

Primary Care in VA

Primer

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Purpose of Primer Series: to help bridge the gap among health services researchers, policymakers, managers and clinicians in an effort to improve the quality and cost-effectiveness of health care for veterans. The primer series is part of a larger set of dissemination initiatives developed by the Department of Veterans Affairs' Management Decision and Research Center in collaboration with the Foundation for Health Services Research.

Purpose of "Primary Care in VA": to provide a common framework for conceptualizing, implementing and assessing primary care. Using a question and answer format, the primer provides an overview of primary care and its appropriate role in a health care system. The primer is not an exhaustive text on primary care and it is not a how-to manual. However, a select list of more in-depth reference materials is provided in the text of the primer.

Suggested Audience: VA hospital and health care system managers working to develop primary care programs — including administrators, clinical managers and policymakers.

Suggested Uses: ■ individual study, ■ discussion at medical staff meetings, ■ orientation for primary care planning committees in VA medical centers and integrated service networks, ■ primary care training programs designed for specialists unfamiliar with primary care concepts, ■ orientation for medical residents, and ■ resource document for VA strategic planning.

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Preface

Since colonial days, the United States has provided some medical care and other support to persons who suffered as a result of their serving in the nation's uniformed services. The veterans health care system was originally established to treat combat-related injuries and to help rehabilitate veterans with service-connected disabilities. Over the years, the system has greatly expanded.

Today, the Veterans Health Administration in the U.S. Department of Veterans Affairs manages the largest integrated health care delivery system in the United States, providing services to over 40 percent of the approximately 11 million veterans eligible for care. These services are provided at more than 950 government-owned and operated facilities, including hospitals, multispecialty clinics, nursing homes, counseling centers and other access points, as well as through myriad contractual and sharing arrangements with private health care providers, other government agencies and more than 100 medical schools and academic health centers.

Although the VA was initially slow in responding to the changing U.S. health care environment, it is now engaged in far-reaching and innovative changes in American health care. In fact, the veterans health care system is poised for one of the most profound transformations of any organization in American history.

One of the most important changes under way in the veterans health care system is the transition from being a bed-based, hospital inpatient system to one rooted in ambulatory care. Central to this transformation is a major expansion of VA's primary care capacity, i.e., assuring that each and every patient has a designated generalist physician or physician-led team of caregivers that is responsible for providing readily accessible, continuous, comprehensive and coordinated care.

This primer on *Primary Care in VA* is one of a number of efforts by VA to promote greater understanding and knowledge about primary care, both within and outside of VA, and to provide a common framework for conceptualizing, implementing and assessing primary care and its appropriate role in the "new VA." The primer succinctly describes many key aspects of primary care, and it provides guidance for accessing more detailed information about primary care.

I compliment the authors on producing this text and hope that administrators, physicians, house staff, nurses and many others will find it a valuable source of information.

Kenneth W. Kizer, M.D., M.P.H.
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Introduction

Over the past 50 years, health care delivery in this country has revolved around the hospital as the hub of activity. This traditional role of hospitals is now in a state of transition as evidenced by the growing influence of managed care, the expanded role of primary care providers, the dramatic shift from inpatient to outpatient services, and the coordination and integration of services across the continuum of care. Within VA these changes have spurred sweeping transformations in the way health care is delivered to our nation's veterans.

Through a series of questions and responses, this primer seeks to provide a basic understanding of primary care and its relationship to the larger health care system. After defining the generic concept of primary care and differentiating it from emergency care, specialty care, ambulatory care and managed care, the primer examines the current state of primary care within VA. Other primary care resources are listed for readers wanting more in-depth information.

What is primary care?

P primary care is the “provision of continuous, comprehensive and coordinated care to populations undifferentiated by gender, disease or organ system.”¹ Primary care is an approach to organizing care for individuals and populations. Primary care is more than services provided in a physician’s office. While many health care providers deliver services that are considered primary care, providing one or more specific primary care services does not necessarily constitute a *primary care provider*.

Textbook primary care is characterized by four key features that enhance the effectiveness and efficiency of services and differentiate it from other levels of health care services. These are: ■ accessible first-contact care, ■ continuity over time, ■ comprehensiveness, and ■ coordination.²

Primary care is the “provision of continuous, comprehensive and coordinated care to populations undifferentiated by gender, disease or organ system.”

Accessible first-contact care. Primary care is the patient’s point of first-contact with the health care system when a need for care is initially perceived. As the entrypoint into the system, primary care must be readily accessible to patients. Considerations such as proximity of the primary care delivery site to public transportation, availability of parking, wheelchair compatibility, cultural sensitivity and convenient office hours are examples of the many important factors that influence primary care accessibility.

Continuity over time. An ongoing relationship between a patient and a primary care provider (or team of providers) is the basis for continuity of care. A patient should receive all non-emergent and non-referred care, regardless of its nature, from the primary care provider. In instances when the primary care provider refers a patient to a specialist, continuity is still maintained. Continuity of care is achieved when patients receive person-focused, not disease-focused, care from the same provider over a period of time.

Comprehensiveness. No single primary care provider (or team of providers) can deliver all the services needed by the population. Clinical problems that fall outside the scope of primary care practice should be referred to other levels of service for advice, guidance or management. A set of criteria for deciding which kinds of problems should be referred to other providers (specialists) must be developed. Comprehensiveness of care is achieved when the primary care provider arranges for the full range of services to meet all but the uncommon health care needs of the population, i.e., unusual or unusually complex clinical problems.

