



Magazine of Ambulatory and Primary Care

map

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Message from the Office of Primary and Ambulatory Care

**By W. Mark Stanton, MD, MHS, Principal Advisor for Primary Care,
Primary and Ambulatory Care Services**

The holiday season comes more quickly each year. Yesterday it was springtime, and now snow threatens. The holiday season and the coming new year prompt reflection, and reevaluation. As the seasons change without fail, so does life and all it entails: family, relationships, work, interests, and challenges. As the folk song phrases it, "there is a season...and a time..." My time to depart is arriving.

I wish I could personally thank all of you for your persevering efforts, often in the face of adversity and unenlightenment, for the benefit of our nation's veterans. You have persevered continually to improve the quality of healthcare provided, to improve access to that healthcare, and to improve continuity with the same individual primary care clinician working in the framework of the same primary care team. You are understanding that healthcare is all about the patient- each individual veteran- and their individual needs, whether physical, emotional, spiritual, social, or economic. Despite system constraints such as data systems and coding issues, you are understanding that healthcare, and evaluation of healthcare cost and quality, is not about where the services are delivered or even by which qualified profession, but about what services are delivered. As the VHA system morphs to facilitate service delivery, each of you will hopefully continue to understand that healthcare is not about which 'program' or 'program office' is involved, but is about utilizing all the available and appropriate tools for service delivery. From 1994's snail pace changes through the accelerated changes continuing today, we have all striven to provide the right care, at the right time, and in the right place. The October 24, 2003 edition of the New England Journal of Medicine reported, "Over the past 8 years, VA has reorganized its healthcare system,...expanded outpatient care and improved primary care." All of us can be proud of our roles in making this happen. And we should continue to remember primary care is the underpinning of excellent healthcare systems, even as we place newer technologies such as home telehealth into our

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“doctor’s bag” along with our stethoscopes and otoscopes.

You are to be praised for improving quality while also improving productivity and efficiency. And you have often done so with less. There are now fewer clinician FTEE in Primary Care than there were in 1998; and there are fewer physician FTEE now than in 1995. Process changes, facilitated in some cases by improved room and support staff ratios, were and will continue to be critical in this effort. These changes came through your realizing that obtaining different results could only come through doing things differently- through your willingness to challenge preconceived notions and to think differently and to act differently- and to bravely move forward. Those of you in the primary care arena are especially important now as the subspecialties in medicine and surgery jump or are pushed onto the bandwagon. You have shown that ‘more clinicians’ is not always the correct answer. The knowledge and wisdom you gained during your trailblazing effort will be vital in helping subspecialty practices understand process evaluation, understand process change, and understand service agreements as facilitation of care rather than barriers to care.

You have made VHA healthcare the standard-setter for this country, indeed for the world, in many ways. I have been privileged to work with and to know many of you, have learned much from all of you, and have enjoyed the shared challenges. But as the seasons change, it is time for me to follow suit, to move on to other challenges, interests, and opportunities. I wish all of you health, happiness, and safety during this holiday season and the new year.

Women’s Health Is Not Just a Pap Smear

By Andrea S. Van Horn, BSN, CNP, Women Veteran Program Manager VISN 5

Provision of medical care became fragmented during the period just after WW II. The age of specialization took over and the family doctor’s practice became in part, extinct. The resurgence of integrated care, which occurred 30 years ago, recognized the importance and value of primary care as well as the need for interdisciplinary approaches to medical care of patients. Women, however, had played no specific part in medical research. Therefore, there was no need for specialized care beyond the gynecologist/obstetrician.

That changed 20 years ago, and so has the practice of women’s health care. There have always been poorly understood differences between men and women in terms of mortality, morbidity and the expression of disease. The 1980s brought about governmental mandates that included women in research and specifically increased support for the study of those problems that predominate or are exclusive to women. Women were now recognized as being different; they now sought care in practices that offered gender care, primary care, and mental health services under the same roof. Medical and Nursing schools developed post-graduate, residency, and fellowship programs which focused on women’s health. A whole generation of MD’s, NP’s and PA’s began practicing.

The Department of Veterans Affairs (VA) and Congress recognized in the 1980’s that women “were veterans too” and began efforts to expand the delivery of health care services to include them. The Women’s Veterans Health Program (WVHP), established in the early 1990’s, is the force behind the move to address the needs of women in the VA.

