

# Delivering Specialty Care in the 21<sup>st</sup> Century VHA

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# Vision

“We are creating a healthcare system that is, first and foremost, patient centered and characterized by team care...

We’re also striving, every day, for a healthcare system that is continuously improving, data driven, evidence based, and characterized by excellence at every level.”

Dr. Robert Petzel  
Under Secretary for Health



# Challenges in Delivery of Specialty Care

- Veterans experience:
  - Lack of care coordination with Primary Care
  - Travels long distances to receive Specialty Care
  - Long wait times for some Specialty Services
  - Variations in the delivery of care

# Veteran Centered Care

- The Veteran must **not** move. The health care system moves around the Veteran.
  - PACT is the Veteran's home. The primary care provider, nurse coordinator, LPN and clerk are the core of the team, with the Veteran in the center
  - Specialty Care and other disciplines (Social Work, Pharmacy, Nutrition, Chaplain, Psychology, etc.) revolve around the PACT core team - providing the Veteran with the highest quality medical care.

# Objectives of Transformation

- Transform Specialty Care to a Veteran-centric system by use of **telehealth and non face-to-face means** of delivering care
- Build strong interface with PACT
- Assess current workload, referral patterns, team based care and staff mix in Specialty Care Services
- Enhance access to advanced disease management and support regional model for delivery of transplant and other highly specialized care
- Develop **innovative training models** to allow clinical providers to practice at the top of their license

# Transformation Plan

- 3 Key Components
  1. Establish infrastructure and conduct assessment of needs and resources
  2. Improve access and efficiency of delivering Specialty Care
  3. Promote innovation and collaboration

# Why Focus Groups?

Initiative success depends on equal acceptance by both Primary Care Provider (PCPs) and Specialist

Standard roles are changing

To understand the current working inter-relationships between Specialist and PCPs

To understand what's working well and identify where opportunities for improvement exist

# Focus Group Overview

Held at VA Medical Centers distributed by location and facility complexity

Primary Care Providers (PCP) and Specialist will be randomly selected and invited to participate

PCP and Specialist groups will be conducted independently of each other by the same facilitator

National Center for Organization Development (NCOD) will assist with facilitator training and question deliverables

# VA SCAN-ECHO

(Specialty Care Access Networks –  
Extension for Community Healthcare  
Outcomes)

# Purpose & Intended Outcomes

- Leverages Telehealth (clinical videoconferencing technology) to allow Specialists from tertiary medical centers the opportunity to provide support to providers in less complex facilities or rural areas
- Intended Outcomes:
  - Improve Access
  - Reduce Fee and Travel Costs
  - Improve Veteran and Provider Satisfaction

# Implementation

- SCAN Centers established to serve VHA facilities (CBOCs and Medical Centers)
- Initial SCAN clinics will focus on 4 diseases / conditions
  - Diabetes, Pain Management, Hepatitis C, Cardiology
- Additional SCAN “clinics” will be added based on the availability of funds, expertise of Specialists at the SCAN Centers, interest among PCPs, success of the initial clinics, and program refinements

# VA SCAN-ECHO Centers

- VA Connecticut Health Care System (V1)
- Richmond VAMC (V6)
- Cleveland VAMC (V10)\*
- VA Ann Arbor Health Care System (V11)\*
- VA New Mexico Health Care System (V18)\*
- VA Eastern Colorado Health Care System (V19)\*
- VA Greater Los Angeles Health Care System / San Diego VAMC (V22)\*

\* Participating in Cardiology SCAN / ECHO

# Roles and Responsibilities

- Teams to develop SOPs for each disease and/or condition
- Training will be provided by staff from University of New Mexico – Project ECHO
- Educational modules will be developed in collaboration with National Program Directors & Specialists
- Evaluation components are under development in partnership with HSR&D and Office of System Redesign/VERC

# Innovations in Consult Management Program:

Electronic Consults (E Consults)  
Phone Consults

# E Consults

- Establishes a new approach to specialty care, providing consultation without face-to-face contact by the Veteran with the specialist
- Circumvents barriers and challenges of traditional consultation methods, eliminating the need for both the specialist to travel to the CBOC or the Veteran to the larger VA facility
- PCP, Veteran, and Specialist must agree to an E Consult (opt in or opt out)
- Nurse or other staff ensure that all needed data are available to Specialist
- Specialist completes and enters consult report in the electronic medical record

# Phone Consults

- Attempts to increase the access to Specialty Care groups in “real time” via a VISN on-call system
- Each participating Specialist in 1a or 1b facility takes calls from Telehealth Center on designated days, with support from Telehealth Coordinators
- Specialists covers all VISN Medical Centers and CBOCs

# Intended Outcomes

- Increased access to Specialty Care
- Decrease travel for Veterans and reduction of travel cost for the VISN
- Reduced referral fee costs
- More efficient use of Specialists time
- Improved communication between Specialist and PCP
- Improved Veteran and provider satisfaction