Coordination. Care must be coordinated to avoid duplication of services, to enhance the efficiency of care, to prevent harm that may result when patients are given conflicting advice or therapies, and to preclude gaps in care. Coordination of care requires diligence by all caregivers and is facilitated when all information pertaining to the patient’s health and health care is integrated and is easily retrievable. This coordination of information is often referred to as *information transfer*; it should occur regardless of where and under what circumstances information is generated by providers. Information transfer is enhanced by: ■ medical records augmented by lists of presenting problems and prescribed medications, ■ computerized information systems, and ■ patient-held records.

How does primary care differ from other levels of health care?

In addition to primary care, health care systems provide other levels of care including emergency care and specialty care. These other types of care can be distinguished from primary care by several structural and process characteristics, although in practice their respective boundaries are not always clear-cut.

The table below summarizes how key features of primary care relate to other levels of care within a health care system.

LEVEL OF CARE	KEY FEATURES OF PRIMARY CARE			
	First-Contact	Continuity	Comprehensiveness	Coordination
<i>Primary Care</i>	Yes	Yes	Yes	Yes, primary care provider assumes responsibility for overall coordination.
<i>Emergency Care</i>	Yes	No	No	Emergency care provider facilitates coordination by supplying information on encounter to primary care provider.
<i>Specialty Care</i>	No	Sometimes. For patients with certain medical conditions, continuity might be a feature of specialty care.	No	Specialty care provider facilitates coordination by supplying information on encounter to primary care provider. For patients with certain medical conditions, specialty care provider might assume responsibility for overall coordination.

... emergency care is often used inappropriately by patients as first-contact care for non-emergent medical needs.

Emergency care. Emergency care is required for sudden or unexpected illness or injury that needs immediate medical attention. Emergency services must be accessible 24 hours a day, seven days a week, and often involve assisted transportation.

Unfortunately, emergency care is often used inappropriately by patients as *first-contact care* for non-emergent medical needs. In emergency care, triage functions are critical; personnel must be trained to quickly recognize the severity of the presenting problem. Neither *continuous* nor *comprehensive* services are features of emergency care. A system for *coordination*, in which the emergency care giver passes along pertinent information to the primary care giver, must be in place.

Specialty care. Speciality care is of two types. The first type is consultative care to assist the primary care provider with the diagnosis or initiation or alteration of treatment strategies. For example, patients whose problems pose diagnostic dilemmas or who have unclear treatment protocols may be referred for one or two visits to a specialist to provide the basis for advice to the primary care provider.

The second type is highly specialized care provided to patients with illnesses that are too uncommon or complex for the primary care provider to maintain competence in their management. This type of specialty care is sometimes long term and requires assimilation of rapidly changing knowledge and developing technology.

First-contact care is not an important attribute of specialty care. Initial access to specialty care providers is controlled by referrals from the primary care provider. Thereafter, and by negotiation with the primary care provider, the patient may contact the specialty care provider directly for specific health care needs. Generally speaking, *comprehensiveness* is not an attribute of specialty care because specialty care, by definition, focuses on a specific medical problem; highly specialized providers generally lack experience dealing with the unique challenges of primary care. The specialist contributes to *coordination* by communicating relevant information to the primary care provider.

Is primary care the same as ambulatory care?

Not all primary care is ambulatory care, and not all ambulatory care is primary care.

P rimary care and ambulatory care are *not* the same. Not all primary care is ambulatory care, and not all ambulatory care is primary care. To illustrate, a primary care provider's responsibility for coordination does not end when a patient leaves the ambulatory care setting and is hospitalized. Similarly, a procedure performed by a specialist in an ambulatory care setting is not considered primary care, nor is the ongoing ambulatory care of, e.g., complicated cancer, being managed by a specialist.

The identifying characteristic of ambulatory care is the site in which it's delivered. Ambulatory care is care provided in all settings *except* hospital inpatient and other institutional settings. Ambulatory care can be delivered in: ■ physician offices, ■ hospital or free-standing outpatient diagnostic and surgical centers, ■ urgent care centers, ■ outpatient rehabilitation centers, ■ outpatient drug and alcohol rehabilitation centers, ■ homes, and ■ hospices.

Advances in diagnostic, therapeutic and rehabilitative services due to technological and pharmaceutical breakthroughs have shifted many specific health care services from inpatient to ambulatory or outpatient settings. Payer and consumer-driven factors, such as cost-containment and convenience, also have influenced the growth of ambulatory services in recent years. These ambulatory care trends, both technologically and economically based, are expected to continue and even accelerate in the years ahead.

Is primary care the same as managed care?

P rimary care and managed care are not the same. Primary care is an approach to provide care to patients and managed care is a strategy to finance services.

Primary care providers are comparable to managed care's *case-managers* in the sense that both coordinate care as well as directly provide the majority of it. Managed care is not necessarily based on a primary care model. Managed care often does not place priority on maintaining continuity of the primary care practitioner over time or assuring services are sufficiently comprehensive to cover all health care needs of patients. Moreover, "managed care" is increasingly used for care of particular types of conditions (such as *managed mental health care*), whereas primary care is, by definition, care of patients regardless of what particular types of problem they have.

The growth of managed care in recent years is largely attributed to the drive for cost-containment and/or the pursuit of value in health care. Managed care seeks to create financial incentives for providers and/or patients to limit unnecessary utilization of services. Primary care, in contrast, is a concept that is independent of financial incentives, although primary care oriented health care systems have been shown to cost less than specialty oriented health care systems.³

Managed care is a broad term encompassing a diverse mix of health plans and systems. Managed care arrangements vary from highly structured health maintenance organizations (HMOs) to more loosely structured preferred provider organizations (PPOs) and point-of-service (POS) plans. By some definitions, even an indemnity plan having a pre-hospital certification requirement that is designed to ensure appropriate use of hospital care represents a form of managed care.

