

Integrating Resident Education into PACT: Experience of the Portland VA Medical Center

Presenters:

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Overview of this seminar

- Key differences between a teaching clinic and a non-teaching clinic
- Unique implications for implementing PACT model in teaching clinic
- Insights and innovations developed in PVAMC Teaching clinic
 - Process used to advocate for change
 - Staffing model
 - Team structure & function
 - Teaching learners about PACT
 - Meaningful integration of residents in PACT teams

Poll Question #1

Please tell us which of the following statements best describes resident education practices in your VA facility:

- We don't do resident education at our facility.
- Residents are not assigned to PACT teams.
- We're developing plans to assign residents to PACT teams.
- Residents are on PACT teams in one clinic/CBOC.
- Residents are on PACT teams at more than one clinic/CBOC.

What's different in a teaching clinic?

- Dual mission: resident education AND patient care
- Provider profiles are different
 - Staff Providers are engaged in teaching and research
 - Only in clinic part time; multiple competing responsibilities
 - Resident Providers
 - Only available episodically; multiple competing clinical responsibilities
 - Variable interest in primary care
 - Frequent turn over
- Clinic staff have to function as educators, evaluators
 - Willing (excited?) to “start over” with each new cohort
 - Willing (excited?) to teach
 - Willing to correct the same mistakes over and over...
- High functioning clinic translates to improved ability to recruit future PCPs

PACT in a Teaching Clinic: Unique Implications

“Natural” disadvantages

- Multiple PCPs (faculty and residents) per PACT team leads to:
 - More challenges for coordination, scheduling logistics, communication
 - PACT team members have to adapt to multiple provider styles
 - Multiple providers from same team may practice simultaneously
- Part-time providers create challenges in preserving continuity & access
- Part-time providers are less available to assist in day to day patient care triage translating to a greater burden placed on nursing staff
- Regular resident turnover disrupts team continuity

“Natural” advantages

- Residents expect to be learning, enabling a true team approach
- Providers often have research and best practice expertise that facilitates PACT activities like population management
- Diversity of roles can contribute to higher staff satisfaction, as supported by Demo Lab employee survey results 2010-2011
- Greater autonomy and potential for leadership for nursing staff

Insights and innovations developed in the Portland VAMC resident clinic

This presentation draws on the work of many clinic staff:

RNs:

Andrew Marges
Denona Lee (Operations Manager)
Jenny Richardson

LPNs/MAs:

Maria Anderson
Kristine Hendrickson
Mystery Wells

Providers:

Elizabeth Allen
Linda Lucas
Carol Sprague
Lisa Winterbottom

Pharmacy:

Eric Huynh

Social Work:

Yvette Arey

Clinic snapshot



- All Residents conduct Primary Care Clinic at same site.
- Resident Primary Care Practice is completely comprised of part- time providers:
 - 12 staff providers
 - 43 resident providers
 - 4587 patients (as of 1/12).
- Majority of staff providers conduct 1-2 half days of clinic and 1-2 half days of precepting per week.
- Since 2011, residents on “3 +1” schedule
- Panel sizes for residents start at 35 patients in Y1, grow to 75 by Y3
- Staff provider panels are 130 patients per half day of clinic.
- 5 PACT teams as of June 2013; 2-4 staff providers plus 8-9 residents per team
- 1-4 providers from the same team may conduct clinic at the same time.

