INFORMING CHANGE

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Mission Possible: Healthcare Safety Net Integration

A Look at Two Projects Funded through Blue Shield of California Foundation's Safety Net Integration Program

INTRODUCTION

With the full implementation of the Affordable Care Act fast approaching, providers are getting ready by making changes to their current systems. They are preparing for an influx of newly insured patients, attempting to position themselves as providers of choice within their communities and working on developing health homes and accountable care organizations. There is growing recognition that healthcare systems need to become more integrated to achieve the "Triple Aim" goals of improved health outcomes, enhanced patient experience and reduced healthcare costs. The current fragmented system can hinder organizations' ability to reach these vital goals. Multiple systemic challenges impede organizations' abilities to coordinate with each other, including:

- The absence of a modern communication infrastructure among providers;
- Financing and reimbursement models that do not encourage care coordination; and
- A culture of independence and self-sufficiency among providers.

While some safety net challenges, such as changing payment models, are better addressed at a policy level, others can be tackled by collaborative groups with support from government or private grants.

Blue Shield of California Foundation believes that integration and coordination of services across the safety net is critical to achieving a stronger, more effective system of care for California's underserved. To this end, in 2011, the Foundation invested approximately $5 million in safety net integration projects across the state. By providing funding to help coordinate services across community health centers and other safety net providers, the Foundation hopes to take advantage of opportunities provided by the Affordable Care Act and move organizations closer to the "Triple Aim" goals. This brief describes the first two projects that the Foundation supported with $500,000 grants each to:

- Implement an electronic specialty care referral and consultation system in Los Angeles County and
- Launch a health information exchange (HIE) in San Joaquin County.

The brief provides an update on project progress, documents preliminary outcomes and shares key learnings for others who may be interested in pursuing similar projects. While the projects receive funding from multiple sources, these summaries focus on activities supported by Blue Shield of California Foundation grants.

E-CONSULT REFERRAL WORK GROUPS

Los Angeles County's public healthcare system serves over 10 million residents. The system—second in size only to New York—includes four hospitals, two multi-service ambulatory care centers, six county comprehensive health centers and numerous private, community health centers that all serve low-income and uninsured patients. This busy system is often overcrowded, which can lead to long wait times—sometimes up to nine months—to see a specialist. Protocols for when and how to refer patients vary across specialists, differing by facility and even by departments within a facility. These limitations hinder primary care providers' ability to deliver quality, timely services and manage their patients' conditions. The fractured referral system can cause confusion, create inefficient scheduling and impede communication among providers, all of which increases stress and costs in the safety net system.

When primary care physicians need to refer patients to a specialist, they typically contact the specialist through a call, a fax with written notes or through Los Angeles County's electronic Referral Processing System. In this system, administrative and clinical staff manually review referrals, then approve or reject them based on available capacity and/or clinical guidelines for each available healthcare organization. Given that no standard guidelines exist to serve the clients in the safety net system, some safety net providers send referrals to multiple specialists with the hope of increasing the chance of securing an appointment for their patient. Consequently, the system is plagued with unnecessary appointments, appointment backlogs and unprocessed referrals.

➔ Introducing eConsult to L.A. County

Key leaders at the Los Angeles County Department of Health Services previously worked together within San Francisco's healthcare safety net. While in San Francisco, these leaders participated in a successful electronic referral and consultation system, which resulted in positive outcomes, such as reduced wait times for specialty care appointments, elimination of unnecessary visits and enhanced primary care provider understanding of patients' needs. Given the challenges with Los Angeles County's Referral Processing System and their intimate knowledge of this eReferral, or eConsult, project, they decided to replicate the system in the Los Angeles healthcare safety net. [1]

TYPICAL E-CONSULT PROCESS

A patient visits their primary care provider with symptoms that the provider cannot address on their own.

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The primary care provider uses the eConsult system to initiate a Web-based conversation with a specialist about the patient's symptoms.

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The eConsult system prompts the primary care provider to provide information, such as the patients' present illness, progress notes and specific clinical questions.