A description of the various roles assigned to primary care providers in three common managed care arrangements follows. These three arrangements are illustrative examples and are not intended to depict the seemingly infinite number of permutations of managed care that exist.

Role of Primary Care Provider in Common Managed Care Arrangements

■ ***Health maintenance organizations (HMOs)***. This highly structured managed care plan requires formal enrollment with a primary care provider in the network. HMOs include staff models, group models and independent practice associations. A referral from the primary care provider is required for all care. If an enrollee chooses to seek care outside the HMO, he/she typically must bear the entire cost for the out-of-network care.

■ ***Preferred provider organizations (PPOs)***. A PPO is a type of managed care plan that offers financial incentives to enrollees to seek care from a designated group of providers — typically physicians, hospitals and labs — that have agreed to furnish services to a specified population at a reduced charge. In return for the discounted charges, the providers expect to experience growth in the size of their patient population. Criteria often used by plans in selecting

Primary care and managed care are not the same.

Primary care providers are comparable to a managed care model's "case-managers" in the sense that they coordinate care as well as directly provide the majority of it.

providers to participate in a PPO are level of discount, patient satisfaction and cost-effective utilization practices. Enrollees can opt to obtain care from this select group of providers or can go to providers not on the PPO list. Formal enrollment with a primary care provider is not a feature of PPOs and the plan does not require referrals for visits inside or outside the PPO. In this way PPOs resemble fee-for-service plans. Enrollees pay more out-of-pocket for using a provider not on the list.

■ **Point-of-service (POS) plans.** This recent entry into the managed care world — the POS plan — requires formal enrollment with a primary care provider, but the enrollment is loosely structured and subscribers are free to use providers inside or outside of the network on any given day, or at any point-of-service. POS plans attempt to balance payers' demands for cost-containment with enrollees' demands for freedom of choice of providers. POS plans are sometimes referred to as open-ended HMOs. A referral from the primary care provider is not required for out-of-network visits but is required for in-network care. Enrollees pay more out-of-pocket for using a provider outside the network.

Although managed care may be organized with a solid primary care infrastructure, managed care arrangements can exist without being grounded in a primary care model. PPOs are evidence of this.

Similarly, primary care — the provision of accessible, continuous, comprehensive and coordinated care — certainly can exist in the absence of managed care. This is evidenced by the many primary care providers who are not in an HMO or POS plan and are not subject to any financial incentives to limit appropriate utilization, but do actively manage and coordinate care across the continuum for their patient population.

What is the status of primary care in VA?

By the end of fiscal year 1996, all VA medical centers will have a primary care program in place.⁴

The Veterans Health Administration is working to adapt its delivery system to align VA with the changes occurring in the larger health care system. The vision for the "new VA" is premised on putting patients first, increasing primary care access points and integrating VA's delivery assets to provide a seamless continuum of care.

What steps are needed to build a VA health care system with primary care as the cornerstone?

In some areas of the country, the building blocks needed to develop a solid primary care foundation within the VA health care system already exist. In other areas, VA needs to start from the beginning to build a primary care infrastructure.

Seven steps to designing a health care system with primary care as the cornerstone are: ■ define the population to be served, ■ document the distribution of health problems within the population, ■ determine the appropriate mix of providers and services, ■ ensure that patients' initial visits are to the designated primary care provider, ■ establish referral protocols and referral networks, ■ develop mechanisms for coordinating care, and ■ create a system for measuring primary care.⁵

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■ ***Define the population that is to be served and characterize that population by gender, age and coverage status so that resources can be allocated efficiently.***

Our country's approximate 26.5 million veterans are a heterogeneous group.⁶

About four percent of the veteran population is female and their median age is 45 years. This is significantly lower than the median age for male veterans which is 57 years.

The age range for all veterans is as follows: □ 24 percent are under 45 years; □ 44 percent are 45 to 64 years; and □ 32 percent are 65 years or older.

Of the 26.5 million veterans, approximately 10.5 million are eligible for health care through VA. Some of the VA eligible veterans have private health insurance or Medicare coverage. About 30 percent of all veterans have incomes at or below the poverty level and have no source of health care other than VA. Not all eligible veterans seek and receive care at VA medical centers; about 40 percent of the nation's eligible veterans use the VA health care system over a four-to-five year period — some for all of their care and some for part of their care.

Recently, one medical center estimated that half of its regular users rely on VA for primary care, and the other half receive uncoordinated care from multiple VA and non-VA sources. Lack of a clearly defined and relatively static patient population makes needs assessments difficult, yet all the more important for VA medical centers to undertake.

■ ***Document the distribution of health problems in the population to be served.***

Some veterans have service-connected conditions requiring highly specialized services, and some are socio-economically disadvantaged requiring a full range of medical and social services.

Documentation of all of the health problems of VA eligible veterans in a given service area may be particularly difficult for VA since many veterans have other sources of health care coverage and may never receive care from VA, or may use VA sporadically or only for certain specialized services. As a result, complete patient data on all VA eligible veterans, needed to document the distribution of health problems, are not captured in VA databases.

