Spotlight on Women Cyberseminar Series

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WOMEN VETERANS HEALTH CARE

Health Care Services For Women Veterans

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An average patient. . .

- ★ A 27 yo female with migraine headaches presents for evaluation
- ★ Her headaches occur 1-2X per month always in the week just before the onset of her menses
- ★ She uses ibuprofen 800 mg tid to manage these headaches but recently has had to call in sick 1-2 days per month due to her headaches

More about the patient. . .

- ★ The review of systems reveals that her menses are regular every 28 days and are normal in flow
- ★ She is not currently sexually active

How should she be managed?

Option #1: Traditional Care

- ★ Her PCP prescribes sumatriptan for acute management of her headaches
- ★ Neurology is consulted for help in managing the headaches (6 wk wait)
- ★ She is given an appt to gynecology for her annual pap smear (8 wk wait)

Option #1: Traditional Care

- ★ Neurology recommends topiramate for her headache management
- ★ Gynecology performs her pap smear
- ★ She returns to you in 3 months still with headaches and now having concentration problems from her topiramate
- ★ Her menstrual cycle is now 2 weeks late

Option #2: Comprehensive Primary Care for Women

- ★ Seen in the Women's Center by a provider with expertise in gender specific primary care
- ★ As part of her initial hx and px, a pelvic exam and pap smear are performed
- ★ Continuous OCPs are initiated for management of migraines

Option #2: Comprehensive Primary Care for Women

- ★ She returns in three months with rare migraine headaches, no subsequent sick days, and no side effects from her topiramate
- ★ As an added bonus, her menstrual cycles remain regular every three months

You do the math . . .

- ★ Traditional care:
  - 2 extra clinic visits taking two months to complete
  - Poor control of headaches
  - Possibly pregnant
- ★ Comprehensive Women's Care:
  - One stop shopping
  - Appropriate management of perimenstrual migraine headaches

But Do Women's Health Clinics Really Make a Difference?

- ★ The answer is yes. . . .
- ★ But how do we know?
- ★ Study published in Journal of General Internal Medicine in March 2003
- ★ Patients from 8 VA Medical Centers in VISN 4 were surveyed
- ★ Overall satisfaction and gender specific satisfaction was measured

Bean –Mayberry et al, JGIM, volume 18, March 2003

Patient Satisfaction

- ★ Patients were randomly chosen for survey
- ★ Stratified by medical center
- ★ Also stratified by whether or not their care was delivered in a women's clinic (WC) or in a traditional primary care clinic (TC)

Patient Satisfaction

- For overall satisfaction, patients were asked a single item question from the VA National Survey of Ambulatory Care
- In addition, gender specific satisfaction was assessed using the Primary Care Satisfaction Survey for Women developed by the HHS funded Centers of Excellence in Women's Health

Results

- ★ 971 women returned surveys
  - 61.7% from Women's Clinics
  - 38.3% from Traditional Clinics
- ★ Patients in WC settings were:
  - Significantly younger (55.5 vs 63 years)
  - More likely to be nonwhite (15.5% vs 9.4%)
  - No difference in marital status, educational status, income, or overall health

Results: Health Care Use

- ★ Equally likely to have seen their regular provider at the most recent visit
- ★ Women in WC less likely to have providers outside of the VA (30.9% vs 52.4%)
- ★ More likely to see other VA providers (65.3% vs 54%)

PCSSW Satisfaction Results

★ 5 Domains of Care Identified
- Getting Care
- Privacy and Comfort
- Communication
- Complete Care
- Follow up Care

On 19 out of 28 questions, WC patients more frequently than TC patients gave ratings of excellent

Principles That Should Guide Care for Women Veterans

High Quality Care for Women Should Involve:

- ★ Comprehensive primary care
- ★ Provided by proficient and interested clinicians
- ★ Focused on safety, dignity, and sensitivity to gender specific needs
- ★ The right care in the right place at the right time
- ★ Using state of the art health care equipment and technology

The Vision (and Now the Mandate)

- The VHA handbook for Health Care Services to Women Veterans delineates the following ***new standard requirement for the delivery of health care to women veterans:***

- *Women patients seen at VA Medical Centers or at associated CBOCs will receive complete primary care and coordination by one primary care provider at one site. This provider should be able to:*
  - *Care for acute and chronic illness*
  - *Provider Gender specific primary care*

What is Gender Specific Primary Care

- ★ Contraception counseling
- ★ Medications in pregnancy and lactation
- ★ Management of menopause
- ★ Evaluation of pelvic and abdominal pain
- ★ Abnormal vaginal bleeding
- ★ Vaginal Infections/STI treatment
- ★ Urinary Incontinence
- ★ Osteoporosis detection and management
- ★ MST, sexual trauma, domestic violence
- ★ Breast and cervical cancer screening

What is NOT Gender Specific Primary Care

- ★ It is important to recognize that those women's clinics offering only gender-specific care (Pap clinics or gynecology clinics alone) do not meet the definition of comprehensive primary care.