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An alert is sent to the specialist's e-mail which prompts the specialist to log in to the eConsult system to review and respond to the request.

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A secure, Web-based dialogue begins between the primary care provider and the specialist where they can discuss the case and ask follow-up questions.

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Based on the clinical question, the specialist makes recommendations for the primary care provider to treat the patient on site or refer them to a specialist for an in-person appointment.

[1] eConsult system is known as the eReferral system in San Francisco.

The eConsult system allows primary care providers and specialists to hold a Web-based conversation about the patient's conditions and determine the optimal manner of care. The term eConsult refers to both a set of technological tools as well as the process of provider engagement and communication that is facilitated through the system. The process aims to build capacity in the healthcare system by increasing primary care providers' ability to address specialty care issues at the patients' medical home and reducing the need for in-person visits with a specialist.

"Access is a problem in the safety net system. There are extremely long delays for specialty care appointments…eConsult is helping to address that."

—Brian Nolan, Community Clinic Association of L.A. County

In 2009, L.A. Care Health Plan, the nation's largest publicly operated health plan, decided to model the San Francisco eReferral system by launching an eConsult pilot project with 45 practices within their contracted provider network.[2] Initial results from the pilot showed improved communication and a reduced need for in-person specialty visits.

Based on the encouraging results from the pilot project, two years later in 2011, L.A. Care invested $1.5 million in expanding the eConsult system to more clinics within the healthcare safety net. The Los Angeles County Department of Health Services also received a $500,000 grant from Blue Shield of California Foundation for the project.

Initially, four partners collaborated on this project: the Los Angeles County Department of Health Services, MedPOINT Management, the Community Clinic Association of Los Angeles County and Health Care L.A. Independent Physicians Association. L.A. Care took on the management of the project as part of its community benefit efforts.

In its role as project manager, L.A. Care finances and supports the implementation of the technological infrastructure and the workflow redesign efforts at participating clinic sites. The pilot project reinforced the viewpoint that technology tools are necessary for success, but not sufficient by themselves. The eConsult project needed to develop common referral standards as the next step for the project's success.

COMPONENTS OF LA COUNTY'S E-CONSULT PROJECT

- **Implementing the technology.** Licensing the Web-based software to deliver a common platform for provider referral, consultation and communication.
- **Redesigning clinic workflow.** Developing processes that primary care providers can use to integrate the new system in their day-to-day practice.
- **Standardizing referral guidelines.** Creating agreed upon standards to guide primary care physicians' referrals in the eConsult system.
- **Creating a culture of collaboration.** Changing the way primary care providers and specialists communicate and consult with each other.

"This represents an exciting milestone in the effective delivery of specialty services to our patients."

—Dr. Paul Giboney, Los Angeles County Department of Health Services

[2] L.A. Care serves more than one million Los Angeles County residents through free or low-cost health insurance programs (e.g., Medi-Cal, Healthy Families).

➔ Starting the Work Groups

The grant from Blue Shield of California Foundation was used to support small work groups of primary care providers and specialists to develop standards and guidelines for referrals in seventeen specialty areas to date:

- Cardiology
- Dermatology
- Neurology
- Ophthalmology
- Podiatry
- Women's Health
- Gastroenterology
- Urology
- Rehabilitation services
- Endocrinology
- Hepatology
- Orthopedics
- Otolaryngology
- Rheumatology
- Sleep medicine
- Hematology
- Nephrology

Rather than select specialties solely based on high appointment demand, the project partners selected areas where people could champion the effort in their respective specialties. Each work group is composed of at least one specialist from each county facility as well as primary care provider representatives from the local county and community clinics. They also have an appointed physician chair who provides guidance and leadership to the group. Over time, the project intends to add more work groups that will develop standards for additional specialties and include the ability to make specialty-to-specialty eConsults.

"I believe most innovation has to be led by a champion."

—Dr. Hal Yee, Los Angeles County Department of Health Services

The project contracted with Community Partners, a Los Angeles-based nonprofit organization that supports community initiatives, to provide facilitation, promote engagement and handle logistics for the work groups.

