



VALLEY CARE
Community Consortium

Coalition of Safety Net Access Providers


C-SNAP UPDATES

June 2010

C-SNAP Vision

SPA 2 providers will work collaboratively to provide timely and convenient access to appropriate, high quality, coordinated specialty care to the low-income, under and uninsured residents of the San Fernando and Santa Clarita Valleys.

NEUROLOGY SPECIALTY CARE



Access to specialty care, including neurological care, remains limited and inconsistent for patients in the safety net system. Patients with neurological disease have chronic medical conditions that benefit from timely access to outpatient neurological care. In California, neurological care may be more difficult to obtain for patients in the safety net compared to other medical specialties. In a recent California Health Care Foundation survey, 69% of federally qualified health center (FQHC) medical directors reported that their uninsured patients were thought to “often” or “almost always” have difficulty obtaining neurological care and this was a greater proportion than any other specialty.

In the Santa Clarita and San Fernando Valleys, the major resource for neurological care for uninsured patients is Olive View-UCLA Medical Center (OVMC) where access is limited. Barriers include:

- Capacity constraints including limited neurologists and clinic space
- Lengthy wait times of nearly 5-6 months
- Nearly 50% of referrals denied
- Underuse of neurological referral guidelines by primary care providers due to inaccessibility and limited ease of use

- Provider frustration with the referral processing system (RPS) leading to limited use of RPS directly by referring MDs
- Low rates of discharge of stable neurological patients back to referring providers due to capacity constraints in primary care
- High no-show rates
- Substantial responsibility placed on patients to follow-up on referral scheduling steps

In order to help develop feasible and sustainable interventions to improve access to outpatient specialty care at OVMC, a second Neurology Specialty Care Training was presented on May 24, 2010. Dr. Christine Bower Baca, MD, a UCLA Neurologist and Robert Wood Johnson Clinical Scholar and Dr. Charles Flippen, MD, a neurologist at OVMC, led the session.

The goal of the session was to review referral procedures and guidelines to OVMC-Neurology in an interactive format in order to get collaborative input from primary care referring providers about how to improve current referral guidelines, develop clinical management guidelines, and refer patients in need of neurological specialty care more efficiently and appropriately.

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NEUROLOGY SPECIALTY CARE

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To this end, Dr. Bower Baca and Dr. Flippen used a case-based approach, in addition to reviewing current referral guidelines, to discuss why some referrals are accepted and others denied. Using actual referrals as samples, each audience participant was asked to answer a series of questions about the referral and ultimately, to render a decision about whether or not the referral should be accepted or denied.

AUDIENCE QUESTIONS

1. Was the primary reason for referral clear?
2. Is there information in the referral that was missing that is needed in order to make an informed decision regarding the appropriateness of the referral?
3. Should a primary care provider be able to care for this problem?
4. Is it likely that a specialty neurology consultation will result in a change of diagnosis, medication, or outcome?
5. Should this referral be accepted for neurology specialty consultation?

These decisions were compared with the actual decision rendered by the triaging neurologist in conjunction with examples of the current referral guidelines.

The interactive discussion that ensued led to several important observations and conclusions:

- Referring providers and neurologists have a high level of agreement about triage decisions of referrals (accept vs. deny)
- One common reason for referral denial is insufficient information upon which to render a decision
- The current referral guidelines need to be modified with respect to content and format
- Referral guidelines could be used as a teaching tool, serving the dual purpose of providing criteria upon which to refer a patient and helping expand a referring provider's capacity to care for patients with neurological disease

As judged by overall participation, post-session survey feedback, and partnership development the session was a success! The group collaboratively and enthusiastically agreed that the topic of the next training session should be the development of neurological clinical management guidelines for primary care providers.

COMMON REASONS FOR OUTPATIENT NEUROLOGY REFERRAL DENIAL

1. Not a neurological problem
2. Stable neurological disease – no active problem
3. Inadequate trial of therapeutics
4. Inadequate preliminary diagnostic work-up
5. Insufficient information in referral request

REFERRAL GUIDELINES RECOMMENDATIONS FOR IMPROVEMENT

1. Make more accessible (increase dissemination) beyond RPS
2. Make more user-friendly (less text – use bullets, algorithm-based, decision-trees)
3. Use as a teaching tool (referral criteria decision trees, simultaneously provide clinical management guidelines)
4. Develop clinical management guidelines for use by PCPs to avert referral and/or temporarily treat/work-up condition while waiting for referral
Examples:
 - a. Management and work-up of 1st unprovoked seizure
 - b. Decision tree for withdrawal of anti-epileptic medications for seizure-free patients
 - c. List of critical questions (exam/history) that PCP can ask for suspected neurological disease (multiple sclerosis)

NEUROLOGY GUIDELINES

Through the provider training program, the Neurologist and primary care providers will evaluate and may revise current guidelines. Below are examples of some of the guidelines.