One strategy to help fill this information gap is to solicit self-reported health status data from a representative sample of veterans. One 1992 study of self-reported data found that more than 30 percent of veterans reported having high blood pressure and slightly more than eight percent reported having diabetes.⁷

Data on the health problems of the subset of veterans who use the VA system are more complete and more readily accessible than data on the entire VA eligible veteran population. This data, however, is less useful in documenting the distribution of health problems among veterans. One study of VA patients indicated that of all VA medical center discharges in fiscal year 1994, the most prevalent diseases were alcohol dependence syndrome (8 percent) and schizophrenic disorders (4 percent).⁸

■ ***Based on the distribution of health problems, determine the appropriate balance between primary and specialty care providers and determine the mix of services to be offered.***

The VA delivery system has traditionally focused on inpatient and specialty care and, as a result, is not yet appropriately staffed to provide primary care. The largest VA medical centers are dominated by

specialty staff and the typical specialist-to-generalist ratio is ten-to-one. While the ideal specialist-to-generalist ratio needed to care for the veteran population is not known, most agree that a ten-to-one ratio is too high. Some analysts recommend a one-to-one ratio for the general population.

VA managers need to develop programs that ensure an adequate number of primary care providers — including mid-level practitioners — and need to explore the appropriate balance between primary care providers and specialists for their population.

One strategy for achieving the appropriate mix of providers combines the use of VA and contract providers. For example, in some communities it might be cost-effective to provide specialty care on a contractual basis with non-VA providers, whereas in others it might be prudent to provide primary care services on a contractual basis. Another model retrains specialists to become primary care providers.

■ *Design the health care system to ensure that all initial visits are to the designated primary care provider except in the case of emergencies.*

... educational outreach is needed to make veterans aware of how they can and should appropriately access care.

Due to limited resources and other considerations, VA's mission does not include being the sole health care system for all veterans. Most veterans receive the majority of their care, including primary care, outside VA. Since primary care planners are charged with designing a system to ensure that initial patient visits are to the designated primary care provider, it is, therefore, appropriate to channel resources to create accessible first-contact care for those VA patients who do not have a primary care provider outside VA.

To ensure that VA primary care providers are the point of first contact for non-emergency care for veterans who do not otherwise have a primary care provider, VA needs to develop its primary care capacity, educate hospital staff about the primary care model (e.g., referral protocols), and ensure that primary care is accessible. To accomplish the latter, educational outreach is needed to make veterans aware of how they can and should appropriately access care. In designing the system, attention must be paid to a customer service perspective, including office reception procedures and telephone protocols. See the chart below.

PRIMARY CARE CUSTOMER SERVICE PERSPECTIVE

Primary care must be responsive to customer needs if it is to be accessible first-contact care. From the veteran's perspective, accessible primary care often means:

- I always call the same office number
- I always go to the same place
- I always work with the same people
- I know that my caregiver will follow me in the hospital
- I know that my caregiver will be available to talk with me and my family about my problems when necessary (on the phone or in person)

Primary care must be responsive to customer needs if it is to be accessible first-contact care.

■ ***Establish referral protocols and referral networks.***

Criteria for deciding which services should be referred to other providers (specialists) must be developed. Relevant considerations for some referral protocols include the frequency with which a practitioner treats the particular medical condition and the complexity of the diagnosis or treatment.

To establish a referral network, creation of a network committee is recommended. The primary care network should complement VA's existing system of specialty care with effective use of community resources. Community health and social service networks should be established as a part of the primary care continuum of care to sustain the veteran in the community setting, ideally in the patient's own home. Veterans have many private and public entitlements separate from VA eligibility, and these services should be considered when developing networks.

■ ***Develop a mechanism for coordinating care to ensure that the designated primary care provider is aware of all visits made by his or her patients.***

Responsibility for coordination of care must reside with a primary care provider or team of providers. One mechanism to facilitate coordination is to establish an information system that can be accessed by providers in the same or different locations. The information system must provide a record on each enrollee, his or her socio-demographic characteristics, a minimum data set on all clinical encounters and an identifier that permits linkage of the individual's encounter data over time. Without such a system, feedback to clinicians is incomplete and coordination of care is not feasible.

The Decision Support System, an executive information system currently being phased in throughout VA, will provide some patient-specific information that will enhance coordination of care. More sophisticated systems are needed, however, to ensure that relevant patient information is transmitted from VA physicians (when providing specialty care) to non-VA physicians acting in the capacity of a veteran's primary care provider.

■ ***Create a system for measuring primary care.***

Primary care providers must be accountable for organizing services to achieve first-contact care, continuity, comprehensiveness and coordination. Accountability requires that each of these four characteristics be definable and measurable and that acceptable standards or benchmarks be developed. This, in turn, requires the collection of several types of data, including population surveys, providers' administrative data and clinical information.

At the time a primary care program is first established and routinely thereafter, a system for measuring primary care needs to be operational. Indicators of how well primary care is being delivered are critical to guide program development, implementation and refinement and must be regularly communicated to providers and managers.

In developing benchmarks, data collection methods and sample size should be specified to assure comparability over time and across delivery sites. Two examples of how the four characteristics of primary care can be translated into measurable attributes follow.

Primary care providers must be accountable for organizing services to achieve first-contact care, continuity, comprehensiveness and coordination.

■ Coordination could be made measurable by monitoring how well specialty providers communicate information to primary care providers. A benchmark or acceptable standard for coordination of care should be specified, e.g., primary care providers should be notified within 24 hours of all emergency room visits or hospital admissions for patients on their panel.⁹

■ Accessible first-contact care could be made measurable by monitoring whether patients can reach the primary care provider by telephone when needed. A benchmark or acceptable standard for telephone access should be established, e.g., all calls for urgent problems must be returned within a certain number of hours and calls for routine queries within a specified timeframe.

When evaluating the accessibility of primary care, measurement should include some assessment of the entire VA eligible population, not just those who actually use services. People who have used services are less likely to experience access problems and are more likely to have good interactions with the health care system. Studying only users may bias the results, making access look more favorable than is the case. To achieve valid indicators when evaluating accessibility of its primary care systems, VA needs to query a subset of eligible veterans who do not receive care from VA.