➔ Framing the Work

As the work groups embarked on developing referral standards, they agreed to follow two rules: 1) everyone in the group would need to agree on the guidelines so they could be implemented more easily across the county and 2) the referral guidelines had to be budget-neutral to help make the processes sustainable in the long term.

Before drafting guidelines, the work group participants define and redefine their thinking about specialty care. Using discussion questions to spark ideas, the groups consider ways to decompress the current, congested system:

- What are the essential specialty care services that should be provided to a patient? What services are not essential that can be reduced?
- Where is the best place (e.g., medical homes, specialty clinics) to provide certain specialty care services when they are needed? How can patients begin controlling conditions closer to their home?
- Who is the right provider to deliver these specialty care services? Can certain services be provided by a specialist, a primary care provider, a nurse?
- What is the optimal way to provide specialty care? What can be done differently?

They approached the work without assuming that access to specialty care needed to equate to an in-person visit with a specialist. Participants wanted to create standards that would match the intention of eConsult: to increase the capacity of primary care providers to deal with patients' conditions through access to consultation with a specialist.

"The eConsult work groups are exceedingly successful in obtaining widespread provider agreement on how to best take care of people that have certain problems."

—Dr. Mitchell Katz, Los Angeles County Department of Health Services

➔ Developing & Agreeing on Standards

For the first time, these work groups are coming together to create mutually agreed upon standards across hospitals and clinics in the expansive Los Angeles safety net system. The work groups are reviewing nationally recognized referral guidelines, developing templates for provider consultations and creating guidelines on how primary care providers should manage common conditions within their practice and within the realities of the Los Angeles County healthcare safety net system.

Some of the groups have established referral standards that are being implemented across the system, while other work groups are in the process of finalizing their standards. It has taken more time than expected to obtain provider approval of the guidelines, but each group plans to have a finished set of standards.

➔ Maintaining Provider Engagement

The project partners' initial goal was to engage between 7 and 10 providers in each work group with an equal number of specialty care and primary care physicians. The specialists have participated fully and willingly volunteer their time, but the groups have encountered difficulties engaging primary care providers to the same extent. The project reimburses the physicians time for $100 per hour; however, this has not enticed enough primary care providers to spend time away from their busy clinic sites. Given that an essential objective of the eConsult system is a culture of collaboration and mutually agreed upon standards that meet the needs of both specialists and primary care providers, the full participation of both groups remains critical.

With Community Partners' assistance, project leaders are developing strategies to more fully engage primary care providers. As a solution, new primary care provider advisory boards have been established, through which specialists can seek advice as they develop system-wide effective practices. Project leaders plan to reach out through local clinic consortium meetings to engage additional primary care physicians and continue to build a spirit of collaboration among the providers.

➔ Seeing Initial Results

The eConsult system went live in August 2012 across an initial group of 7 clinic sites. As of September 2013, the eConsult system is in use at 126 clinic sites in Los Angeles County—40 Los Angeles Department of Health Service sites and 86 community health center sites.

Over 30,000 consultations have been exchanged across the eConsult system among the 14 specialty services that have been launched. Many of these consultations have resulted in a resolution of the patient's issues, without the need for an in-person visit to a specialist (Exhibit 1). Project partners report a significant shift toward a more coordinated approach to patient care as providers share more information and data. They are beginning to see the silos between providers erode and think this is in part due to the trust and empowerment generated from the work groups and eConsult system.

> ***"eConsult is strengthening the collaborative relationships between primary care providers and specialists for the benefit of the patients."***
>
> —Mary Franz, L.A. Care

Exhibit 1

Preliminary eConsult Outcomes

Specialty	Number of eConsults	% Reduction of In-Person Visits
Cardiology	2801	55%
Echocardiogram	107	40%
Dermatology	5696	40%
Diabetes	61	59%
Neurology (adult)	2526	59%
Neurology (pediatric)	160	49%
Ophthalmology	6388	13%
Podiatry	1730	22%
Gynecology	3497	26%
Obstetrics	114	39%
Gastroenterology	5659	31%
Urology	2304	37%
Nephrology	743	31%
Endocrinology (adult)	134	55%
Endocrinology (pediatric)	16	69%
Hepatology	65	73%

➔ Moving Forward

Over the coming months, the project will use the remaining grant funds to continue supporting work group activities, re-engaging primary care providers, expanding the number of specialties involved in the project and developing a sustainability plan. Future work groups are planned for pulmonary, infectious diseases and general surgery.