Since 1973, when the draft ended, the percentage of active duty women has increased from 1.6 percent in 1973 to

15% in 2003. Women veterans are younger (44y/o), belong to a minority group (52%), are better educated (12th +), and live longer (80.2 yr) than their male counterparts. Women veterans also were found to have been victims of sexual assault during their lifetime in more than double the community average (68% vs. 25%.) These numbers have been replicated in several studies conducted at several VA Medical Centers.

Women have unique medical conditions, including uterine and cervical cancer, and menopause (and don’t forget pregnancy.) They also have a higher incidence of breast cancers, and osteoporosis. Women are treated more frequently for thyroid disease, fibromyalgia, collagen diseases and increasingly, coronary artery disease.

A women’s health provider must be at ease with a speculum and a stethoscope, a microscope and colposcope. They should be well versed in the treatment of hypertension and diabetes, and equally versed in advances in the treatment of breast cancer, contraceptive management, and prenatal care. They should also be aware of the newest clinical trials regarding mammography, chemotherapy and osteoporosis treatment. In addition, domestic violence issues, substance abuse, prevention and treatment of sports injuries, sexually transmitted diseases, infertility, and hysterectomy are topics women’s health providers discuss daily.

The intensely private nature of women’s health delivery requires actions to be taken by the VA to provide safety and privacy for all our female veterans. The incidence of sexual trauma experienced by many women requires waiting areas without men present. Women share experiences and a sisterhood develops in separate waiting areas at most VAs.

The following guidelines have been developed by the American Academy of Family Physicians:

- A. An understanding of the desire of women to be treated as competent participants in their health care, in a caring and compassionate fashion.

- B. An awareness of the role that being female plays in bringing women into the health care system more frequently than men.
- C. An appreciation of the role that women play in the health of the family by choosing a health provider, making meal selections, and providing family care at home.
- D. The realization that a woman's health is affected not only by medical factors but also by family, life cycle, relationships and community.
- E. Awareness that many research studies of accepted medical practices and procedures has excluded women.

Yes, women's health is doing a Pap smear but a whole lot more. The interdisciplinary team is key to maintaining a woman's health, and the VA is doing that better every year.

**Cardiac Care Education Initiative:
"Time is Life for Heart Attacks"
By Marianne Mathewson-Chapman PhD,
ARNP, VA Central Office, Washington, DC**

With coronary heart disease as American's number 1 killer for men and women, the VA has developed a new campaign called "Time is Life" for Heart Attacks. This new VA logo and theme will increase the awareness of veterans to call 9-1-1 and seek immediate medical attention at the nearest medical facility if they are suffering with a heart attack. Today there are available clot-busting drugs to stop heart attacks, reduce disability and save lives but they must be given immediately after symptoms. The National Heart, Lung and Blood Institute have a similar campaign called "Act in Time" for the general public. We are all telling the same message concerning the urgency to seek medical treatment when experiencing a heart attack and to not delay. For the VA cardiac program, veterans will be assisted by their providers in developing a personal action plan and in talking with their family members about what to do if they are uncertain whether they are actually having a real heart attack. At the same time, providers and nurses will be asking patients at each clinic visit (1) Do you know the signs and symptoms of a heart attack (2) Do you realize how important it is to call 9-1-1 and receive treatment on-route to the medical center? Don't Delay and Get Help Right Away! and finally (3) Do you have a personal plan on what to do if you experience a heart attack? Patient education is the key to behavior changes in our population of 3 million high-risk veterans with a known history of heart disease, diabetes and hypertension.

Through the talents of a graphic artist from EES and the contributions of the members of the working group, a "Time is Life" logo was developed as well as many products to spread the word. Brochures (English and Spanish), wallet cards, posters and a brief tear off sheet with information on heart attacks and ways to prevent

them have been developed and will be distributed to each facility. The three themes listed above are utilized in all of the educational materials. During the campaign kick-off at the Integrated Ambulatory Care Conference in June, participants had the opportunity to learn about all 10 of the Cardiac Action Plan Initiatives from the table display. They were able to preview samples of each of the heart attack products and evaluate content, readability and design. This feedback was invaluable to assist us in improving the products and making sure that they were acceptable and utilized by veterans. The cardiac education budget has been recently been submitted in order for printing, distributing and storage of brochures to begin. We are attempting to identify a point of contact at each facility to monitor, receive and re-order materials to meet their needs at the facility. We also will be distributing brochures to VSO members at conventions, meetings and mail-outs as well as facility and VISN newsletters, employee pay stubs and web pages. The new cardiology web page will allow patients and providers to download brochures and important cardiac information. Another exciting initiative is a VA video production with interviews with our veterans who would be willing to talk about their experiences after suffering a heart attack at home, riding in the ambulance, and receiving treatment in a hospital/emergency room.

