

# Primary Care at the Providence VA Medical Center: Challenges, Opportunities and Innovations

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**Almost one out of ten Rhode Island residents** is a US veteran. About 30,000 of them get their care at the VA. Their needs reflect both the aging demographic of World War II and Korean War veterans now in their 80s and younger men and women returning from the Iraq and Afghanistan wars. The veteran population also tends to be sicker, with more medical conditions, overall poorer health, and to use more medical resources than the US general population.<sup>1</sup>

From a primary care perspective, caring for today's veteran requires a focus in three core areas: (1) chronic disease management including early detection, reducing the risk of disease progression and preventing/treating acute exacerbations; (2) the interface between public health and clinical medicine which encompasses everything from universal screening for post traumatic stress disorder, depression and substance abuse to implementing a first-line response to the H1N1 pandemic and promoting weight reduction and smoking cessation; and (3) the capacity to address health disparities and the needs of vulnerable populations disproportionately represented in veteran populations.

To address these areas, primary care within the VA began a major transformation about 15 years ago in its organization.<sup>23</sup> VA-based care is organized around the **Patient-Centered Medical Home (PCMH) Model**. Every veteran is assigned a primary care provider and clinical team. Comprehensive care is coordinated within an integrated medical system model that promotes continuity along with population and patient-based disease management and health promotion.<sup>4</sup> A comprehensive electronic medical record system allows for timely communication across services as well as care planning, population tracking, and clinical feedback. It also allows the provider to have access to records of all care across all VA facilities nationwide. Together the medical home model and electronic medical record provide the capacity and tools needed to apply the Chronic Care Model within a primary care setting: promoting patient self-management, engaging community resources, use of decision sup-

ports, optimizing organization of care, tailoring delivery systems to chronic disease care, and utilizing clinical information systems for population health.<sup>5,6</sup>

At the Providence VA, about 18,000 patients receive care at the Providence Medical Center campus; the remaining 12,000 patients receive their care in one of three **Community-Based Outpatient Clinics (CBOCs)** located in Middletown, RI, New Bedford, MA and Hyannis, MA. In 2006, the Providence VA Primary Care Service underwent a further reorganization to better align itself with VA objectives and to prepare for anticipated challenges facing our veterans. Three initiatives stemming from this reorganization are described in further detail.

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### THE VA PRIMARY CARE MEDICAL HOME

Core to the primary care reorganization was the need to strengthen the medical home model as a treatment entity. This required re-organizing the existing "Firm" system into smaller clinical units of 3,500 to 4,500 patients each and re-assigning clinical staff to increase the number of "hands-on" providers involved in day-to-day patient care. Each patient is assigned to a primary care provider and a medical team based on specific needs and preferences. Each general medicine clinic team consists of 4-5 primary care providers, an RN, 2 nursing assistants and a shared social worker and LPN. In addition, intensive metabolic disease management and cardiac risk reduction clinics are available for short term intensive management of patients with difficult-to-control diabetes and hyperlipidemia, telehealth services are available for high-risk patients, and an integrated primary care-mental health team can assist in

the on-site management of patients presenting with depression or anxiety disorders. Monthly clinical reports drawn from the electronic medical record are provided to each clinician, RN and team that includes aggregated chronic disease management measures (most recent blood pressures, LDL and hemoglobin A1C) and a listing of all outlier patients in that team. These data are used in bi-weekly team meetings to both promote effective care planning and serve as the benchmark for team-based quality improvement initiatives. Since implementing this care structure in 2006, we have seen a significant improvement in chronic disease management performance and the proportion of patients at target for blood pressure, lipid and diabetes control, exceeding both national VA targets and community standards.

### PROMOTING PATIENT SELF-CARE

A significant component of the Chronic Care Model is the promotion of patient self-care and self-empowerment. Patients who are able to assume more proactive roles in their care tend to feel better and have better care outcomes.<sup>7</sup> To help achieve this goal, we established several self-care initiatives within primary care that can be accessed independent of a PCP referral and are intended to promote enhanced chronic disease self-management or disease prevention goals. Structured as either group or individual education and/or medication management sessions, they include: (1) MOVE, a program led by the PVAMC dietician service to assist patients trying to lose weight; (2) Smoking Cessation Program, co-led by a primary care provider and clinical pharmacist and structured as a walk-in group session with follow-up one-on-one counseling and medication prescribing; (3) Diabetes Self-Management groups led by a diabetes nurse educator; (4) Economic Hardship Program led by the primary care clinical social workers to assist patients having difficulties following through on prescribed medical care due to financial hardship; and (5) a Caregiver Support Group led by the Special Populations social worker to assist families of loved ones suffering from Alzheimer's

Disease. Taken together, these efforts are intended to complement the efforts of the clinic team, improving compliance and patient satisfaction.