In addition, at the end of 2012, Blue Shield of California Foundation granted the project an additional $200,000, and L.A. Care matched this with $250,000 of its own funds. These grants are being used to expand the number of clinics in the project, with plans to grow to a total of 180 clinic sites by the end of 2013, and to support workflow redesign at the new sites.

➔ Learning from the Experience

The project partners report many lessons learned through this experience that could be useful to others who are designing, piloting or implementing specialty care referral systems. The lessons below arose from both positive and challenging project experiences:

- **Identify provider champions.** Champions create momentum around a new project and engage others. They are critical for obtaining the needed organizational buy-in.
- **Reach out to primary care providers through existing meetings.** Take advantage of existing meetings (e.g., consortium trainings, physician roundtables) to inform and engage physicians.
- **Ensure enough attention to shifts in culture and workflow.** While technology is important to innovate in healthcare, take time to think about what people need to embrace change. Projects need to address culture shifts, give adequate time to redesign workflows to incorporate the technology and standardize practices for using the technology tools.
- **Work with providers closely.** Learning how to use a new system can be time consuming and frustrating for providers. Develop minimum standards for utilization and provide adequate assistance to help with the change process.
- **Dedicate staffing to oversee the work.** Assigning a project manager or hiring an external consultant can help ensure steady project progress. Key roles include: planning logistics, facilitating conversations, following up on action items and promoting a shift in culture among physicians.

DEVELOPING A HEALTH INFORMATION EXCHANGE

In San Joaquin County, like many other counties across the state, patients frequently move among different settings of care (e.g., primary care, specialty care, behavioral health, emergency departments). Unfortunately, the patients' medical records are not always accessible to providers as they transition between these settings. In an attempt to ensure continuity of care, doctors often exchange patient information by calling, faxing or hand delivering materials; at times they rely on the patient to communicate information about their condition. These practices can be inefficient and unreliable, leading to duplicative services, wrongly diagnosed health conditions and frustration for both patient and provider.

Four healthcare safety net providers in San Joaquin County decided to address these challenges together. These organizations—San Joaquin General Hospital, San Joaquin County Behavioral Health Services, Community Medical Centers and Health Plan of San Joaquin—have similar missions to serve the low-income and uninsured population in the area (see box). Their shared missions led them to form a Safety Net Partnership (the Partnership), which meets quarterly to discuss ways to provide high-quality care for the underserved.

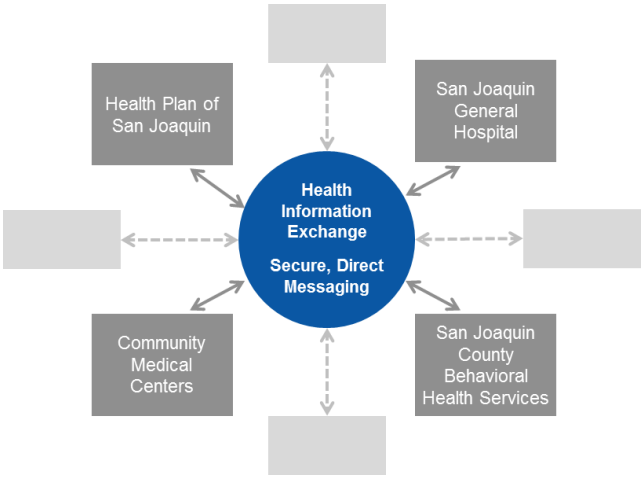
HEALTH INFORMATION EXCHANGE INITIAL PROJECT PARTNERS

- **San Joaquin General Hospital**, the county's 196-bed acute care hospital, provides a range of inpatient and outpatient care.
- **San Joaquin County Behavioral Health Services**, a division of the county's healthcare services agency, provides mental health and substance abuse services.
- **Community Medical Centers,** a local federally qualified health center, provides primary and preventative services at eight sites throughout the county.
- **Health Plan of San Joaquin**, the local Medi-Cal managed care plan, provides low-cost insurance to over 140,000 San Joaquin residents.