The Cardiology Care Team Conference in 2004 will be a grand opportunity to receive instruction on how to use the new toolkits at facilities throughout VHA, help VA spread the word that "Time is Life", become a partner with our veterans in improving health outcomes, and reducing morbidity and mortality after heart attacks. Review of Heart Attack Warning Signs: Signs and Symptoms: ***** (Women's signs may be different then men).
* Unusual fatigue
* Sleep disturbance
* Shortness of breath
* Indigestion and anxiety and limited chest pain
DON'T WAIT: Call 9-1-1 and take one aspirin (unless you are allergic to aspirin) and tell the ambulance driver that you are having chest pain or no pain. ----Don't drive yourself.

BE-PREPARED: have a plan on what to do and tell your family members too.

TIPS to PREVENT a HEART ATTACK:

- Stop smoking
- Eat a low fat diet
- Exercise 30 minutes a day
- Control diabetes and hypertension
- Manage cholesterol levels and blood lipids

Know if you are a high risk with a family history and reduce the risk by regular check-ups

<http://www.va.gov/cardiology>

Revision of Ambulatory Care Space Planning Criteria and Design Guides

By Sara McVicker, RN, MSN, VA Central Office, Washington, DC

The Office of Facilities Management has contracted to update and revise the VA Space Planning Criteria and Design Guides. The updated criteria will address healthcare industry benchmarks, reflect the needs of providers and administrators, and provide flexible internet-based tools to facilitate space planning, design and construction. The first two sections to undergo revision will be Ambulatory Care and Imaging.

The contractor, Cannon Design, has extensive experience in healthcare design and received an Honorable Mention in the Annual Design Awards Competition sponsored by Modern Healthcare and the American Institute of Architects' Academy of Architecture for Health. Cannon Design was cited for its work on the BJC Healthcare and Washington University School of Medicine Center for Advanced Medicine & Siteman Cancer Center, a 750,000 square foot Ambulatory Care Center on the campus of Washington University Medical Center in St. Louis, MO.

A VA-wide steering committee made up of designers and planners will set goals and guide the general revision process of VA Handbook 7610. An Ambulatory Care Advisory Committee composed of representatives of various services is reviewing the existing criteria. Early discussions have stressed the need to make the space criteria and designs reflect not only the needs of the veterans VA serves, but also the ways in which VA now delivers health care services. Input from users in the field will be sought. The VISN Primary Care Points of Contract will be asked to obtain input from primary care providers and staff. Other clinical offices in VACO will also seek input using their field advisory groups or contact persons.

Update on Chiropractic Care in VHA

By Sara McVicker, RN, MSN, VA Central Office, Washington, DC

P.L. 107-135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Section 204, established a Chiropractic Advisory Committee to provide assistance and advice to the Secretary of Veterans Affairs

on the development and implementation of a chiropractic health program within Veterans Health Administration.

In October 2002, the Committee submitted a recommendation to the Secretary requesting that the major occupational study necessary to provide information for development of a qualification standard and compensation schedule be initiated as soon as possible. The Secretary concurred with that recommendation. The occupational study is currently underway and is expected to be completed in late January 2004.

In November 2003, the Committee completed work on 38 recommendations that focus on major programmatic issues that the members believe VA must address in order to successfully integrate chiropractic care into its health care system. The recommendations have been submitted to the Secretary for his consideration. After the Secretary makes decisions regarding the Committee's recommendations, VHA must draft an implementation plan and select sites for implementation. Other tasks VA must complete include finalization of the qualification standard, and other human resources tasks such as developing an application form.

Until the administrative steps necessary for hiring doctors of chiropractic or contracting for chiropractic care at VA sites are completed, VHA Directive 2000-014 (<http://vawww.va.gov/publ/direc/health/Direct/12000014.htm>) remains in effect. Chiropractic care is available to enrolled veterans through the fee basis program upon referral by a VA clinician. Data entered into the fee basis program is easily retrievable only for CPT codes 98940-98943 (chiropractic manipulative treatment) as the "purpose of visit code" (POV) for chiropractic care (75) is inconsistently and infrequently used. Data entered into the fee basis program as of April 2003 indicated that in FY 2002 VHA provided chiropractic manipulative treatment to 1077 veterans (10,968 visits) at a cost of \$362,833. Other expenses related to evaluation and management codes, diagnostic radiology, ultrasound, application of heat and cold and other treatments are not included in these cost figures except when the POV code is used.