A number of other examples of how to measure primary care exist. A primary care measurement tool — designed to assess how well each of the four key features of primary care have been attained — is being tested at The Johns Hopkins University’s medical facilities and is expected to be available by the end of 1995. One version of the instrument was developed for telephone interviews of households in the community, and another was developed for self-administration by knowledgeable staff in health care facilities. This tool, adapted for VA use, may provide a means for monitoring the implementation of VA’s growing primary care orientation.

Other measures that can be used to evaluate the effectiveness of primary care programs include: ■ tracking primary care sensitive admissions to hospitals, i.e., monitoring admissions for diagnoses that likely could have been successfully managed by a primary care provider, thus obviating the need for hospitalization, and ■ other outcomes measures.

What are VA medical centers doing locally to attain a primary care focus?

A number of VA medical centers have made primary care a high priority, despite constraints imposed by veteran eligibility regulations and a disproportionately high staff complement of specialty providers. The following models — a large portion of which ascribe to a team approach to care — represent advancements in attaining a primary care orientation. These are but a few of the many creative primary care programs within VA.

Examples of VA Medical Center Primary Care Initiatives

■ **Physician assistants and nurse practitioners are valuable assets in assembling a primary care work force.** At the Little Rock and Providence VA Medical Centers, about 75 percent of ongoing care is provided by nurse practitioners in interdisciplinary prac-

Reminder systems

assure that patients

receive regular preven-

tive care and promote

comprehensive care.

tice plans. The nurse practitioners assume responsibility for continuity of care once a care plan is established. Physicians act as supervisors and managers, following their panels of patients and overseeing care rendered by physician assistants and nurse practitioners.

■ **Multidisciplinary primary care program is the foundation of VA medical center's managed care system.** The North Chicago VA Medical Center instituted a multidisciplinary primary care program, called PrimeHealth, as the foundation of its managed care system. All patients have a primary care provider who is responsible for delivering essential and preventive health care, coordinating all health care services and serving as the point of access for specialty care. Each primary care provider has a panel of patients for which he/she provides continuity in the ambulatory, acute inpatient and long term care settings. These providers are supported by a team of professionals (registered nurses, social workers, dietitians, clinical pharmacists and team secretaries) who also ensure continuity over time and across clinical settings.

The program is organized around three patient-centered and self-directed work teams that function as independent small group practices. Customer service is a priority. The teams have clear responsibilities and accountability, as well as the authority to ensure that quality care is provided in a timely and cost effective manner. Performance data is distributed to team providers on a regular basis.

■ **Extended primary care networks help a rural VA medical center create an integrated primary care program.** In the Amarillo VA Medical Center's service area, geographic accessibility was problematic; one in three veterans traveled over one hour each way to receive VA care and over 5,000 individuals traveled two hours each way. To reduce travel time to the site of care and improve geographic accessibility, the Amarillo VA Medical Center negotiated a contractual arrangement with a group of community-based clinics to care for veterans. The resulting community-based delivery system integrates care provided in the non-VA clinics with that provided at the VA medical center.

■ **Providers can use data to improve services.** The Providence and Boise VA Medical Centers have initiated programs to evaluate data relevant to primary care, in particular access and provider availability data. Current databases also alert primary care providers when one of their patients is hospitalized and produce routine computerized reports that include information on visits and visit cancellations.

■ **"Firm systems" provide continuous, coordinated care and enhance medical education.** Firm systems are an organizational mechanism that integrates the functions of generalists, specialists and allied health professionals who are responsible for a defined panel of patients. In a number of VA medical centers, among them Boise, Sepulveda, Providence and Cleveland, the primary care practice has been subdivided into *firms* or practice groups, designed to provide continuity of care between the inpatient and outpatient settings. In one version of the firm model, an interdisciplinary primary care team delivers most of the care. When a patient of a firm is hospitalized, responsibility for acute care shifts to the appropriate specialist. The primary care team participates in long term treatment decisions and resumes caring for the patient after discharge.

The Sepulveda VA Medical Center's Pilot Ambulatory Care and Education (PACE) project, a more elaborate variant of the firm system, integrates the efforts of generalists and specialists by creating

teams that follow patients from the outpatient setting into the hospital and when necessary, to long term care settings.

■ **At rural medical centers, greater use of general internists enhances inpatient-outpatient continuity.** Outstanding examples of integration at smaller VA medical centers include the programs at Grand Junction (Colorado) and Boise. At these medical centers, general internists provide general medical care to their patients and provide specialty care as they follow patients into the hospital. This contrasts with the more traditional practice at larger VA medical centers, where clinical functions are more narrowly defined and internists act as consultants and perform technical procedures, while generalists provide primary care services.

■ **Reminder systems ensure that patients receive regular preventive care and promote comprehensive care.** Several VA medical centers have implemented quality improvement plans to ensure that patients receive regular preventive care such as vaccinations and screening procedures. At the Indianapolis VA Medical Center, reminder systems have been employed successfully to ensure that comprehensive primary care is provided. Other ongoing reminder system efforts in VA include decision support systems for pharmacy utilization and physician alerts for notification of abnormal radiology results. VA's Health Services Research and Development Service currently is supporting research to assess the value of various reminder systems.

■ **VA "call centers" facilitate a customer-focused system of care.** VA's Telephone Liaison Care Programs (TLCP) have the potential for improving access to providers, reducing unnecessary clinic visits and decreasing waiting times.¹⁰ At Portland, Oregon's VA Medical Center, Telephone Linked Care (TLC) provides access to: 1) advice nurses; 2) advice pharmacists; 3) eligibility specialists; and 4) the patient's primary care nurse. With the TLC program, emergency care visits have decreased 20-25 percent over the last year and continuity of care and accessibility have improved. The Minneapolis VA Medical Center has a Telephone Care Communications System (TCCS) staffed by four nurses, two administrative staff and one part-time pharmacist to do phone triage. These programs have decreased the number of walk-in visits and increased access for patients and family members.