These Partnership discussions led to the decision in 2011 to develop a regional HIE. The Partnership established a project budget of approximately $1.3 million and secured contributions of over $800,000 in organizational funds and staff time. The group received a grant from Blue Shield of California Foundation in late 2011 for an additional $500,000 needed to implement the project. Health Plan of San Joaquin agreed to serve as the fiscal agent and project manager, and the Partnership has moved forward with several phases of the project.

Exhibit 2

Initial Partners in the San Joaquin Community Health Information Exchange



➔ Launching the Project

In April 2012, the Partnership's first step in launching the project was developing a memorandum of understanding among the partners that outlined the project's goals, as well as the expectations for governance and financing. Once the agreements were signed, the Partnership formed a Governance Committee comprising the CEOs of the four organizations, who meet monthly to discuss project progress and make joint decisions. The CEOs are advised by key staff from their organizations (e.g., Chief Information Officers, IT Directors) on technology matters.

During the launch phase, the Partnership researched best practices for HIEs by talking with others in California who have implemented a similar regional system (e.g., Redwood MedNet, Santa Cruz HIE) or

were in the process of implementing their systems (e.g., HealthShare Bay Area). These conversations resulted in valuable advice and tools. For example, HealthShare Bay Area shared their vendor request for proposal, which allowed the San Joaquin partners to move forward more quickly with their vendor selection process. After slightly adapting the document to fit their unique needs, the Partnership released the request for proposals to HIE vendors across the nation in February 2012.

As vendors began submitting proposals, the Partnership developed a framework to select a vendor. Each partner assessed their internal HIE needs, and then they jointly developed a "score sheet" to rate the extent to which individual vendors could meet these needs. Of the 12 proposals received, the Partnership invited 5 vendors to demonstrate their products. Each vendor spent a day demonstrating their product and answering questions about three key areas: clinical information exchange, data security and system operations. An HIE expert hired by the Partnership was on hand during the demonstrations and throughout the selection process to provide advice.

The Partnership considered a range of product prices and functionalities. Because the County's Behavioral Health Department was going to participate in the HIE, it was important to understand each system's ability to control access to especially sensitive information (e.g., behavioral health status, substance abuse histories). While most systems offered a "break the glass" functionality that allows limited types of information to be shared with providers outside of a patient's care team, the group decided that Orion's product offered the best functionality for the price. Their system also allowed providers without electronic health records to view health data through a Web-based portal, a feature that could help these providers with patient care and could potentially entice them to participate in the HIE in the future.

"During the planning for this project, we continued to hear how important it is for providers to understand both the medical and behavioral conditions of their patients."

—Jeff Slater, Health Plan of San Joaquin

➔ Cultivating Broader Membership

An HIE is only as valuable as the number of people and types of organizations exchanging data within it; therefore a successful HIE needs participation from a diverse group of regional providers. With this in mind, the Partnership invited other regional healthcare providers to attend product demonstrations and learn about the system early in the project. The Partnership worked to recruit the region's major healthcare players, including the key hospitals and clinics. Some expressed interest in the idea of an HIE, but only the local medical society and the public health department attended and engaged in the demonstrations. The Partnership valued their reactions and input on the HIE products even though the two organizations were not yet formal members of the HIE.

The Partnership understood the importance of planning for membership expansion down the road and proactively discussed opportunities and challenges of recruiting new members. One potential barrier was cost; the fee for HIE membership could be prohibitive for independent physicians who run small practices. As a result, the Partnership explored an alternate option for providers to securely communicate with each other, separate from the HIE. They also discussed the potential risk in this separate solution: offering a less costly communication option could unintentionally encourage providers to opt out of the larger, more comprehensive HIE system.