The Advisory Committee held its fifth meeting in early December. During that meeting the Committee began discussion of the education material required by P.L 107-135. The Committee will discuss quality and performance measures at later meetings.

Improving Patient Access to Specialty Care Through Implementation of Service Agreements”.

Organizational Information:

The organization discussed in this case report is a Healthcare System, established in 1939, which offers general medical and surgical inpatient care, day surgery, extended nursing home care, primary and specialty care, mental health services and substance abuse treatment to a population of 75, 000 veterans in Texas, New Mexico, Oklahoma, Colorado and Kansas. The center of the service area is a small city of 175, 000 with a technological and agricultural economic base. The areas surrounding the satellite clinics (CBOCs) are mainly agricultural, with many of these areas designated as medically underserved. The organization has transitioned from a stand-alone hospital and satellite outpatient clinic to a multi-facility health care system through the placement of community based outpatient clinics (CBOCs) in medically underserved areas. The organization discussed is part of the Department of Veterans Affairs and subsequently operates in a political environment subject to the Congressional budget cycle, national priorities and changes in administration. This environment routinely affects short and long-term planning, budgeting, and staffing in the organization since the Congressional budget cycle is only one year and planning for service changes and capital investment often span 2 years or more (Source #1).

Description of the Problem:

The table below contains a summary of the types of service agreements and their implementation dates:

The VA Healthcare system, like other healthcare systems has been plagued by long waiting times and delays in care, including access to specialty care. Waits and delays in specialty care have the potential to lead to adverse clinical outcomes. When patients are informed that they will be “referred” to a specialist they often have little knowledge of the process or how long the expected wait will be. This leads to patients probing the system through increased telephone calls both to primary care and specialist offices, increased visits to other primary care providers; urgent care providers or emergency departments. Access problem to specialty care represents a delay between the initiation of the demand (referral) and the application of the supply (visit with the specialist) (Source #2). The management goal here is to balance the demand for specialty care with the supply through the implementation of service agreements developed jointly between primary care and the specific specialty clinic physicians. Service agreements are contracts between primary care and specialty care physicians that create referral agreements that rationalize this relationship. If this balance cannot be achieved waiting times will continue to extend. Delays to specialty care are dissatisfying to patients because of the anxiety of the delay and the fear about their clinical condition deteriorating during the delay.

This case report aims to measure the wait times for specialty care clinics, which have service agreements in place, before and after the implementation of service agreements. Additionally this case report looks to measure the demand for specialty care clinics before and after the implementation of service agreements. It is also important to recognize the significant process change that this represents for physicians.

Table #1 Service Agreements Overview:

Service	Implementation Date
Podiatry	March 10, 2003
Audiology	March 10, 2003
Ophthalmology	April 23, 2003
Dental	April 24, 2003

The service agreements above involved the podiatry, audiology, ophthalmology and dental. The specialty providers are responsible to the Chief of Surgery. The Chief of Surgery and the author (Chief of Ambulatory Care) are responsible to the Chief of Staff. The primary care providers were involved in the process through an education session with the specialty provider on how to initially treat some specialty care issues in primary care prior to referring them to specialty care. The education session extended into a partnering session where both the primary care and specialty care physicians decided on what medical conditions could be initially treated in primary care and when primary care physicians needed to refer the patient to the specialist. The Appendix contains a sample service agreement and service prerequisites for this service as they appear in the Computerized Patient Record System (CPRS).

Administrative Decisions and Results:

The creation of referral (service) agreements rationalizes the referral process for the patient, primary care physician and the specialist. They can assist the primary care provider to be more selective about which patients they refer to the specialist through the use of referral guidelines, which determine the clinical conditions to be referred. The referral guidelines, accompanied by an education session with the specialist for the primary care providers, can assist the primary care provider to be more thorough in their pre-referral work-up. The challenge, especially in the organizational environment discussed above, is that this **requires significant process change for physicians**. The physicians, both in primary care and specialty care need to be able to look outside the box and see themselves as part of the same healthcare delivery system. The referral guidelines were based on common clinical conditions referred to the specialist. Developing the guidelines involved partnering between the primary care physicians and the specialists in order to determine the appropriate radiology and laboratory testing, expected initial treatment by primary care providers and the sequence of the work-up. The Computerized Patient Record System (CPRS) added to streamlining this process through use of templates which require certain clinical information to be entered (e.g. lab tests, radiology tests) on the consult request.

