VA OPTOMETRY SERVICE

VETERAN ACCESS TO CARE WORKGROUP CONFERENCE CALL

January 27, 2016

DIRECT SCHEDULING

- Eliminating the need for a consult to be generated in order for a patient to be scheduled into the eye clinic.
- For some facilities this applies only to routine appointment requests, for others there are no consults available for any reason. This is not same day or walk-in scheduling for routine care.

  Process to make "routine "appointments is different but does not mean walk in clinic concept.

  For pilot sites:
  - Mountain home eliminated consult(s) and has no consult at all
  - Bay Pines and Orlando continue to utilize a consult to track disease and track urgency but do not use a consult for "routine" eye examinations.

1. Consult: in order to track urgency (stat) or disease (plaquenil, glaucoma, DM)
2. Whether or not you continue with a consult on a limited basis depends on:
   -your clinic access: can accommodate "walk-ins"
   -comfort level of your facility's administration (PCP chief, Chief of Staff, etc)

CLINIC ACCESS

1. SPARQ data

Review clinic productivity - not critical but can be used as metric especially for resource requests.

2. Supply and Demand Analysis:
   - Count the number of slots per week for routine exams. Do not count low vision, tbi, contact lens, or c&p slots
   - Add or average the number of consults you receive for routine exams per week

This is your supply and demand (take into account snow birds etc, cycle or pattern of consult submissions). Work with your AO or HAS to pull past data to help determine this number.

3. CUSS reports to review clinic utilization
    - Adjust those clinics that are infrequently utilized (ex, too many low vision slots etc.) and re-distribute to another clinic in need of coverage

4. Create "routine" grid that matches your demand
    - Reduce the number of appointment types (ex: too many: full, short, refract), hvf, c&p, teleretinal, difficult for HAS to schedule correctly.
      More choices can increase the chance of a scheduling error
      Watch variable length appointments
      Restrict scheduling access into specific grids in this case the "routine" exam grid only
    - routine grid and consult grid
      Consult grid for disease state monitoring and acute, urgent, emergent, stat requests.
    - do not eliminate your low vision, tbi or c&p grids, each of these has it's stop code that is very important when demonstrating the productivity of your clinic and your providers
      Monitor use of slots for scheduling errors and utilization of slots to balance supply and demand
      Restrict scheduling access to routine only clinic for non-Eye Clinic HAS staff

5. What if you have a back-log ?
    a. Does not prevent you from starting direct scheduling
    b. Will not eliminate your back log
    c. Extend clinic hours (4-10's), hire additional FTE (providers & technicians) fee basis, choice care, PC3
    d. Reduce demand:
        1. Teleretinal imaging for eligible diabetic patients
        2. Extend appointment intervals if possible:

a. Have clinic discussions on return intervals for routine patients (does that 42 year old with no pathology need a one year f/u or can they be discharged)
   patient can call back for next appointment in 1 or 2 years when no consult is needed for routine/preventative care

b. Diabetics with reasonable Ha1c and no retinopathy ok for exam every 2 years
   Primary Care education on availability of Teleretinal Imaging and no need for consult for routine diabetic eye evaluations (although this may be facility dependent as to whether a consult is needed for this disease management diagnosis)
c. Hire a float provider – may be geographically impossible
   Primary Care is developing float teams especially to cover for Annual and/or Sick Leave

SCHEDULING

1. Involvement of HAS clerks-need to get HAS admin on board with the change in culture of needing a consult in order to schedule into a specialty clinic
   Change can be a challenge
2. HAS clerks are "not allowed to triage" patient complaints
   National policy regarding this
   a. Is this for a routine appointment ? ok to schedule into the routine grid or providers 1-4 etc….
      Development of "routine" appointment grid with restricted access
   b. Patient complaint "not routine"-transfer by clerk to nurse telecare, eye clinic triage line etc
3. Central scheduling phone number
   a. Creation of "call center" to handle the inbound calls (same clerks that scheduled consults now handle inbound calls)
      Examples:
      Bay Pines 18 HAS clerks in a Call Center setting
      Orlando 25 Nurses and 25 HAS clerks in a Call Center/Triage setting