"The value of an HIE corresponds to the amount of relevant data that is effectively exchanged; therefore, we want to work on increasing the number of partners involved."

—Don Johnston, San Joaquin General Hospital

➔ Selecting Vendors

Before contracting with Orion to develop an HIE in San Joaquin County, the Partnership looked into the possibility of contracting for services with an existing HIE on the Orion system. The Partnership's consultant and Governance Committee members were aware of an HIE operating in Riverside and San Bernardino counties that had recently begun live data exchange in April 2012. The Inland Empire HIE comprises over 50 participating hospitals, medical centers, physician practices, health plans and public health organizations sharing health records for more than 4.1 million people and is considered one of the country's largest and most successful HIE systems. The Partnership identified the pros and cons of joining Inland Empire's existing HIE as compared to purchasing the product directly from the vendor and designing their own HIE. Primary factors in the decision were:

- It would be less expensive to contract services than to create a new system.
- The Partnership could participate in and learn from the Inland Empire HIE Governing Council, while keeping the option to set up their own local governance structure.
- The Partnership could have a better chance of recruiting several local hospitals to join the San Joaquin Community HIE since some hospital systems were already involved in the Inland Empire HIE.

After contemplating these considerations, in January 2013 the Partnership contracted with the Inland Empire HIE to allow participating San Joaquin providers to exchange patient data, report immunizations and send and receive lab results. The partners also decided that the potential benefits of providing a separate messaging system outweighed the risks. Therefore, they finalized a contract with Informatics Corporation of America for a secure direct messaging system that operates outside of the HIE.

"We wanted to partner with an established HIE because their thought leadership is already established and we can leverage that knowledge in our own work."

—Cheron Vail, Health Plan of San Joaquin

➔ Launching the System & Moving Forward

In the first half of 2013, the Partnership piloted the HIE with the four core partners. During this period, project leaders fixed bugs in the system and established interfaces among partner organizations and the Inland Empire HIE. A launch event for the San Joaquin Community HIE was held on August 20, 2013 and the live exchange of patient data is expected to begin soon.

The partners are now focusing on creating structures for the long-term sustainability of the HIE. For example, they are setting up a separate 501(c)3 health information organization and recruiting an executive director to lead the new organization. They are also working on resolving complex consent issues around exchanging behavioral health information in an HIE.

The new executive director will be responsible for expanding HIE membership to additional hospitals, private physicians and medical groups.[3] Recently, the HIE added San Joaquin County Public Health Services as a new member that will be integrating its immunization registry with the HIE. The Partnership expects that the number of HIE members will continue to grow over time and that the HIE will allow them to improve communication

[3] The Partnership received a $25,000 HIE planning grant from the California Health eQuality Program at University of California, Davis to help them with this work (e.g., develop a formal governance structure, engage more providers, develop a long-term sustainability plan).

and data exchange across care settings. Ultimately, they hope the HIE will facilitate more timely and appropriate care for their patients.

"Providers usually see only one piece of the puzzle. An HIE offers an opportunity for providers to see the whole picture when determining how to treat their patients."

—Brian Castro, Community Medical Centers

➔ Learning from the Experience

Many of the lessons learned by the Partnership may be useful to others who are launching or implementing HIE systems in their region. Drawing on the group's positive and challenging experiences as well as conversations with field experts, the key lessons emerging from this grant project are:

- **Clearly understand and identify key needs before implementing an HIE.** Take the time to identify the exact types of information that need to be exchanged. Think about who would be helpful to determine the appropriate product (e.g., secure direct messaging, full data exchange, "break the glass" functionalities). Also, identify the business case for participating in an HIE (e.g., positioning the organization for federal or state incentives, creating more efficiencies in day-to-day work, reducing duplicative services and re-admissions).

- **Consider involving a managed care health plan in the HIE membership.** Health plans have a unique structure that is different from other organizations that commonly participate in HIEs. They often have more capacity to manage and oversee projects, do not compete with providers for patients and have a greater incentive to reduce duplication of services through the HIE.