- ★ Primary care may be delivered utilizing a team model, but it is expected that gender specific primary care is provided by the same clinician that renders other routine care without multiple encounters or visits scheduled over different days

VA Standard vs Community Standard

- ★ How many of you in the audience receive your care in a one stop-shopping model?
- ★ Certainly not the community standard
- ★ Reflects that the VA is striving to be a national leader in the provision of health care for women, thereby raising the standard of care for all women!!!

Key Components of the Model

Include all of the following:

- ★ Designated Women's Health Primary Care Providers
- ★ Delineation of WH PCP proficiencies
- ★ Models of delivery for comprehensive care
- ★ Access to specialty care

Designated Women's Health Primary Care Providers

- ★ All enrolled women veterans must receive comprehensive primary care from a designated WH PCP who is interested and proficient in the delivery of comprehensive care to women
- ★ An interested provider is one who is knowledgeable, concerned, engaged, and willing to participate in the primary care of women

Designated Women's Health Primary Care Providers

- ★ Women veterans assigned to a PCP who is not a designated WH PCP must be offered the opportunity for reassignment
- ★ HOWEVER, all patient requests will be honored, even if the request is for a non designated WH PCP
  - In all cases, arrangements must be made to provide gender specific care within the primary care setting
- ★ Designated WH PCPs must be preferentially assigned women veterans within their primary care panels

Designated Women's Health Primary Care Providers

- ★ Each facility must ensure that an appropriate number of designated WH PCPs is available to ensure that access goals are met for women veterans
- ★ The receipt of basic mental health services is also a required component of comprehensive primary care
- ★ Women veterans must be able to designate a preference for a female or a male provider; if necessary, fee basis can be used

WH PCP Proficiency

- ★ To maintain proficiency in women's health, each site must ensure that the patient panel of every designated WH PCP is comprised of al least 10% female patients
- ★ Each designated WH PCP will spend at least one half day every week practicing or precepting in a women's health practice
- ★ For facilities where women's health is integrated into primary care, designated WH PCPs must have an equivalent number of women patients (currently 10% panel size is 120 female patients)

WH PCP Proficiency

- ★ If insufficient numbers of female patients are available to support the recommended numbers, an alternative plan must be developed. Suggestions include:
  - A provider being precepted at a VA Women's Clinic on a regularly scheduled basis
  - Working with a contract to hone practice skills
- ★ Each facility must participate in and support an ongoing staff and provider education plan to promote, improve and maintain skills

Models of Comprehensive Primary Care Delivery for Women

- ★ Model 1: General Primary Care Clinics
  - Designated WH PCPs see women in a gender-neutral primary care clinic
  - Mental health must be co-located
  - Efficient referral to gynecology must be available
- ★ Model 2: Separate but Shared Space
  - Separate but shared space located within or adjacent to the Primary Care clinic areas; gyne and mental health must be co-located as well
- ★ Model 3: Women's Health Center
  - Geographically separate space
  - Specialty services available on site

Recommendations for Structural Change in Delivery of Care

★ Appointment times recommended
- New women: 60 minutes
- Routine follow up: 30 minutes
- Urgent Appointment: 30 minutes

★ Panel Sizes
- Strong consideration should be given to adjusting panel sizes downward to accommodated the unique needs of women veterans in the primary care setting
- Recommend that the panel size will be reduced by the number of unique patients equal to 20% of the total number of women veterans in the mixed provider panel

Special Considerations

- ★ How do we measure proficiency?
- ★ How do we develop and maintain competent women's health primary providers that can meet these proficiency standards?
- ★ How do we incentivize providers to seek and maintain this designation?
  - New skills
  - More responsibility for added areas of care AND for ongoing training
  - More to do in an office visit
- ★ Given that there are increased proficiency requirements, should there be increased pay?

Patient-Aligned Care Teams (PACT) & Women's Health

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July 15, 2010

NCQA
Measuring quality.
Improving health care.