For a list of contacts who can provide more details about these VA medical center primary care initiatives, see *Appendix A*. Other examples are described in *VA's Primary Care Resource Guide*.¹¹

What large-scale efforts are under way to achieve a primary care focus in VA?

A number of large-scale primary care projects have been completed or are under way throughout VA. Examples of large-scale efforts include VA's Primary Care Directive, the VA National Primary Care Training Program, the Primary Care Education Initiative, the new Chicago Area Network, Women Veterans Comprehensive Health Programs and the Ambulatory Care Education Project.

*Integrating certain
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VA medical centers
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Examples of Large-scale Primary Care Initiatives

■ **Primary Care Directive.** VA issued a directive (10-94-100) to establish guidelines and provide direction for the implementation of primary care in VA. This effort is to facilitate a shift from the provision of episodic care to delivery of a coordinated continuum of care emphasizing primary care within referral networks. VA medical centers are mandated to implement primary care by the end of fiscal year 1996. The VA Office of Ambulatory Care is charged with overseeing this effort.

■ **National Primary Care Training Program.** The National Primary Care Training Program is an example of coordinated interdisciplinary training initiated by VA's Offices of Ambulatory Care, Academic Affairs, Nursing and Social Work. No longer operational, the training program brought together interdisciplinary teams from across the country and reviewed innovative primary care models from VA and the private sector. Trainees developed primary care action plans to improve primary care delivery in their respective medical centers and provided progress reports on subsequent accomplishments at their medical centers.

■ **Primary Care Education Initiative.** To assist VA medical centers in organizing their delivery of care around the principles of primary care, VA's Office of Academic Affairs established the Primary Care Education Initiative (PRIME) in 1993. The goals of the educational intervention is to better prepare residents in internal medicine, family medicine and preventive medicine, administrative and management trainees, and affiliated health professionals to deliver care under this new paradigm. Applications were invited from VA medical centers that had pre-established programs for delivering primary care, and were interested in adding trainee education to their primary care program. In July 1994, 49 participating facilities began receiving trainee salary support for additional medical residents and associated health trainees. In July 1995, 20 additional facilities initiated primary care education programs. The 69 programs in place for academic year 1995-96 provide support for 375 medical residents and almost 750 associated health trainees.

■ **Chicago Area Network.** In 1994, the Chicago Area Network was established to design a health care delivery system that would enhance services to veterans while minimizing the inefficiencies of operating four VA hospitals in close geographic proximity. Integrating certain functions of the four area VA medical centers promises to reduce duplication of services and eliminate unproductive competition. The network's operating assumptions are that: (1) all patients are identified with physician providers rather than medical centers; (2) primary care sites are entrypoints into the network; and (3) network facilities are integrated systems for planning, construction, transportation and information management.

■ **Women Veterans Comprehensive Health Programs.** VA has always provided medical treatment to women but not always with the sensitivity, physical accommodation and equipment necessary to ensure comprehensive care. The Women Veterans Health Program Act of 1992 authorized new and expanded services for women veterans, including eight Women Veterans Comprehensive Health Care Centers. Four of these centers — Chicago, the Southeast Pennsylvania Network, San Francisco and Tampa — use the primary care provider approach, with primary care practitioners coordinating patients' specialty care needs.

■ **Ambulatory Care Education.** The Ambulatory Care Education (ACE) initiative has been successful in fostering the development of primary care in what has historically been referred to as VA's Western Region. The product of a planning process that began in 1988, ACE's cooperative management and committee structure's have enabled significant progress toward improving medical care and medical education in practice settings outside the hospital. An ongoing process of program development in education, management, informatics, research and development, nursing and operations, and managed care has resulted. For example:

- Support for educational programs was obtained through Stanford's Faculty Development Program and made available to all participating medical centers;
- The research and development component of the ACE initiative developed a grant process that involves peer review of applications and dissemination of information gathered through the projects; and
- A comprehensive consultative service was established to provide advice on improving care delivery and education.

ACE now includes 13 states, 15 medical schools and 36 VA medical centers.

For a list of contacts who can provide more detail on these large-scale VA initiatives, see *Appendix B*.

What additional primary care resources are recommended?

For more in-depth information about primary care and its role in health care delivery, the following resources may be helpful:

- Department of Veterans Affairs, National Center for Cost Containment, *Primary Care Resource Guide*. August 1995.
- Department of Veterans Affairs, Veterans Health Administration, *Guidance for the Implementation of Primary Care in Veterans Health Administration*, VHA Directive 10-94-100. October 6, 1994.
- Department of Veterans Affairs, Health Services Research and Development Service (in conjunction with the Foundation for Health Services Research), "The Firm System: An Organizational Concept for Improving Access and Continuity of Care." *Forum*. November 1993.
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Concluding Remarks

Redirecting and restructuring resources to support primary care within VA presents a remarkable opportunity not only to improve the delivery of care for veterans, but also to work with medical schools in reorganizing training.

To achieve coordinated and integrated systems of care requires reworking VA's hospital-based system into a flexible health care system that is responsive to veterans' needs across the continuum of care. The transformation of the VA health care delivery system requires a solid foundation of primary care in which the primary care provider and VA are accountable for the accessibility, continuity, comprehensiveness and coordination of care to veterans.

