Integrating VA Specialty and Primary Care and Improving the Referral Process

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Why specialty-primary care integration is important

- Evidence of multiple perceived deficiences in the process (Mehrotra et al 2011, Bodenheimer 2008) - but little evidence of what works to fix it

- Conceptually, improved primary-specialty care integration could contribute to
  - Improved patient health outcomes
  - Better patient experience
  - More efficient use of system resources

- PACT requires a *systemic* culture change to succeed – limiting it to primary care creates organizational challenges (and rivalries)

Portland VAMC Primary Care Workgroup Initiatives

- As part of PACT transformation, Primary Care leadership identified areas for internal innovation and improvement:

Chronic Pain Management
Referral Management
CHF Management
Pre-Operative Management
Team Formation & Function

- Workgroups composed of staff in all PACT roles from across facility – different CBOCs, different experiences
- Participants allowed to block out time for participation, providers had surrogate coverage for long sessions

Referral Management Workgroup Process

- Mostly face-to-face meetings
- Used data review of all consults from last FY to develop initial focal points
  - Frequent referrals (Prosthetics, GI, Dermatology, among others)
  - CBOC –to-CBOC variation
- Invited specialty services to dialogue sessions

Participating Specialties

- Cardiology
- Dermatology
- Endocrinology
- ENT
- GI/Liver
- Hematology/Oncology
- Neurology
- Orthopedic Surgery
- Prosthetics
- Pain Clinic
- Rehab Medicine
- Pulmonology
- Urology
- + Computer Applications Coordinator (CPRS consult system)

A few expected findings

- Primary care often doesn’t ask a clear question in the consult
- Volume of consults is challenging, results in delayed access

Surprises

- High level of variance in PCP practices related to consults
- High level of variance in Specialty processes for reviewing consults
- Patients not always aware why they were being referred
- Specialty would like MORE calls/paging from Primary Care
- Some specialty services do not access CPRS
- Specialty services don't always have working knowledge that Primary Care is not "on the hill" (at the main VA facility): this has many practice implications (short stay consults, imaging)

Recommendations

Draft report has 20-30 recommendations organized into:

- General Recommendations
- Recommendations internal to Primary Care
- Service Specific recommendations
- Recommendations beyond the scope of the workgroup

General Recommendation: Consult Template Overlay

- Reason for consult discussed with patient
- Guidelines/testing ordered
- Guidelines/testing completed (Comment Box)
- Clinical summary
- What is the question for this consult?
- What is the patient's expectation for the consult? (optional for now)

Internal Primary Care recommendations

- Click & print patient information “what to expect” sheet unique to each specialty clinic – with specialty clinic contact information
  - Content templated but determined with specialty input
  - Admin order, can be in letter format
  - Link to all specialty sheets to make process easier for facilitators

Specialty Specific recommendations

- Develop interdisciplinary panel to manage suspicious mass/rule out cancer pathway (came out of dialogue with H/O)

- Changing to an order menu format for Prosthetic items

Recommendations beyond the scope of the workgroup

- Improve processing of outside scanned records so specialists can easily locate relevant test results
- Specialty presence on an intermittent basis for education in the CBOCs

Concluding thoughts

- Specialty of primary care is relationship to the patient
- Key to improving the consult process is improving the relationship between primary and specialty care
  - Better communication between teams
  - Better communication with patients about referral process

References

Mehrotra, A, Forrest, CB, and Lin, CY. 2011. *Dropping the Baton: Specialty referrals in the United States.* The Milbank Quarterly 89 (1):39-68.

Bodenheimer, T. 2008. *Coordinating care – a perilous journey through the health care system*. New England Journal of Medicine 358 (10): 1064-1071.

