Embedding Dermatology in a VA Geriatric Primary Care Clinic

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The authors describe an exportable dermatology specialty care model to address aging veterans' needs for same-day appointments.

U.S. health care and the Department of Veterans Affairs (VA), Veterans Health Administration, are transforming a fragmented health care delivery system to a cohesive Patient Centered Medical Home (PCMH) known in VA as the Patient Aligned Care Team (PACT). A PACT encompasses care coordination among health care team members maximizing veterans' health outcomes and access to other services. In particular, timely specialty care availability can be problematic. Thus PACT emphasizes strong specialty service collaborations using service agreements and fostering specialty services as "neighbors" within the PACT.[1-3]

This article describes an innovative, exportable model, embedding dermatologic specialty care within geriatric primary care at the North Florida/South Georgia Veterans Health System (NF/SGVHS), Gainesville division. We believe this prototype embedded clinic could readily be adopted in any VA primary care setting, thereby paving the way for specialty care-PACT partnerships.

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BACKGROUND

Since the NF/SGVHS Geriatric Primary Care Clinic began in 1997, we have served about 1,800 unique veterans annually, 90% of whom are 75 years and older. Skin cancers are up to 20 times more common in the elderly and particularly for us because our Floridian veteran population often has a ubiquitous sun exposure history.[4] Hence, we often referred veterans with skin lesions to our off-site VA dermatology specialty clinic about 6 miles away. Before inception of our embedded clinic, our provider staff submitted about 300 dermatology consults yearly to this off-site clinic. Moreover, because our dermatology clinic was distant from our Geriatric Primary Care Clinic, same-day appointments were impractical or unavailable. This posed a hardship for frail veterans or those traveling long distances. Primary care providers (PCPs) rarely had time during routine visits to evaluate veterans' skin problems in depth due to the pressing need to manage chronic diseases, disabilities, and psychosocial issues. These brief appointments usually resulted in dermatology referrals that might otherwise have been managed on the same day. Serendipitously, this need for greater access to a "user-friendly" dermatology specialist for our geriatric veterans coincided with one of our physician's interest in skin diseases. Thus, the concept of embedding a dermatology clinic in our Geriatric Primary Care Clinic was born.

PLANNING AND IMPLEMENTATION

Dr. von Zabern, an internal medicine board-certified physician with dermatology, fortified her skills in dermatologic disorders by working directly with our chief of dermatology until he verified her competence to independently manage dermatology cases. Additionally, Dr. Von Zabern attended the University of Florida College of Medicine Dermatology grand rounds for continuing education and other academic dermatology conferences providing surgical skill labs. Dr. von Zabern's clinical privileges were amended, adding complete dermatology examinations, cryosurgery, and punch, excisional, and saucerization biopsies. Our local medical executive committee approved the additional privileges with the chief of dermatology's concurrence. Similarly, the Geriatric Primary Care Clinic nursing staff were trained and developed dermatologic competencies collaborating with the physician providing dermatologic care.

We obtained supplies, including a cart containing biopsy materials, an appropriate examination chair, and a hyfrecator, which emitted low-power electrical pulses for lesion desiccation or fulguration. Our Medical Administration and Clinical Informatics Services team created the clinic schedule and Clinical Patient Record System (CPRS) Geriatric Primary Care Dermatology Consult for our clinic providers. The CPRS consult prompts

providers to order a Medical Media consult for digital images before consult submission. Photography documents the lesion's location for clinical review. Additionally, the image enables the physician to assess whether the veteran's condition is right for the clinic's level of care vs requiring formal dermatology consultation. Currently we are not performing teledermatology services.

PROCEDURES

The dermatology consults of the geriatric PCPs are sent to the printer of the geriatric dermatology physician's office for image and case review and scheduling. The consults appear as CPRS view alerts to 2 assigned clinic clerks and the physician for redundancy, ensuring veterans are scheduled. Veterans receive an appointment within 14 days of consult submission, and in some cases a same-day appointment. Presently there are five 1-hour weekly morning consult appointment slots with overbooking allowed. We also have 6 half-hour appointments in a separate dermatology return clinic. Staff attempt to accommodate walk-in veterans with a concerning skin lesion on the same day. One registered nurse assists the physician who provides the dermatology services.

