected Health Policy
- Kaiser Permanente
- Veterans Health Administration



## Formal Network Coordination

### State of Adoption

Partnerships have been implemented in various forms around the country, but remain opportunistic and ad hoc.

### Opportunities for Further Implementation and Scale

#### Where to start

- **Local data on disparities** presented in a compelling way can initiate political momentum and interest in seeking systemic solutions to specialty care access challenges.
- Depending on the local context, **various models for network coordination can be effective**. In places where there are strong pre-existing relationships between medical centers and safety net providers, coordination can be achieved simply through developing shared referral protocols. In many cases, however, a dedicated organization is needed to help coordinate available donated services.

#### Success factors

- **Ancillary supports** that go beyond matching patients with needed donated services by providing services such as transportation assistance, translation services, or patient education.
- **Data on outcomes and cost effectiveness** to increase the level of healthcare system commitment to organizations providing coordinating services.

#### Examples include

- Cuyahoga Health Access Partnership (CHAP)
- Voices of Detroit Initiative (VODI)
- Project Access
- Carolina Health Net



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# Breaking the Barriers to Specialty Care

*Practical Ideas to Improve Health Equity and Reduce Cost*

## Increasing Specialty Care Availability

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