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Thank you

Generalist-specialist collaboration in care for veterans with chronic illness

Case study: HIV care in rural Iowa

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Factors favoring generalism vs. specialism in chronic illness care

- Specialism: rarity, technicality, rapidity of innovation

- Generalism: complexity due to multimorbidity, comprehensiveness, holism

- HIV care has features of both, to varying degrees depending on the individual

HIV Care Challenges In Iowa City VAMC - 2010

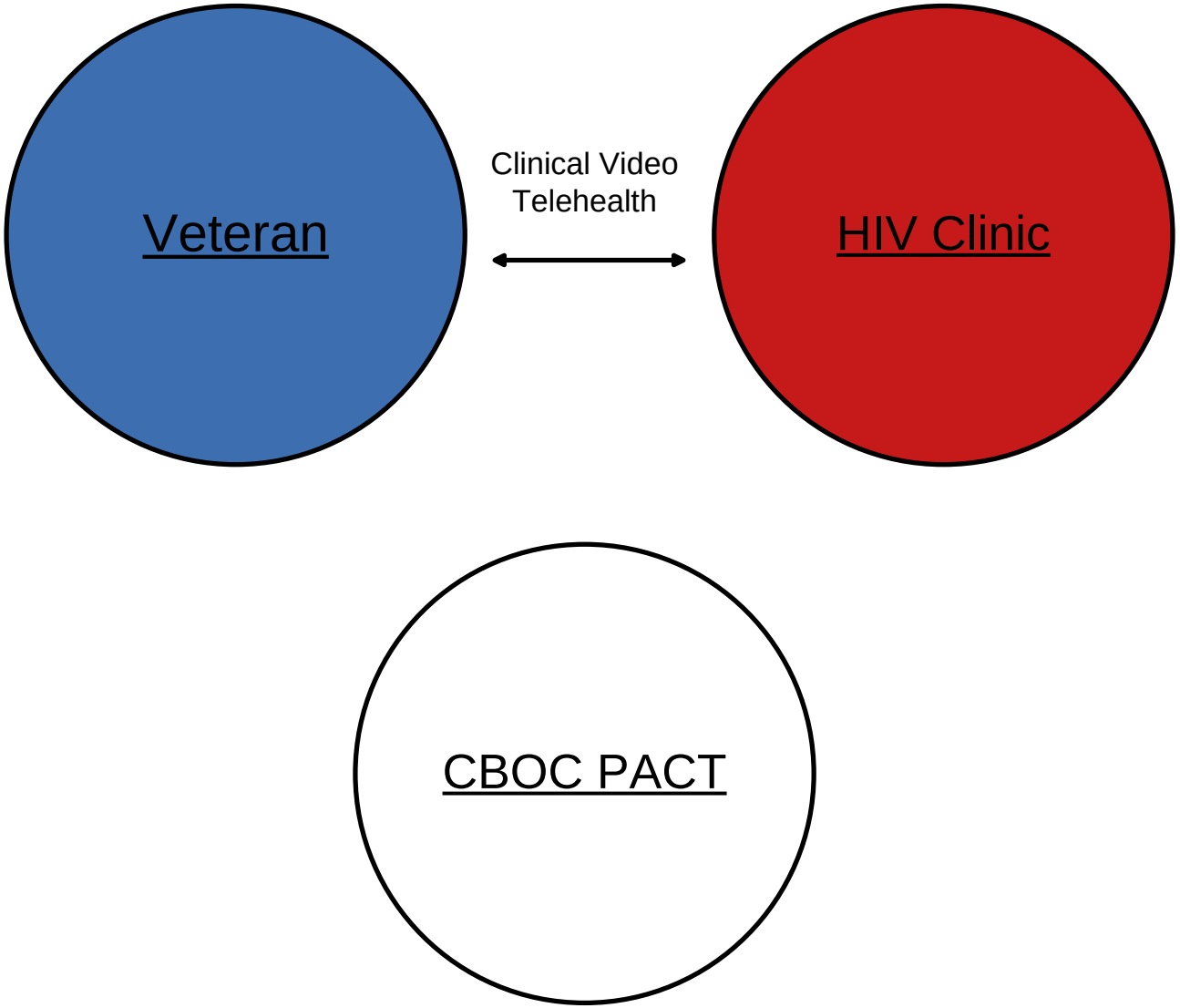
- Access

- 30 veterans with HIV living > 1 hour drive from HIV specialty clinic in Iowa City, historically bypassing care in nearby CBOCs to receive all care in specialty clinic