OVMC NEUROLOGY REFERRAL GUIDELINES: SEIZURES AND HEADACHE

SEIZURES

Patients with established epilepsy do not need consultation following a solitary seizure, if an obvious reason (e.g., non-compliance with meds, concomitant illness) for the breakthrough exists. If the patient has had a 20% increase in seizure frequency in the recent past, then a request for an earlier appointment may be submitted if the patient's scheduled visit to Neurology Clinic is >1 month into the future. Patients who have run out of anticonvulsant medication(s) may be given a supply to cover them until the next scheduled Neurology Clinic visit. If an appointment does not exist, then a 5-month supply should be given and a Request for Outpatient Consultation form submitted. If a patient has a stable seizure disorder (no seizures on anticonvulsant medication with the past half-year or more) there is no requirement that the Neurology Service follow them. Medication may be refilled by Primary Care.

Studies to be obtained prior to Neurology Clinic consultation:

- Anticonvulsant levels
- EEG
- Brain MRI

HEADACHE

Patients with established migraine headache who have failed primary care attempts at management may be referred to the Neurology clinic. Patients given a new diagnosis of migraine by Primary Care, Medical Walk-In, or the DEM, who have not yet had reasonable attempts at management (use of triptans &/or appropriate preventive medications) should be referred to Primary Care prior to seeking specialist care.

Studies to be obtained prior to Neurology Clinic consultation:

- If DEM referral, the patient should be referred to Primary Care first. If referral from Primary Care, and headache of long duration (> 1 year), documentation of prior management attempts.
- Medication history
- If patient >50 years old, ESR
- Documentation of neurology exam (to determine urgency of referral)
- If focal findings on neurology exam, neuroimaging results or at least a request for MRI of brain.

PROJECT UPDATES

Both these programs have been made possible by our C-SNAP grant with Kaiser Permanente Foundation.

TELEDERM PROJECT

In efforts to reduce the wait time to obtain an appointment to a Dermatology specialist, the Telederm project was implemented at Tarzana Treatment Center the week of June 14. It is anticipated to be implemented at the San Fernando Health Center by mid-July where necessary photos will be taken as part of the primary care visit and images uploaded into RPS for reading by the Dermatologist. This electronic process will more effectively diagnose patients whose care can be managed in the primary care setting and those who need a referral to the specialist.

AUTOMATED APPOINTMENT REMINDER PROJECT

In an effort to increase access to specialty care by reducing the no-show appointment rate, an automated appointment reminder system is being implemented at Olive View-UCLA Medical Center. Effective August 1, 4Patient Care will provide computer-generated reminders using both mailed cards and telephone calls for patients with appointments in the Neurology specialty clinic. After implementing at Neurology, this service will be implemented in other specialty clinics where the need is the greatest.

NEWS INSIGHT

Since the current recession began, public hospitals:

- Have treated more patients overall, including 23% more uninsured patients
- Account for 2% of hospitals nationwide, but provide 19% of all hospital-based uncompensated care
- Experienced more than 80% of their rise in patients from people who are uninsured or receiving Medicaid
- Have reported a 10% increase in uncompensated care costs; averaging \$2.3 million per hospital with some hospitals incurring more than \$16 million in additional costs

Source: "Numbers of Uninsured on Rise In Nation's Public Hospitals," NAPH Press Release, February 24, 2010
<http://hewmobile.healthexecmobile.com/t/9309957/52085558/69415/0/>

IMPROVEMENTS TO THE REFERRAL PROCESSING SYSTEM

In April 2010 DHS successfully transferred RPS to a new server. This simultaneously increased both the speed and capacity of system. It did not, however, affect or change the current RPS user interface.

In 2011, DHS hopes to upgrade the software that RPS runs on to the latest Oracle platform – the Oracle Business Process Management or BPM software. "RPS2" (the name for RPS on Oracle BPM) should make the system more responsive to user-driven changes, needs and requests. It will provide real time dashboard reports allowing staff at all levels of the DHS organization to better understand the demand and flow of referrals at their clinics. This enhancement will greatly improve the efficiency and effectiveness of the system. It includes upgrades that increase the speed of referral processing and decrease the administrative burdens on PPP and DHS referral creators as well as DHS administrative referral center staff and clinical reviewer staff.

Our long-term project to improve the accuracy of referrals and decrease the administrative burden is to standardize DHS clinical prerequisite requirements countywide and embed them into RPS for automatic referral review.

ValleyCare/PPP Meeting on RPS and Clinical Prerequisites

On June 10, representatives from Olive View-UCLA Medical Center (OVMC) and the ValleyCare Public Private Partners (PPP) gathered at Tarzana Treatment Center's clinic in Northridge to meet and discuss the OVMC referral process and the Department's Referral Processing System (RPS). Representatives from all ValleyCare PPP were present. Additionally, several representatives from SPA 1 PPP and High Desert Health System participated remotely via webinar.

The meeting began with a panel on OVMC clinical prerequisite criteria featuring Linda Kim-Fung, RN, Nurse Manager for the OVMC referral center, Dr. Nina Park, the Associate Medical Director for Primary Care and Community Medicine, and Dr. Christine Bower Baca a UCLA Robert Wood Johnson fellow.