Agenda

- **Patient-Aligned Care Teams (PACT) /Patient-Centered Medical Home (PCMH)**
- **NCQA's Medical Home program**
- **Medical Home & Women's Health**

NCQA: A Brief Introduction

- **Private, independent non-profit health care quality oversight organization founded in 1990**
- **Committed to measurement, transparency and accountability**
- **Unites diverse groups around common goal: improving health care quality**

PCMH (aka PACT)

- **Model of care that provides patient-centered, comprehensive, accessible, and coordinated care and a systems-based approach to quality and safety**
- **First articulated in pediatrics in 1960s**
- **Joint Principles adopted by primary care physician groups in 2008**
- **Growing adoption of model in public and private sector, including VA, where it is known as PACT (Patient-Aligned Care Teams)**

Promise of the PCMH

- **Different stakeholders emphasize different benefits**
- ***Physician groups:*** **Improve work life of clinicians and staff, particularly primary care**
- ***Policymakers & payers:*** **Reduce costs of care, Improve quality of care**
- ***Consumer advocates:*** **Improve patient experiences**

Evidence for the PCMH

- **Well-designed trials support many components of the medical home (e.g., RCTs demonstrating benefits of Chronic Care Model)**
- **Preliminary studies suggest benefits (Group Health, North Carolina, Geisinger)**
  - **Improved quality**
  - **Reduced clinician burn-out**
  - **Improved patient experiences (sometimes)**
  - **Reduced costs of care**

Definitions of PCMH

	Joint Principles (AAFP, AAP, ACP, AOA 2007)	*Consumer Principles* (NPWF 2009)
Care Team	• Ongoing relationship with a personal physician. • Team at practice level is led by physician	• interdisciplinary team • Qualified provider of the patient's choice leads team
Whole-Person Orientation	• Whole-person orientation. provide all the patient's health care needs and for arranging care with other qualified professionals.	• "Knows" its patients, care is whole-person oriented and consistent with patients' unique needs and preferences.
Care Coordination	• Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community	• Coordinates its patients' health care across care settings and services over time, in consultation and collaboration with the patient and family.
Self-Mgmt Support	• Practices advocate for their patients, a care-planning process driven by a compassionate, robust partnership of physicians, patients, and patients' families.	• Patients and their caregivers are supported in managing the patient's health.
Shared Decision making	• Patients actively participate in decisionmaking, and feedback is sought to ensure that their expectations are being met.	• Patients and clinicians are partners in making treatment decisions.

Definitions of PCMH

	Joint Principles (AAFP, AAP, ACP, AOA 2007)	*Consumer Principles* (NPWF 2009)
Access	• ***Enhanced access*** **to care is available through systems such as open scheduling, expanded hours, and new options for communication among patients, their personal physicians, and practice staff.**	• **The patient has ready access to care.** • **Open communication between patients and the care team is encouraged and supported.**
Quality Improvement	• **Evidence-based medicine and clinical decision-support tools** • **Quality improvement efforts** • **Patient & family participation** • **Health IT support optimal care**	• **Collaborates with patient and family advisors in quality improvement and practice redesign.** • **Regularly evaluates and improves care** • **Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients.**
Payment	• **Payment recognizes the added value provided to patients who have a PCMH.**	
Communication and Trust		• **The PCMH fosters an environment of trust and respect.**

NCQA's Program for the Patient-Centered Medical Home

- Originally developed to address purchaser desires for tool to evaluate outpatient care efforts to improve systematic care
- In January 2008, aligned standards with Joint Principles
- Endorsed for use in demonstrations by numerous physician organizations (ACP, AAFP, AAP, AOA, AMA), as we as Patient Centered Primary Care Collaborative (PCPCC)
- Endorsed by National Quality Forum as "practice systems assessment survey"
- Leading tool in demonstrations using payment reform (Bitton 2010)

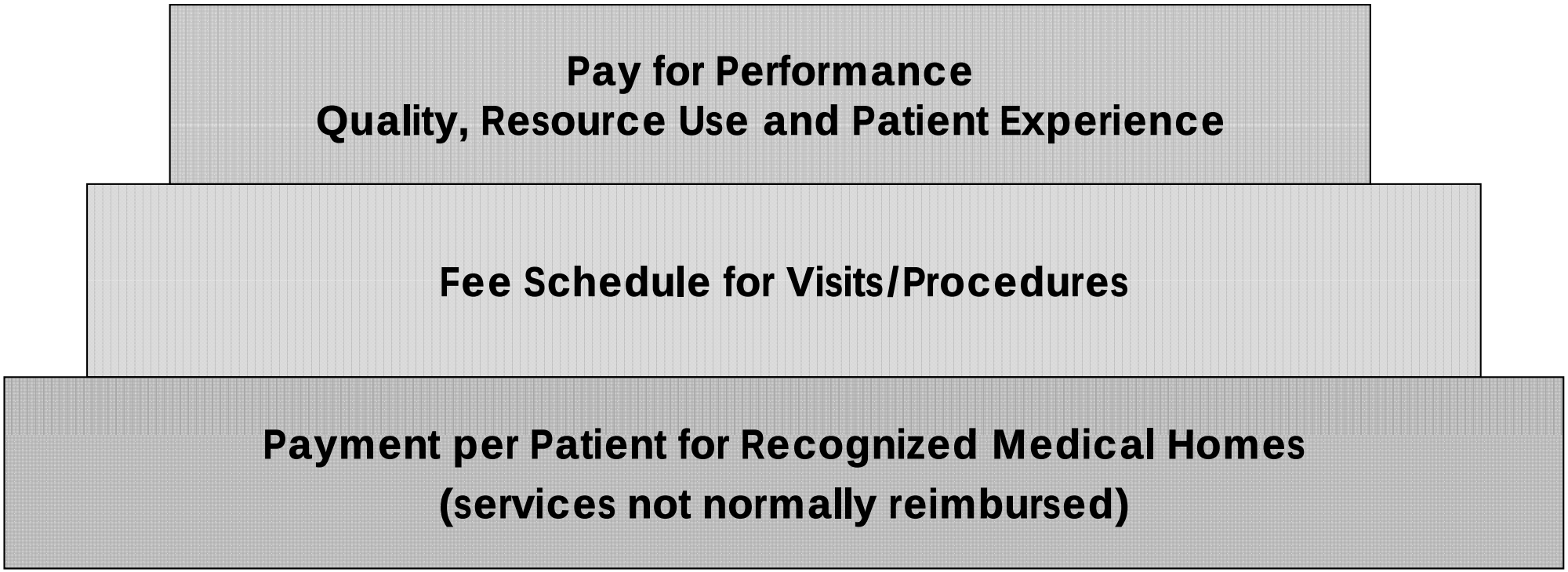
Theoretical Frameworks Informing Development of PPC-PCMH

