Integrating VA Specialty and Primary Care and Improving the Referral Process

*Presenters:*
Ron Grewenow  
Group Practice Manager, West Linn CBOC  
Anais Tuepker  
Investigator, VISN20 PACT Demonstration Lab

*Referral Management Workgroup Members:*
Why specialty-primary care integration is important

- Evidence of multiple perceived deficiencies 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


Contact: Anais Tuepker
anaiistuepker@va.gov

Thank you
Generalist-specialist collaboration in care for veterans with chronic illness

Case study: HIV care in rural Iowa

Michael Ohl, MD MSPH
Iowa City VAMC
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

Veteran

Clinical Video Telehealth

HIV Clinic

CBOC PACT

PACT: Patient Aligned Care Team – VA’s Medical Home Initiative
Current HIV SCAN – ECHO model

Veteran → CBOC PACT (Face-to-face visits) → HIV Clinic

CBOC PACT (Clinical Video Telehealth) → CPRS
Telehealth Collaborative Care

- CPRS
- Telephone

CBOC PACT
- Provider
- Clinical Telehealth Technician
- RN Care Manager

HIV Clinic
- Provider
- Pharmacist
- Psychologist
- RN Care Manager

Veteran
- Face-to-face visits
- Clinical Video Telehealth

- 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
Check-in at CBOC

Visit with PACT PC providers

Telemedicine visit with HIV team

Care coordination “huddle” with Patient, PACT RN care manager, and HIV clinic team

Structured TCC note in CPRS
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?