- Comprehensiveness

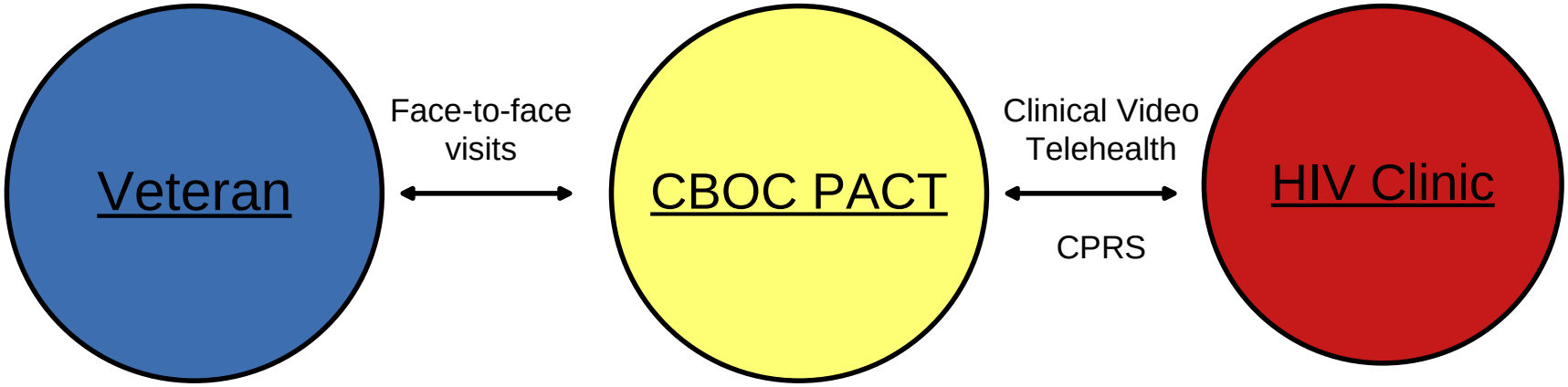
- High quality HIV specific care, but….
- Limited systems and expertise in specialty clinic for comprehensive primary care