Table#2 Measures for Clinics With Service Agreements:

Service	Measure	January 03	February 03	March 03	April 03	May 03
Podiatry	#Consults	58	41	35	38	30
Podiatry	Wait time (days)	181.7	202.6	198.7	203.4	195
Audiology	#Consults	48	46	76	60	66
Audiology	Wait time	18.7	12.8	10.8	11.6	14.2
Eye	#Consults	128	129	115	147	140
Eye	Wait time	20.5	20.8	16.8	19.1	21.5
Dental	#Consults	12	19	22	28	21
Dental	Wait time	4.9	5.1	4.8	3.7	0

The referral (service) agreements resulted in a process change for both the primary care and specialty care providers. It is difficult to draw conclusions from the above table due to the multiple variables involved. Podiatry waiting times, measured in days are increased due to shortage of podiatrists in the system and are not expected to improve until two more podiatrists are hired. The service agreement in podiatry was put into effect March 10, 2003 and given the change in process; with the shortage of podiatrists it will likely take more time before the benefits can be realized. For audiology the referral (service) agreement was put into place March 10, 2003 with a relative decrease in wait time, measured in days, despite the increased number of consults. It is difficult to predict the average number of consults due to care being provided across sites and seasonal variation in the number of consults requested. For the eye and dental clinics it is too early to fully appreciate the impact of referral (service) agreements as they were implemented April 23, 2003 and April 24, 2003 respectively.

Overall I believe that the service agreements have had a positive impact on the referral process based on feedback from primary and specialty care providers. The feedback that I have received is favorable in that service agreements address the need for both primary care and specialty care physicians to see themselves as part of the same healthcare delivery system, with the common mission of meeting the patient's needs. Referral (service) agreements streamline the process through specifying the appropriate pre-referral workup including radiology and laboratory testing, expected initial treatment by primary care providers and the sequence of the work-up.

Source Materials:

- (1) Amarillo VA Health Care System Organizational Profile
- (2) "Reducing Waits and Delays in the Referral Process" Murray M, *Family Practice Management*. March 2002: 39-42.

Appendix:

The following is the service agreement between Surgical Service and Ambulatory Care for Podiatry care:

- 1. The routine yearly diabetic foot screenings will be performed in primary care. Dr. F agrees to educate providers on the appropriate monofilament testing if needed.