Redirecting and restructuring resources to support primary care within VA presents a remarkable opportunity not only to improve the delivery of care for veterans, but also to work with medical schools in reorganizing training for medical students, residents and fellows. Progress made in primary care medical education also has implications for advanced training in the medical and surgical subspecialties. New methods are necessary to prepare trainees for their roles as consultants and team members. Much more needs to be done to integrate the training of specialists and subspecialists into a comprehensive model for care.

As VA builds its primary care capacity and refines its delivery system, managers and policymakers at local, regional and national levels need solid data on how to use staff and other resources to best meet the continuum of veterans' health care needs. Health services research can play an integral part in reshaping the VA health care system. Research can inform VA decisionmakers about primary care and under what circumstances various primary care models work in an effort to improve access, quality and cost-effectiveness of care to the nation's veterans.

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3. Starfield, B. "Is Primary Care Essential?" *Lancet*. 1994; 344: 1129-33.
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5. Adapted from Starfield, B. *Primary Care: Concept, Evaluation, and Policy*. New York: Oxford University Press. 1992.
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7. Department of Veterans Affairs. *National Survey of Veterans*. Washington, DC: U.S. Government Printing Office. April 1995:35.
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10. Department of Veterans Affairs, Veterans Health Administration, *Telephone Liaison Care Program (TLCP)*. VHA Directive 10-94-022. October 1994.
11. Department of Veterans Affairs, National Center for Cost Containment, *Primary Care Resource Guide*. August 1995.

Appendix A

Contacts for more information about local VA medical center primary care initiatives described on pages 9-11:

Use of physician assistants and nurse practitioners:

Cynthia Joe, M.D., Acting Associate Chief of Staff for Ambulatory Care (11C), John L. McClellan VA Medical Center, 4300 West 7th Street, Little Rock, AR 72205-5484, FTS (700) 742-1202, Com (501) 660-2022, Fax (501) 671-2529

Thomas A. Parrino, M.D., Assistant Chief of Staff (11), Providence VA Medical Center, 830 Chalkstone Avenue, Providence, RI 02908-4799, FTS (700) 838-3483, Com (401)457-3045, Fax (401) 457-3363

Cheryl Fitzgerald, R.N., N.P., Operations Manager for Primary Care (11B), Providence VA Medical Center, 830 Chalkstone Avenue, Providence, RI 02908-4799, FTS (700) 838-3483, Com (401) 457-3045, Fax (401) 457-3363

Multidisciplinary primary care program:

Carter Mechner, M.D., Chief of Staff (11), North Chicago VA Medical Center, 3001 Green Bay Road, North Chicago, IL 60064, FTS (700) 384-3701, Com (708) 578-3701, Fax (708) 578-3737

James Tuchs Schmidt, M.D., Chief, Medical Service & Director, Managed Care, (111), North Chicago VA Medical Center, 3001 Green Bay Road, North Chicago, IL 60064, FTS (700) 384-3879, Com (708) 578-3879, Fax (708) 578-3863

Community-based primary care network:

Gerald Holman, M.D., Chief of Staff (11), Amarillo VA Medical Center, 6010 Amarillo Boulevard West, Amarillo, TX 79106, FTS (700) 735-7711, Com (806) 354-7803, Fax (806) 354-7860

Use of data to improve primary care:

David Lee, M.D., Chief of Staff (11), Boise VA Medical Center, 500 West Fort Street, Boise, ID 83702-4598, FTS (700) 554-7201, Com (208) 338-7201, Fax (208) 338-7257

Scott Smith, M.D., Chief of Internal Medicine (111), Boise VA Medical Center, 500 West Fort Street, Boise, ID 83702-4598, FTS (700) 554-7220, Com (208) 338-7220, Fax (208) 338-7219

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Firm systems:

Alan Robbins, M.D., Chief of Staff (11), Charleston VA Medical Center, 109 Bee Street, Charleston, SC 29403-5799, FTS (700) 259-7202, Com (803) 577-5011 ext. 7202, Fax (803) 937-6100 (formerly with Sepulveda VA Medical Center's Firm system)

Dennis Cope, M.D., Associate Chief of Staff (11), Charleston VA Medical Center, 109 Bee Street, Charleston, SC 29403-5799, FTS (700) 259-7304, Com (803) 577-5011 ext. 7457, Fax (803) 937-6100 (formerly with Sepulveda VA Medical Center's Firm system)

John Aucott, M.D., Chief, General Internal Medicine and Director,
VA Firm System 111(W), Cleveland VA Medical Center, 10701 East
Boulevard, Cleveland, OH 44106, FTS (700) 290-3800, Com (216) 791-3800
ext. 4816, Fax (216)231-3289

Thomas A. Parrino, M.D., Assistant Chief of Staff (11), Providence VA
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(208) 338-7220, Fax (208) 338-7219

PACE project:

Alan Robbins, M.D., Chief of Staff (11), Charleston VA Medical Center,
109 Bee Street, Charleston, SC 29403-5799, FTS (700) 259-7202, Com
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Dennis Cope, M.D., Associate Chief of Staff (11), Charleston VA Medical
Center, 109 Bee Street, Charleston, SC 29403-5799, FTS (700) 259-7304, Com
(803) 577-5011 ext. 7457, Fax (803) 937-6100

**Greater use of general
internists:**

William Berryman, M.D., Chief of Staff (11), Grand Junction VA Medical
Center, 2121 North Avenue, Grand Junction, CO 81501, FTS (700) 322-0261,
Com (303) 242-0731, Fax (303) 244-1303

David Lee, M.D., Chief of Staff (11), Boise VA Medical Center, 500 West
Fort Street, Boise, ID 83702-4598, FTS (700) 554-7201, Com (208) 338-7201,
Fax (208) 338-7257