# Implementation

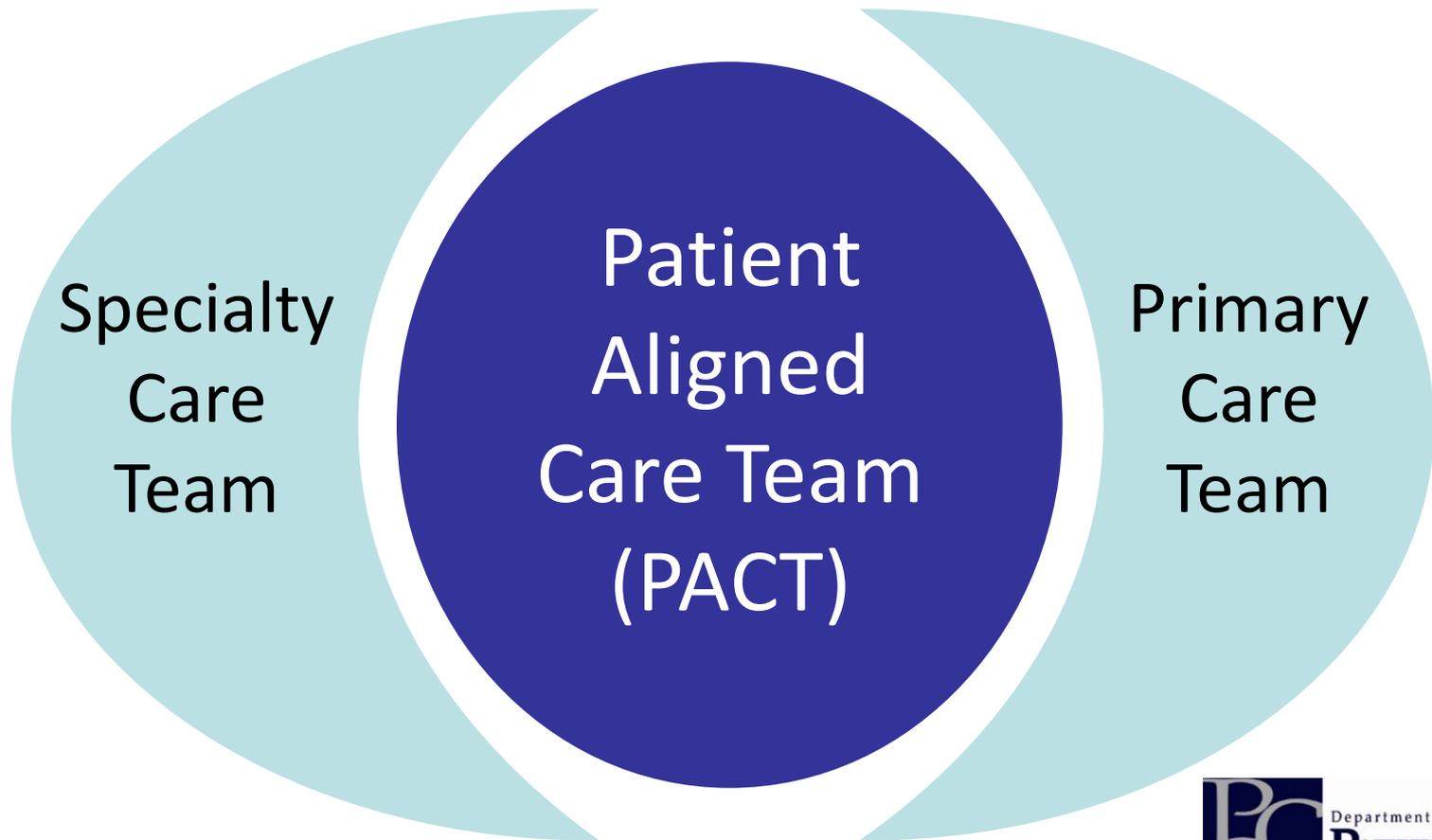
- **Pilot Programs:**
  - Ten (10) sites selected for Alpha Pilot (April-May 2011)
  - Five (5) sites selected for Beta Pilot (May-June 2011)
  - Initial disease focus areas: Diabetes, Hepatitis C, Cardiology, Geriatrics, Pain Management, Surgery, Infectious Diseases, Liver transplant
- **National Expansion**
  - Pilot VISNs will expand sites and clinical focus, non-pilot sites will implement at least one disease condition.

Group	Expansion Date
Alpha Pilot	June 2011
Beta Pilot	July 2011
Remaining VISNs	July 2011

# Multiple Sclerosis Home Automated Telemanagement (MS-HAT)

- Web-based application that assists patients in following and take more control of their self-care plans
- Allows practitioners to monitor their patients' status and facilitate multi-component chronic disease management according to the current clinical guidelines
- Goal is to develop a unified HAT platform that is accessible via the Internet and can be expanded into other chronic diseases/conditions
- Currently, a prototype is in development by the Washington DC VAMC and Johns Hopkins

# Primary Care & Specialty Care Collaboration



# Specialty Care 2013

- Timely access; no unneeded visits; care close to home
- Focus on Veteran's experience and shared decision making
- Evidence-based care; reduce readmissions and unwarranted variations
- Measure and correct deficiencies (continuous improvement)
- Data sets looking at overall health of population

# Specialty Care 2013

- Team based care – all disciplines are valued partners (e.g., pharmacy, nursing, social workers, dietitians, chaplains, etc)
- Coordinated care with PACT and in-patient providers
- Unified view of patient – focus on prevention; reduction of risk; maintenance of health and function
- Acute care and end of life care designed around the patient and family
- State of the art care, including genomics medicine

# Success Factors for Transformation

- Percentage of consults completed either through electronic or phone consultations as a percentage of total consults
- Provider and Veteran satisfaction with SCAN and Electronic and Phone Consults
- Access to Specialty Care Services is improved by decreasing wait times in Specialties where initiatives were conducted

# Challenges to Transformation

- Securing adequate resources (personnel, space, budget)
- Acquiring timely support from partners in other program offices
- Coordinating multiple projects
- Leadership support
- Provider “buy-in”