- **When beginning an HIE project, look for partners with common referral patterns or that serve similar populations, but continually cultivate interest in and support for the HIE with other partners.** While not every provider or medical group will sign on as an early member of the HIE, it is valuable to get input from a range of potential members during the vendor vetting and selection process. This allows agencies to understand the project and its benefits, which is helpful when the time comes to expand membership. As the project progresses, continue to educate providers about the HIE and its progress as a way to build interest in future membership.

- **Create an organized and rigorous selection process.** Meet with project partners to form clear objectives and commitments, and use shared tools that meet the needs of all partners to vet and select vendors (e.g., score sheets, common questions). Ensure that all partnering organizations have input on the process.

- **Consider different permutations of an HIE contract.** While directly contracting with one vendor may seem like the simplest way to move forward with an HIE, do not exclude other available options (e.g., see if existing HIEs are open to contracting out their services, discuss the benefits and the risks of contracting with separate vendors for particular services).

- **Use existing knowledge, resources and tools.** Talk with others who have implemented HIEs and/or hire a consultant who has expertise in the area. Request examples of others' tools (e.g., sample RFPs, vendor score sheets or MOUs) to adapt. Also refer to the California Health eQuality Web site[4] for resources about HIEs, such as the Health Information Organization Development Guide and grant opportunities.

[4] The California eHealth Quality Web site: http://www.ucdmc.ucdavis.edu/iphi/Programs/cheq

- **Identify steps to help sustain the system from the start.** Develop a plan to sustain the HIE over time, especially as initial grants and organizational commitments expire. Consider expanding membership as a strategy to help sustain the HIE through membership fees. Also, make sure that organizations with large volumes of patient data (e.g., hospitals, acute care centers, laboratories) are included in the membership to make the data exchange more comprehensive and useful.

- **Do not underestimate the time and costs related to HIEs.** In addition to the hard costs, which include the technology, the project must anticipate soft costs for support, staff planning and building internal expertise to operate and troubleshoot system problems. Be realistic about how much in-kind support partners will be willing to allocate to the project and the time it will take to garner support for the project, select vendors and test systems. Ensure that senior leaders and board members support the project and their organization's financial commitments; formalize this through MOUs. Cost savings from HIEs are not likely to happen immediately. Even after people are re-tasked and have more time for patient care, it can take time to see financial benefits.

CONCLUSION

The two projects funded by Blue Shield of California Foundation are successfully heading toward their goals of coordinating care among healthcare safety net providers.

While this work can be long and arduous, the partnerships formed among agencies and providers have started to break down the walls that have historically separated and siloed health systems. As these walls come down, providers are in a better position to work toward the "Triple Aim" goals of improved health outcomes, enhanced patient experience and reduced healthcare costs. Tangible evidence already exists (e.g., for the eConsult project) that specialty care needs are being addressed in a more timely and effective manner for a growing number of patients.

As the projects progress, it will be important to continue to identify and address issues that can hinder efforts to more fully integrate care within these healthcare systems. This includes continuing to bring a diverse group of participants together to learn about the new systems, give input to design and generate buy-in to these changes. As the partners involved expand, different payment structures will need to be addressed, especially with those that can create a disincentive (e.g., fee-for-service reimbursements) to coordinate and streamline care electronically. Finally, ongoing collection of data that documents the roll out and impacts of these projects remains key for process improvements and demonstrating the value of these efforts for scale and replication. While there is still more work to do, Blue Shield of California Foundation's grants are supporting promising models that other healthcare safety net providers can learn from as they approach integration efforts in their own community.

ABOUT THIS PROFILE

This product was produced in September 2013 by Regina Sheridan and Kim Ammann Howard at Informing Change. The report is based on nine interviews with project staff and field experts, a review of grant documents from the project, and a review of literature related to health information exchanges and electronic referral systems.

For more information about Blue Shield of California Foundation's support for this project or other related activities and investments, visit www.blueshieldcafoundation.org. For more information about Informing Change, contact Kim Ammann Howard at kahoward@informingchange.com or visit www.informingchange.com.