Telehealth Specialty Care

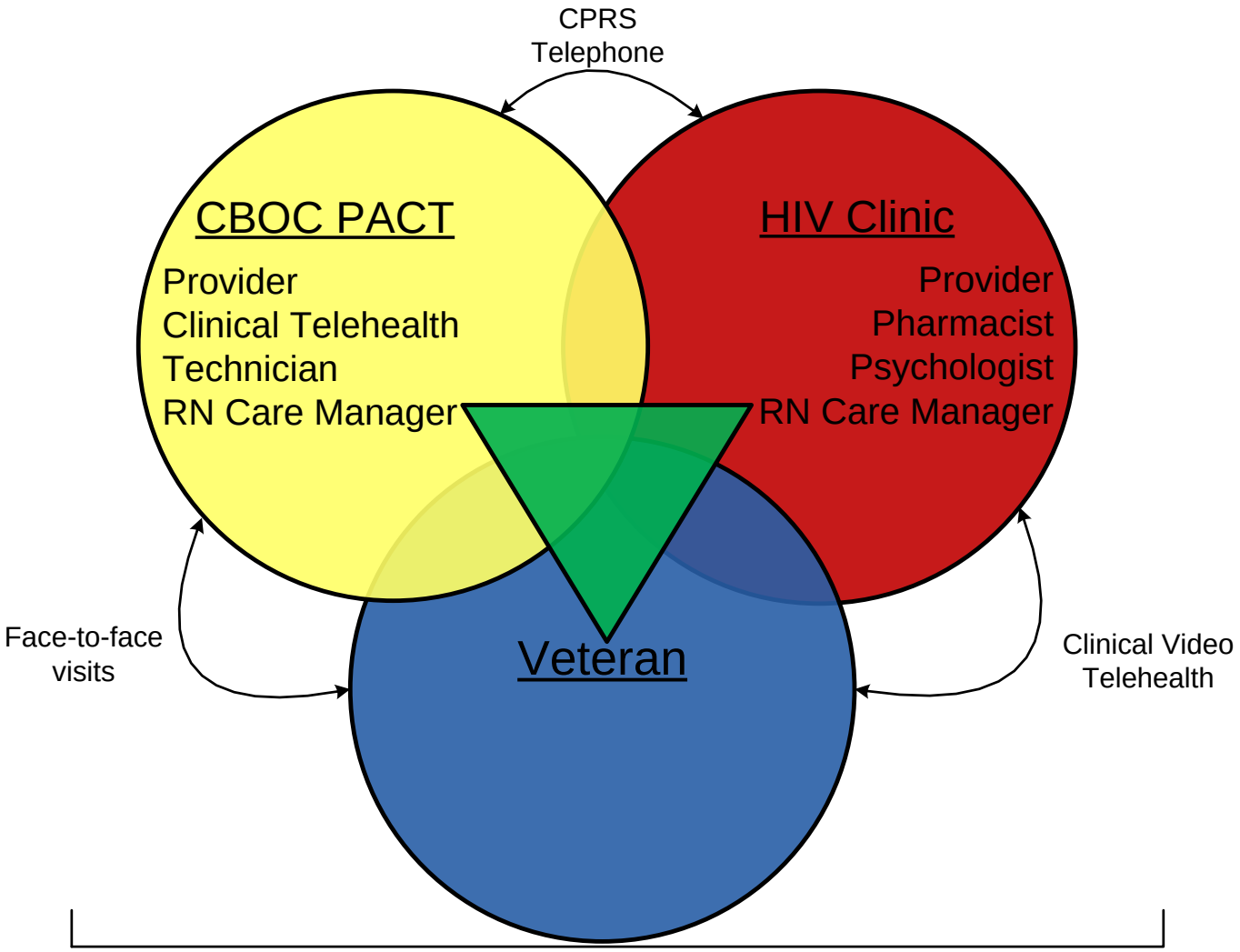


PACT: Patient Aligned Care Team – VA's Medical Home Initiative

Current HIV SCAN – ECHO model



Telehealth Collaborative Care



- Shared Registry
- "True Team": self aware as team, defined roles, responsibilities, and communication processes

Telehealth Collaborative Care

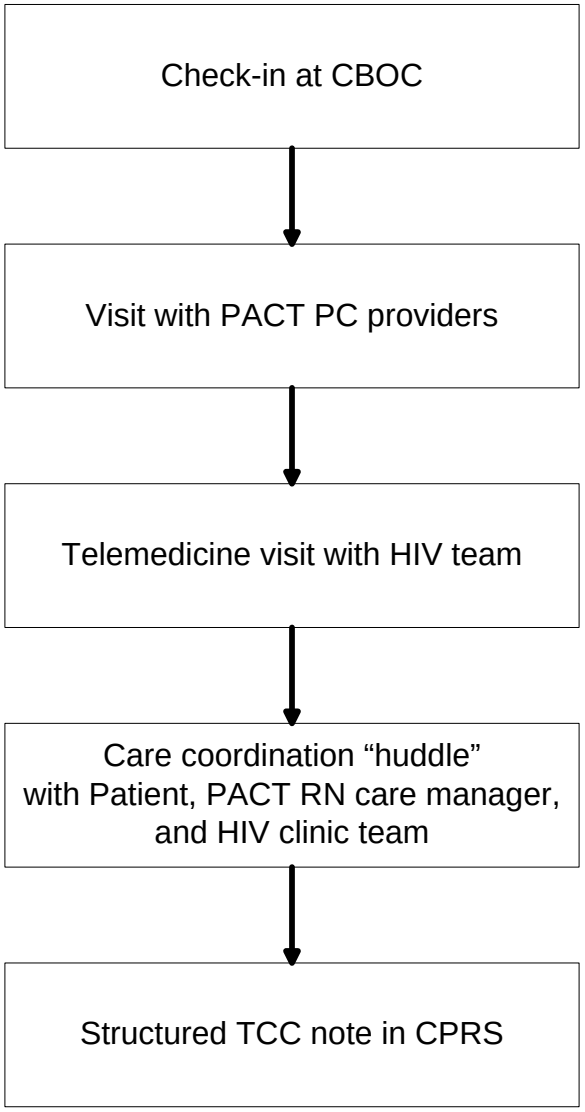
Key Design Principles

- Integration of primary care by CBOC PACTs with HIV specialty care by video telehealth
- Clear definition of primary and specialty roles
  - Defined care tasks
  - Undefined tasks/undifferentiated veteran care needs
- Care coordination/information routing
- Population management across sites
  - HIV patient registry with data for HIV and comorbidity/preventive care
  - Goal: separate summary reports for CBOC PACTs and specialty team

Implementation Steps

- Face to face and vtel meetings with CBOC PACTs
  - Develop relationships/communities of practice
  - Negotiate and define roles
  - Mutual education
- Sequential addition of pieces
  - Establish HIV clinical video telehealth
  - Patient navigation brochures
  - PACT nurse care manager “telehealth care coordination huddles”
  - Structured telehealth collaborative care notes in CPRS
  - Registry