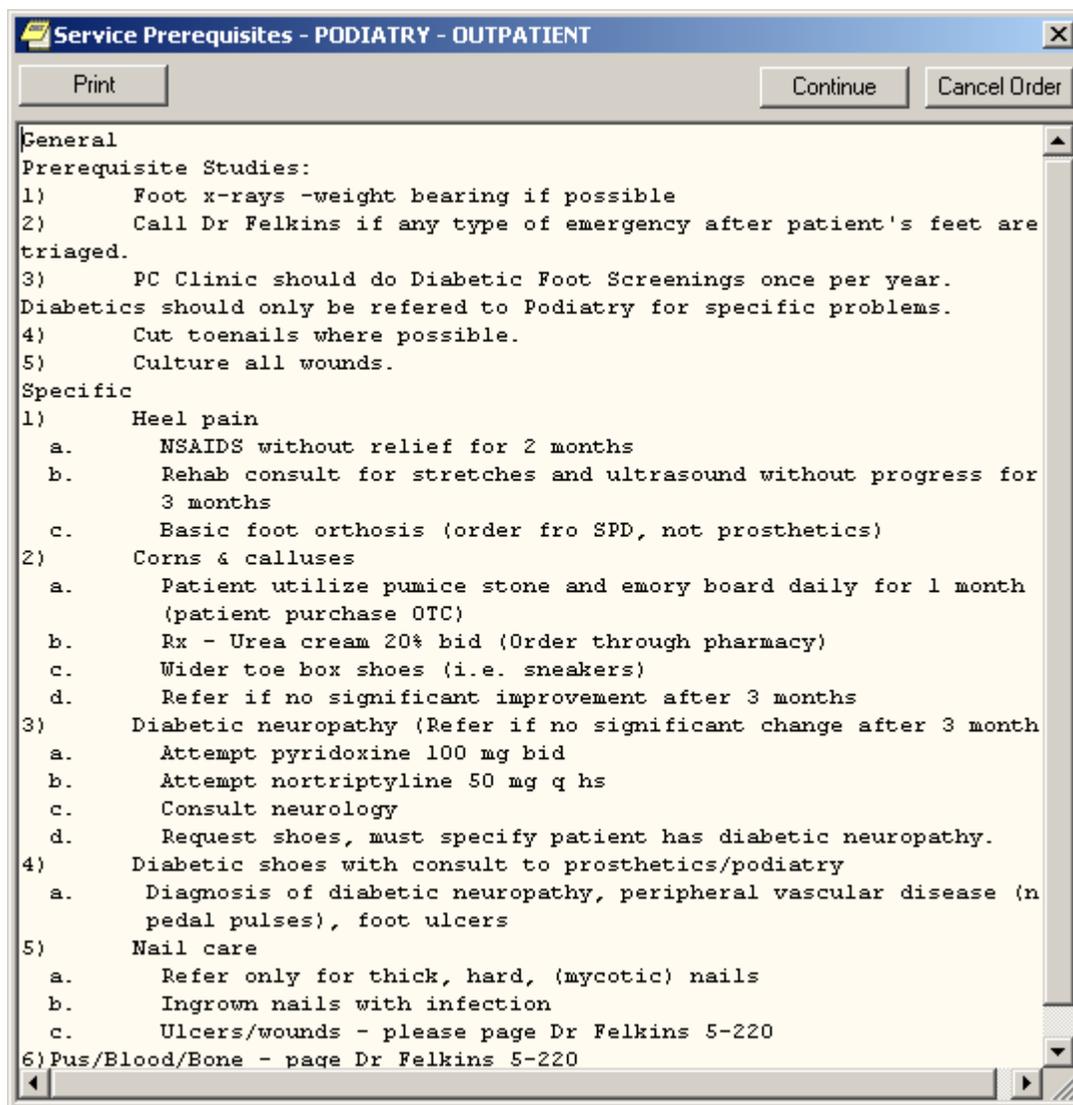
2. Prerequisites for the top six consults will be available in CPRS for Primary Care Providers to utilize when placing consults to Podiatry.
3. Dr. F will discontinue inappropriate consults and copies will be provided monthly to the Chief of Ambulatory Care for review, tracking, and possible corrective action.
4. Dr. F will perform an in-service to primary care providers on heel pain, corns and calluses, diabetic neuropathy, diabetic shoes, and nail care.

Concur/ Do Not Concur

Concur/ Do Not Concur

Dr F, M.D
Chief of Surgical Service

Dr A, M.D
Chief of Ambulatory Care



Verification Statement

In preparing my Fellow project, I did not use the assistance of an editor on my manuscript. My signature attests that this Fellow project:

“Improving Patient Access to Specialty Care Through Implementation of Service Agreements”.

Represents my own work and that any editorial assistance that I had in its preparation was minor, consisting of editing as defined in the American College of Healthcare Executives' Fellow Project Guide.

I give full permission to ACHE to duplicate this Fellow project as submitted.

Anticipated Changes in the Next Newsletter

The next quarterly newsletter will reflect the re-organization of Medical/Surgery/Primary Care Services. We will have a new name and will include articles submitted by authors involved in patient care activities from many different perspectives. We will

continue to post the Newsletters on the primary care website: <http://vaww.va.gov/primary>. Newsletters are only as interesting as the information shared. You are invited to send your articles to Renee Hodges or me.



Have a Happy and Safe Holiday!

Mildred Eichinger, RN, MPH
Clinical Program Manager

Schedule for MAP articles

FLOW	2 nd Q/2004			3 rd Q/2004			4 th Q/2004		
	Jan	Feb	Mar	April	May	June	July	Aug	Sept
Articles Submitted	21			21			28		
Distribute to Board Members		11			12			18	
Comments to 111/PC			3			2			8
Final Presentation to 111			17			16			22
Electronic & Hard Copy Distribution			31			30			29

111/PC: Mildred Eichinger

111: Michael Kussman, MD, MS, MACP, Chief Consultant, Medical/Surgical Services and Deputy Chief PCS Officer.

Website <http://vaww.va.gov/primary>

Articles may be submitted electronically at any time to Mildred Eichinger

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Note: Congratulations to Renee Hodges. She will be joining the Office of Information Technology starting December 28, 2003.

Thank you Renee for being a major contributor to the MAP publication and the Primary and Ambulatory Care office.

Mildred