4. Primary care HAS have access to schedule ?
   Eye appointment can be made by Primary Care HAS clerk for routine appointments

Roll out of direct scheduling process:

1. Involve leadership (Chief of HAS, Primary care, COS, Director)
2. Determine roll out date and stick to it-all parties are accountable
   a. Call center established, direct scheduling phone number, clinical application coordinators have removed the routine consult option from primary care menus, triage lines set up non-routine calls
      create pop up possibly when consult is ordered to reminder ordering provider of when the consult should actually be utilized
      Qualified technicians, nurses, providers can assist with answering/triaging when appointment to be made becomes "non-routine" ie. Patient states they are having a challenge of some sort and not just requesting vision check and/or eyeglasses
      Phase in roll out example eliminating "routine" consult first and then consider how and when the actual consult will be utilized or if it can be eliminated in all scenarios

3. Office of public affairs or designee
   Recommend involving section very early on like to key employees
   speak at provider meetings especially Primary Care Team
   a. Targeted communications to various employee groups regarding direct scheduling process (FACT SHEET)
      Primary Care will play large role in deploying program
   b. Update all patient appointment cards reminders with message about direct scheduling, web site, information slide for electronic bulletin boards, info sheet at the primary care check in desk
      Signage within Eye Clinic and education when you finish visit with patient.

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How to track patients without consult what metrics

Still up for debate as to what source to use

Add comment in VISTA profile when appointment is made and they can be queried for example routine PCP through Primary Care

Advantages to direct scheduling

1. Patient satisfaction
   Very positive
2. Reduce burden on primary care
   One less reminder to mind when managing panel
3. Reduce time in triaging routine consults
   Exception would be if the consult is still in play for disease management and acute care consults but if facility receives large number of "routine" requests each day responsibilities can be re-organized for facilitate roll out
4. Eliminate HAS time spent trying to schedule the patient
   Especially if Primary Care HAS has access to schedule into "routine" grid
5. Eliminate provider time spent discontinuing those consults that couldn't be scheduled after two phone and letter was mailed
   Break the cycle of consults being re-ordered since appointment can be made when leaving a Primary Care appointment

Disadvantages:

1. Time and effort working to change grids, hire providers, work with admin and HAS to create new process
   There will be a lot of pre-work and effort to organize the roll out
2. Possibly a temporary increase in demand (should even out over a few months if the initial demand estimate was correct)

Tentative Roll Out Throughout VA

Quarter 2 FY16: VISNs 1, 8, 9

Quarter 3 and Quarter 4: remaining VISNs

Toolkit is still in development

Drs. Cantrell and Varanelli have seen and used some elements but do not know when it will be released

Other Pertinent Points:

VERA allocations will change

- No primary care provider is necessary to start to be seen in the VA as patient can just walk in after enrollment and request an appointment in the Eye Clinic (Audiology too)

Questions from callers:

1. Dr. Gardner – South Carolina
   Does this mean PCP will not order?
   Patient can make appt when checking out from PCP visit
   HAS clerk will need access to schedule into clinic
   Has it been manageable for HAS clerks to review last note to see if it is appropriate for patient to be scheduling an appointment?
   There may be some inappropriate appointments if HAS clerks are not allowed to review notes. Pathway will be important to prevent this from happening

2. Dr. Matt Cordes - The Villages
   What is time frame for Toolkit?
   Still under review but will be soon
   Site getting pressure to implement

3. Dr. Joanie - Tallahassee
   CMO instructed to roll out
   So far, so good
   Problem related to diabetic eye reminder
   May need to work with CACs for issues related to reminder
   Part of PACT initiative
   No routine option on consults, STAT only

4. Dr. Capelli - Jacksonville
   More demand then access
   Access for HAS clerks for scheduling
   Consider Primary Care scheduling access only along with call center or triage line
   Restrict other eye specialty clinics
   VCL for routine patients

5. Dr. from VISN 7
   What does PCP tell patient about scheduling
   Suggest card hand out etc
   Remember non routine still may need consult

6. Dr. Varanelli - Detroit
   RVU issue without a consult
   Coding new patient vs. consultative visit affects RVU calculation and productivity

7. Dr. caller discussing New patient time frame 2 years vs 3 years