Scott Smith, M.D., Chief of Internal Medicine (111), Boise VA Medical
Center, 500 West Fort Street, Boise, ID 83702-4598, FTS (700) 554-7220, Com
(208) 338-7220, Fax (208) 338-7219

**Preventive care
reminder systems:**

William Tierney, M.D., HSR&D Service (11H), Richard L. Roudebush VA
Medical Center, 1481 West Tenth Street, Indianapolis, IN 46202,
FTS (700) 332-2206, Com (317)635-7401 ext. 2887, Fax (317) 269-6392

Dan Berlowitz, M.D., M.P.H., Associate Director, Center for Aging Veterans
(152), Edith Nourse Rogers Veterans Hospital, 200 Springs Road, Building 70,
Bedford, MA 01730, FTS (700) 687-2962, Com (617) 687-2962, Fax (617) 275-
6855

Stephen Fihn, M.D., M.P.H., Director, Northwest Center for Outcomes
Research (152), VA Medical Center, 1660 South Columbian Way, Seattle, WA
98108, FTS (700) 396-2420, Com (206) 764-2420, Fax (206) 764-2935

**Telephone Liaison
Care Programs:**

Traci Fox, R.N., M.S., Ambulatory Care Nursing Supervisor (118-P), or Lisa
Cochran, Ambulatory Care Hospital Based Clinic Manager (11C-OPC), Port-
land VA Medical Center, 3710 Southwest U.S. Veterans Hospital Road, P.O.
Box 1034, Portland, OR 97207, FTS (700) 424-7300, Com (503) 273-5300,
Fax (503) 293-2963

Jana Conlin, R.N., Nurse Manager for Telephone Communication Systems
(118), Minneapolis VAMC, One Veterans Drive, Minneapolis, MN 55417,
FTS (700) 780-1694, Com (612) 725-1694, Fax (612) 725-2196

Appendix B

Contacts for more information about VA's large-scale primary care initiatives described on pages 11-13:

Primary Care Directive:	Ronald J. Gebhart, M.D., Deputy Associate Deputy Chief Medical Director for Ambulatory Care (112), VA Central Office, 810 Vermont Avenue, N.W., Washington, DC 20420, FTS (700) 565-7242, Com (202) 565-7242, Fax (202) 565-4153
National Primary Care Training Program:	Ronald J. Gebhart, M.D., Deputy Associate Deputy Chief Medical Director for Ambulatory Care (112), VA Central Office, 810 Vermont Avenue, N.W., Washington, DC 20420, FTS (700) 565-7242, Com (202) 565-7242, Fax (202) 565-4153 Elwood Headley, M.D., Chief of Staff (11), Boston VA Medical Center, 150 South Huntington Avenue, Boston, MA 02130, FTS (700) 839-4000, Com (617) 232-9500 ext. 5276, Fax (617) 278-4549 Rose Mary Pries, M.S.P.H., CHES, National Coordinator for Patient Education (14B-JB), St. Louis VA Medical Center, 915 North Grand Boulevard, St. Louis, MO 63016, FTS (700) 278-4100, Com (314) 894-6534, Fax (314) 894-6573 Rivkah Lindenfeld, R.N., Ph.D, Director, Regional Medical Education Center (141-D), VA Medical Center, 79 Middleville Road, Northport, NY 11768, FTS (700) 663-4400, Com (516) 261-4400 ext. 2900, Fax (516) 754-7996
Primary Care Education Initiative:	Elizabeth M. Short, M.D., Associate Chief Medical Director for Academic Affairs (14), VA Central Office, 810 Vermont Avenue, N.W., Washington, DC 20420, FTS (700) 656-7091, Com (202) 565-7091, Fax (202) 565-7522 Gloria Holland, Ph.D., Special Assistant to the Associate Chief Medical Director for Academic Affairs (14C), Office of Academic Affairs, Department of Veterans Affairs, 801 I Street, N.W., Washington, DC 20420, FTS (700) 656-7525, Com (202) 565-7525, Fax (202) 565-7522
Chicago Area Network:	Joan Cummings, M.D., Director, Edward Hines, Jr. VA Hospital (00), 5th Avenue and Roosevelt Road, Hines, IL 60141, FTS (700) 381-2500, Com (708) 343-7200 ext. 5639, Fax (708) 381-2506
Women Veterans Comprehensive Health Program:	Susan Mather, M.D., Associate Chief Medical Director for Public Health and Environmental Hazards (116), Department of Veterans Affairs, 801 I Street, N.W., Washington, DC 20420, FTS (700) 656-4182, Com (202) 565-4182, Fax (202) 565-7572
Ambulatory Care Education:	David Lee, M.D., Chief of Staff (11), Boise VA Medical Center, 500 West Fort Street, Boise, ID 83702-4598, FTS (700) 554-7201, Com (208) 338-7201, Fax (208) 338-7257 David Nardone, M.D., Associate Chief of Staff for Ambulatory Care (11C), Portland VA Medical Center, 3710 Southwest U.S. Veterans Hospital Road, P.O. Box 1034, Portland, OR 97207, FTS (700) 424-7300, Com (503) 721-7897, Fax (503) 721-7942 Alan Robbins, M.D., Chief of Staff (11), Charleston VA Medical Center, 109 Bee Street, Charleston, SC 29403-5799, FTS (700) 259-7202, Com (803) 577-5011 ext. 7202, Fax (803) 937-6100 Dennis Cope, M.D., Associate Chief of Staff (11), Charleston VA Medical Center, 109 Bee Street, Charleston, SC 29403-5799, FTS (700) 259-7304, Com (803) 577-5011 ext. 7457, Fax (803) 937-6100

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