Linda Kim-Fung, RN discussed the importance of submitting a complete referral in order to facilitate timely administrative referral review. Providing examples of complete and incomplete referrals, she offered helpful suggestions to improve accurate referral submission by the PPP.

Dr. Nina Park presented an overview of the clinical content of the referral prerequisite requirements. Participants followed along using RPS reference manuals provided by C-SNAP containing copies of the OVMC prerequisites. Dr. Park provided a general overview of the OVMC referral guidelines, including their strengths, weaknesses and applications. She highlighted specific criteria that can be used as guidelines for clinical pathways versus those that function only as prerequisites. Dr. Park suggested that PPP providers explore the best way to incorporate the guidelines into their clinical process.

The final panelist, Dr. Christine Bower Baca, a Robert Wood Johnson Neurology fellow from UCLA, presented the work she has done with the OVMC Neurology prerequisites; identifying ways to improve their usefulness and application by PPP providers.

After the panel presentations the meeting opened up to a dialogue and where the PPP asked questions as well as gave feedback to OVMC on specific ways to alter the guidelines to best meet everyone's needs. The group came up with concrete next steps to work together on the referral prerequisites as well as other aspects of the referral process including return of progress notes and appointment notification.

After the panel presentation, Hayley Buchbinder from the DHS Office of Ambulatory Care went over future planned enhancements to the Referral Processing System. Hayley and Rodrigo Andrade, Mid-Valley Comprehensive Health Center Information Systems discussed best practices for use of RPS, ending the session with refresher training on RPS.

Office of Ambulatory Care RPS Website

The Office of Ambulatory Care has an RPS website that has a wealth of resources for RPS users. Contents include: RPS training documents, DHS referral policies, DHS facility updates; lists of DHS clinics. To get to the website go to <http://ladhs.org/wps/portal/AmbulatoryCare> and click on "WebReferral" on left side of the page.

Eleven Referral Processing System (RPS) Best Practices



1. Look up any future OVMC appointments in RPS and place a reminder in the PPP patient's chart so their PPP primary care provider (PCP) can discuss it during the patient's visit.
2. Cancel any appointments a patient cannot make both in RPS and by calling the OVMC referral center. Cancel any referrals that were saved and never submitted.
3. Lab test delays: If a test result is not available, do not submit the referral. For referrals returned for additional information let OVMC know how long the delay will be.
4. Encourage your PCP to review the OVMC Clinical Guidelines prior to writing the referral. Maintain a hardcopy of the guidelines where the PCP write their referrals.
5. When writing a referral, be specific about the reason for the referral. With x-rays, identify the part of the body. For CT Scans, specify Contrast/No Contrast/PO and IV.
6. Create one referral per item requested. For example, an MRI/MRA Neck and Head is 4 referrals = 1. MRI Head, 2. MRI Neck, 3. MRA Head, 4. MRA Neck.
7. Multiple persons can work on one referral using the RPS team referral page.
8. If the physician is not entering the referrals, staff responsible for this function should scan the original referral.
9. A suggestion to resolve requests for additional information and denied referrals for a facility/clinic; assign a lead physician to review requests on a bi-weekly basis.
10. Make good use of your RPS Site Administrator. They are your first contact for RPS help, including: training, resetting passwords, and bringing new users and physicians onto RPS.
11. Don't send a copy of the referral via fax or mail. It causes delays for the referral center to determine whether it is a duplicate.



Days to the Next Appointment for Referrals through RPS

Service	May 2010
Podiatry	42
Cardiology	36
Chest	141
Dermatology	73
Diabetic	118
Endocrinology	225
Gastroenterology	60
Hematology	32
Infectious Disease	9
Infectious Disease-Specialty	45
MDA Neuromuscular	8
Memory Loss	73
Neurology	155
Oncology	31
Orthopedic Adult	57
Renal	82
Rheumatology	156
OB/GYN - Antepartum/Genetics	0
OB/GYN - Gynecology Endocrinology	140
OB/GYN - Gynecology -Urology	75
OB/GYN - Gynecology After Care	20
OB/GYN - Gynecology PAP/ Colpo	62
OB/GYN - Gynecology (Re-design Clinic)	32
OB/GYN - Gynecology - Oncology (Re-design Clinic)	58
OB/GYN - High Risk Prenatal	16
OB/GYN - Prenatal Intake	15
OB/GYN - Post Partum	76
OB/GYN - Sterilization English	33
OB/GYN - Sterilization Spanish	11
Surgery Audiology	187
Surgery Breast	5
Surgery Cleft Palate	34
Surgery ENT	29
Surgery General	21
Surgery Laser (Part of Optometry)	71
Surgery Ophthalmology	60
Surgery Optometry	35
Surgery Plastic	38
Surgery Proctology	61
Surgery Urology	70
Surgery Vascular	54

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Valley Care Community Consortium

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