Based on best avaialble empiric evidence in each area and on testing of reliability and validity of elements in field tests using on site audit as "gold" standard

Chronic Care Model	Patient Centered Care	Cultural Competence	Medical Home
Clinical information Systems	Respect Patient Values	Culturally competent interactions	Personal physician
Decision Support	Accessible	Language services	Physician directed team
Patient Self-Management	Family-Centered	Reducing disparities	Whole person orientation
Delivery System Redesign	Continuous		Care is coordinated and integrated
Community Linkages	Coordinated		Quality and safety
Health Systems	Community Linkages		Enhanced access
	Compassionate		
	Culturally Appropriate		
	Emotional Support		
	Information and Education		
	Physical Comfort		
	Quality Improvement		

PRIMARY CARE
First contact-comprehensive-continuous-coordinated

Linkage of PCMH to Reimbursement: One Model



PCMH 2011 Overview (6 standards/25 elements)

1. **Access and Continuity**
   - A. Access During Office Hours
   - B. Access After Hours
   - C. Electronic Access
   - D. Continuity
   - E. Medical Home Responsibilities
   - F. Culturally/Linguistically Appropriate Services
   - G. Practice Team
2. **Identify/Manage Patient Populations**
   - A. Patient Information
   - B. Clinical Data
   - C. Comprehensive Health Assessment
   - D. Using Data for Population Management
3. **Plan/Manage Care**
   - A. Implement Evidence-Based Guidelines
   - B. Identify High Risk Patients
   - C. Manage Care
   - D. Manage Medications
   - E. Electronic Prescribing
4. **Self-Care & Community Support**
   - A. Self-Care Process
5. **Track & Coordinate Care**
   - A. Test Tracking and Follow-Up
   - B. Referral Tracking and Follow-Up
   - C. Coordination with Facilities/Care Transitions
6. **Performance Measurement /Quality Improvement**
   - A. Measures of Performance
   - B. Patient/Family Experience
   - C. Report Performance
   - D. Quality Improvement
   - E. Electronic Reporting

Optional Patient Experiences

Optional Performance Measurement

Issues in Defining PCMH

- How to further assess patient-centeredness, including patient survey results?
- What are the responsibilities of PCMH practice versus larger entity?
  - Integrate behavioral health/risk factor assessment & management
  - Comprehensiveness at a single site
- When should performance results be part of scoring?
- What about meaningful use of health IT?
- How to adapt to promote quality and cost gains across settings?
- How to streamline requirements, documentation?

How does the PCMH address Women's Health?

- NCQA's tool is silent on specialty
- ACOG: "women's health homes"
- Ob/gyns are seeking PCMH designation

PCMH & Women's Health

- **Access: how to provide timely access to all of women's needs?**
- **Comprehensive vs. coordinated: how to ensure integration of women's general, reproductive and behavioral health needs?**
- **Patient-centered: how to encourage shared decision-making and patient engagement in care/practice?**

Gaps in Current Measures for Women's Health

- **Measures focus on access to visits**
  - Do not consider the content of care received
- **Measures address women's cancers and Chlamydia but not the full range of preventive needs**
  - Depression, weight assessment, and illicit and non-illicit substance use
- **Measures do not address the interrelatedness of women's general and reproductive health**
  - Preemptive family planning discussions
- **Where many important measures do exist, they are not captured in routine ways**
  - Can not be used in quality improvement and accountability

Issues

- Leadership
- Consumer demand
- Evidence base
- Feasibility

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