Telehealth Collaborative Care Encounters



Evaluation – selected findings

- 30 of 32 eligible veterans preferred TCC over traveling to ICVA specialty clinic
- Quality of HIV care maintained, all 32 maintained undetectable HIV viral loads on therapy
- Performance measures improved for some comorbidities
  - e.g. VA smoking cessation counseling/pharmacotherapy offered measure improved from 29% to 100%
- Mean travel time 320 to 170 minutes per year

($p < 0.001$)

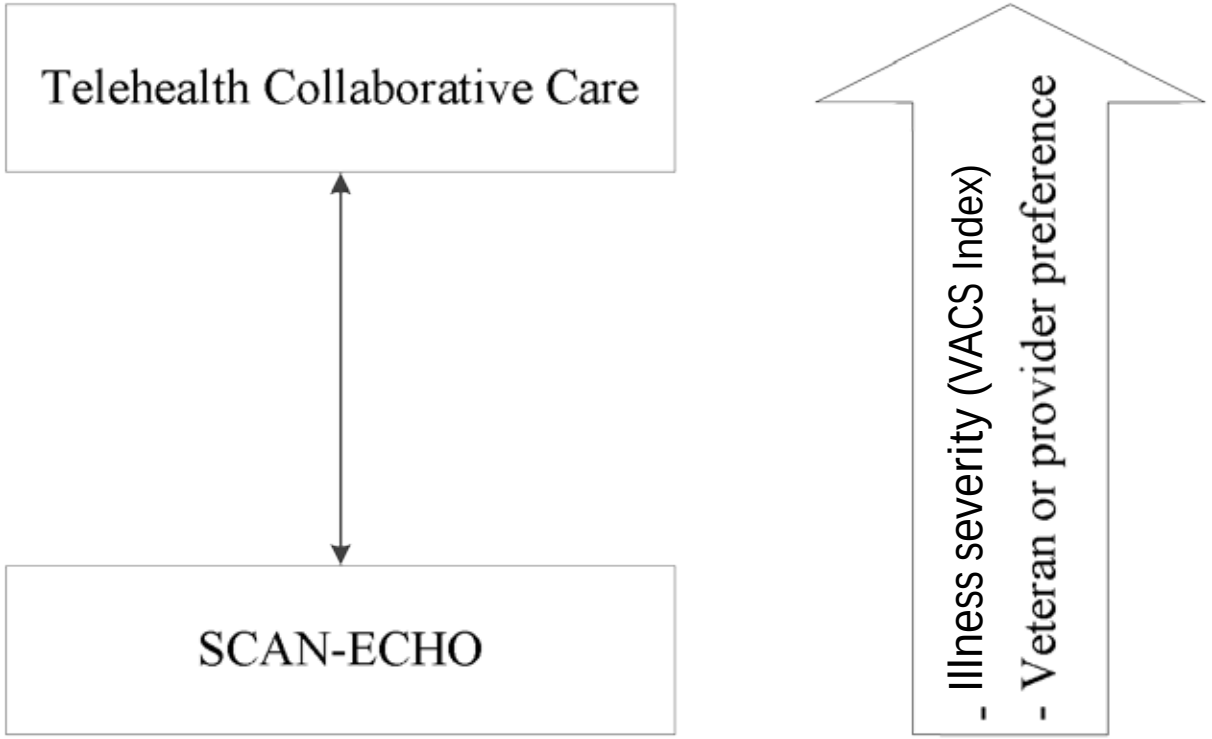
Evolution

- As veterans and CBOC providers have developed comfort with this model, care has migrated to become more like SCAN/ECHO for selected veterans with less severe HIV infection (well-preserved immune function and stably suppressed viral load on simpler antiretroviral regimens)

Lessons Learned

- It is first necessary to establish trusting relationships between specialty and primary clinic teams, and create communities of practice around specific patient populations
- Role clarity is critical, focus on defining how undifferentiated care needs/tasks are triaged and unambiguous responsibility assigned
- Telehealth collaborative care and SCAN/ECHO are not distinct models, but two points on a continuum of generalist specialist collaboration in chronic illness care

Stepped care SCAN/ECHO for Veterans with HIV infection



Thank you

Questions?