On the veteran's arrival, the physician introduces herself as the internal medicine physician serving the clinic and has the veteran change into a gown. The veteran's history is obtained regarding the referring chief concern, past medical problems, and previous skin cancers. The physician completes a thorough skin examination from the vertex of the scalp to between the toes. Rarely is the referring concern the only problem, and often additional dermatologic issues are present. Diagnostic procedures are performed the same day as the examination, reducing appointment bookings and travel and increasing access. Because our geriatric veterans have sustained extensive solar damage, cryosurgery of actinic keratoses is frequently required the same day as skin neoplasms are addressed. Anticoagulant cessation is not required. Biopsies are typically limited to 3 per visit, to reduce veteran confusion. After informed consent process completion and prior to biopsy, the veteran signs the informed consent document electronically, using the VA's iMedConsent software program.

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The clinical approaches are (1) performing a thorough skin and lymph node examination; (2) managing the simpler dermatology needs of our veterans; and (3) facilitating a specialty referral when appropriate. Lesions suspected of being a superficial cutaneous malignancy will have saucerization excision to a depth below the deep margin of the tumor, followed by curettage and electrodesiccation 3 times.[5-7] A biopsy of pigmented lesions is performed for diagnostic purposes, using a deep shave biopsy to a depth greater than 1 mm, usually 2 mm to 3 mm, with a 4 mm border. Although once controversial, saucerization biopsy has been shown to be the right approach for diagnosing melanoma.[8-11] However, veterans are always counseled that further excision and specialty care are required.

When pathology shows a localized malignant neoplasm, veterans always return within 3 months to the dermatology clinic to confirm the malignant neoplasm's eradication. Each biopsy site is examined visually and by palpation. If there is any possible malignancy recurrence, the physician performs a punch biopsy to further evaluate. Veterans are referred to the surgical specialists for complete neoplasm excision when lesions are high risk, either by ill-defined margins, facial H zone location, or histopathology.[9,12] Dermatology or plastic surgery referral occurs for difficult or questionable cases, using the lesions' initial photographs to facilitate the specialty consultation. All pathology results are compared to preoperative diagnoses for clinical care, practice evaluation, and performance improvement purposes.

Although the clinic was designed for basic dermatology problems, we treat primarily precancerous and superficial nonmelanoma cutaneous malignancies. Occasionally, veterans have presented with other important previously unrecognized dermatology problems. For example, one veteran was newly diagnosed with herpes simplex virus 2, through the process of history, examination, and confirmatory studies. Another veteran presenting for biopsy of a suspicious skin lesion was treated for shingles during the same visit.

Following biopsies, the nurse and physician provide the veteran with verbal and written instructions and wound care supplies. Veterans are educated on skin protection by using sunscreen daily, wearing pro-

tective clothing, and avoiding the sun between 10 AM and 4 PM. They receive the physician's business card with contact instructions if there are wound healing or other concerns. Finally, veterans are instructed that the physician will contact them in about 2 weeks with the pathology results.

If veterans have had a localized cancer diagnosed, they are scheduled to the Geriatric Dermatology Return Clinic in 3 months where the biopsy results are reviewed and the skin examination is repeated, confirming all lesions were completely treated and for new skin cancer surveillance. If new suspicious lesions are identified, biopsies are performed. If no new suspicious lesions are present, veterans are discharged to their PCP with instructions to the provider to perform an annual skin exam. Veterans are also educated that they and their caregivers should examine the skin for new lesions. If veterans find a suspicious area on skin examination, they are asked to come to the Geriatric Dermatology Clinic the same day whenever possible. The Geriatric Dermatology physician will then see the veteran (scheduled in the urgent dermatology appointment slot) and perform a biopsy, if warranted, right then. This saves the veteran repeated trips to the medical center.

RESULTS

Since the start of the Geriatric Dermatology Clinic, March 2010 through late September 2010, we saw more than 50 veterans and diagnosed multiple skin cancers, including melanomas. Moreover, we had about 75 consults quarterly to the offsite Dermatology Clinic reduced to about 2 consults quarterly, after the clinic began—an impressive 97% decrease. Since September 2010, we have performed an additional 250 consultations. Often we accommodated veterans on the same day of their routine primary care appointment, obviating a second clinic trip. This is particularly helpful for elderly veterans who find travel difficult due to distant geographic location, marginal family support, or their frailty.

CONCLUSION

As part of system redesign principles and veteran-centric care in the spirit of the PACT, the NF/SGVHS Geriatric Primary Care Clinic implemented a successful embedded specialty Geriatric Dermatology Clinic within its primary care framework, to better meet the growing demand for dermatology care in our aging veteran population. The demand is demonstrated by the clinic's popularity such that we have added appointments to the original clinic schedule, thereby allowing health care trainees to participate in a geriatric dermatology learning experience. Because all PCPs have basic dermatology skills, serving as building blocks for further education and training in this specialty, this particular model can be readily exported to any other VA primary care clinic with the local expertise and interest. ●

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