Specialty Care Transformation Initiatives

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“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
<table>
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<tr>
<th>Work Stream</th>
<th>Name</th>
<th>Brief Description</th>
<th>General Start Date</th>
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<tr>
<td>6A</td>
<td>Specialty Care Transformation Infrastructure and Assessment</td>
<td>Establish Office of Specialty Care Transformation. Complete gap analysis of Specialty Care Services.</td>
<td>10/01/2010</td>
<td>12/31/2012</td>
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<td>6B</td>
<td>Improved Access and Efficiency of Specialty Care Services</td>
<td>Implement SCAN-ECHO and Consults throughout VHA. Conduct Collaboratives to enhance access.</td>
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Why Focus Groups?

• Initiative success depends on equal acceptance by both Primary Care Provider (PCP) and Specialist
• Standard roles are changing
• To understand the current working inter-relationships between Specialists and PCPs
• To understand what’s working well and identify opportunities for improvement
Focus Group Overview

• Held at VA Medical Centers distributed by location and facility complexity
• Representative sample of PCPs and Specialist invited to participate
• PCP and Specialist groups conducted independently by the same facilitator
  – Assistance of National Center for Organization Development (NCOD) for facilitator training and 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
Steps

• Train physicians, nurses, pharmacists, other team members
• Conduct teleconference clinics – “Knowledge Networks”
• Initiate co-management – “Learning loops”
• Collect data and monitor outcomes centrally
• Assess cost and effectiveness of programs
SCAN-ECHO Core Team

• Core Team could include:
  – Specialists
  – Nurses including Advanced Practice Nurses
  – Clinical Pharmacists
  – Psychiatrists and/or Psychologists
  – Project Coordinator/Manager
  – Education Specialist
  – Telehealth Coordinator

• Individuals from other disciplines may rotate in and out depending on disease/condition
Hub and Spoke Model

- VA SCAN-ECHO Center
- Rural CBOC
- Urban CBOC
- Rural CBOC
- Urban CBOC
- Small VAMC
- Small VAMC
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)

4 initial medical conditions
- Diabetes, Pain Management, Hepatitis C, Cardiology
Potential Benefits to Health System

• Quality and safety – rapid learning – reduce variation in care
• Access for rural and underserved patients – reduce disparities
• Workforce training and force multiplier
• Improving professional satisfaction / retention
• Supporting the PACT model
• Cost effective care
  – Avoid excessive testing and travel
• Prevent cost of untreated disease
  – Liver transplant or dialysis
• Integrate public health into treatment paradigm
Benefits to Rural Clinicians

• No-cost CMEs and Nursing CEUs
• Professional interaction with colleagues with similar interest
  – Less isolation
  – Improved recruitment and retention
• A mix of work and learning
• Obtain special disease-related recognition
• Access to specialty care team
Concept of a Meta-SCAN-ECHO
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 Specialist’s time
• Improved communication between Specialist and PCP
• Improved Veteran and provider satisfaction
Implementation Status

• 20 VISNs implemented by the end of FY 11
• 31 Facilities currently implementing
• 368 E-Consults have been completed in FY 11
• Specialties:
  – Diabetes, Hepatitis C, Cardiology, Geriatrics, Pain management, Surgery, Infectious Diseases, Liver transplant, Hematology-Oncology, Neurosurgery and Rheumatology
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
Specialty Care Collaboratives

• 2 Collaboratives (each with 3 Learning Sessions) will be conducted in FY12
  – ALL medical specialties would be designed for one Collaborative with a strong presence from Dermatology, Cardiology and Endocrinology
  – Second Collaborative would have a focus on surgical specialties (Orthopedics and Urology)

• 2013 thru 2014
  – Larger Collaborative effort from lessons learned in 2012, and additional specialties
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 genomic 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”