### THE ENHANCED MEDICAL HOME FOR VULNERABLE POPULATIONS

Within the VA as well as in our country, vulnerable populations of patients have difficulty accessing care, navigating the health system or have specific health needs that are difficult to address in traditional settings. For example, veterans represent between one quarter and one third of all adult homeless and have well documented challenges accessing care with resulting high rates of premature morbidity and mortality.<sup>8</sup> Similarly, veterans with serious persistent mental illnesses (e.g. schizophrenia, bipolar disorder) have repeatedly been shown to have a higher physical health disease burden and difficulty engaging in primary care.<sup>9</sup> Female veterans suffering from post traumatic stress disorder have both poorer health and higher rates of hospitalizations and emergency department visits underscoring specific and unique challenges in developing care models for this population.<sup>10</sup> Finally, the fastest growing population within the VA are veterans >80 years old, many of whom are cognitively impaired, frail, and at high risk for hospitalization and institutionalization.<sup>11</sup> Together, these four groups have substantially more co-morbidity, use emergency departments and inpatient medical services at much higher rates and have much worse health outcomes.

As part of the reorganization of the Providence VAMC Primary Care Service, we tailored clinical programs based on the Medical Home model to better engage each of these “high risk populations” in treatment and to optimize clinical and social outcomes. The Homeless Oriented Primary Care Clinic was established in November, 2006 followed by the Geriatrics Primary Care Clinic in July, 2007. A clinic for female veterans suffering from PTSD or military sexual trauma was also started in 2007. The **Serious Mentally Ill (SMI)** clinic, co-located with mental health, was established in the Fall of 2007 for patients with serious persistent mental illnesses who were unable to successfully access and/or navigate the general medicine primary care clinics. The clinics are defined by four consistent features: (1) Access to care is modeled after the needs of that population. For example, the homeless clinic operates as an open-access model with no ap-

pointments needed on fixed clinic days to accommodate the difficulties many homeless persons have keeping appointments set within narrowly defined times. The SMI clinic is co-located within the outpatient mental health unit and runs concurrently with scheduled mental health appointments to create a more seamless transition from mental to physical health service delivery. (2) All the clinics also have case management incorporated into their care models with the use of patient registries to minimize loss to follow-up. (3) Care within the clinics is tailored to issues relevant to that population. For example, the initial assessment at the homeless clinic specifically queries patients on food security, current sheltering needs and benefits status. There is also a multidisciplinary team on-site during clinic days that includes primary care, a VA housing coordinator, a VA benefits representative, and a mental health practitioner. The Geriatrics Clinic has specific assessments and supports for caregivers of those veterans suffering from Alzheimer’s Disease and other cognitive impairments. (4) Lastly, each clinic team is trained in care nuances and priorities relevant to that population. For the homeless clinic, the emphasis is on harm reduction; for women’s health, on integrated PTSD and MST related care needs, etc.

To date, over 800 patients are enrolled in these “special-populations enhanced medical homes” with significant clinical outcomes to date. In all four clinics primary care contacts per patient have increased significantly and the rate of potentially preventable, ambulatory sensitive admissions (e.g., congestive heart failure, COPD) among patients transferred to these clinics has declined by 12%. Chronic disease management has also significantly improved; less than 40% of the patients in the SMI and homeless cohorts were at lipid target (LDL <100) in 2006; now over 70% are at goal. There has also been a 48% reduction in the number of homeless patients accessing the emergency department and a 40% drop in overall ED visits since creating this clinic model. A sophisticated electronic medical record makes possible this data gathering regarding the outcomes of clinic reorganization.

The potentials of an integrated, population-based care system are being realized in the primary care model at the Providence VA. However, our model needs to adapt to the challenges posed by the stagnant economy, the evolving needs of the aging World War II and Korean War era veter-

ans and those new veterans returning home from Iraq and Afghanistan, and the need to provide care in a patient-centered, evidence-based and cost-efficient manner. Health care delivery in the United States is at a watershed moment as policy leaders grapple with burgeoning costs, disparate access and inadequate outcomes. The VA system serves as a model for what can be accomplished and should be referenced in the ongoing health care debate.

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### Disclosure of Financial Interests

The author has no financial interests to disclose.

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