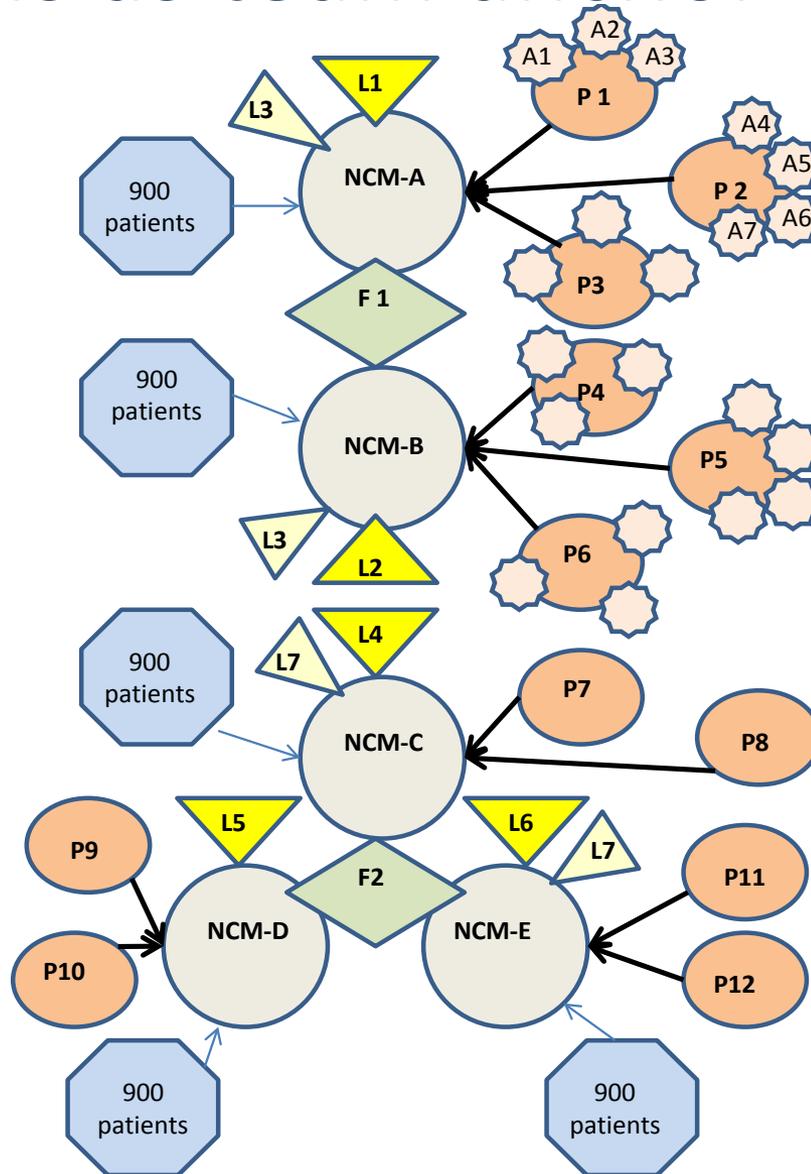
How we advocated for change – and got it

- Our group developed a detailed proposal for what WE needed
 - Identified what was different about the resident clinic
 - Highlighted mismatches with current PACT model
- We took a multidisciplinary approach, involving invested people from all roles in clinic
 - Team members collected data on time use
- Our Primary Care leadership was open and supportive, asked clinic team to present the plan to executive leadership

Advocating for Change

Team Member	Staffing Level in 2011	Proposal/Rationale
RN – team anchor	-3 RN’s for 4600 patients -Panel size 1500 – 1600 pts/RN	5 RN’s for 5 teams -Maximum panel size 800-900 pts/RN -70% time direct care, 30% other PACT roles
LPN/MA	-1 LPN per team -Total of 3 LPN’s	1.5 LPN’s/team (7 LPN’s total) -This number would allow 1 team LPN to always work with team providers
Admin	1 facilitator 2 LPN’s cross-covering this role 1 admin	4 Administrative Staff: -2 full time facilitators -1 front desk administrative assistant -1 dedicated administrative CSS staff
SW	1 SW for 5800 patients	-1.5 SW for Area 4 (1 SW/3100pts) -Separate SW for Women’s Health
Pharmacy	1 Pharmacist for 5800 pts plus additional work for pharmacy	1 Pharmacist for Area 4 (4600 pts) -remove Women’s Health, remove extra Pharmacy work

Staffing model as of 6/2013: NCMs as team anchor



NCM-A Nurse care manager team A

L1 LPN/MA team A

L2 LPN/MA team B

L3 LPN/MA team A & B

P1 Staff Provider team A

A1 Associate provider team A

F1 Facilitator team A and B

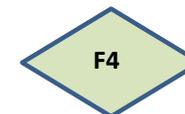
F2 Facilitator teams C, D & E

F3 Front desk

F4 CSS



Covers Front Desk



Covers Phone Calls (CSS)

Team roles: some observations

- Since the NCM is the core of the team, s/he must function more autonomously and have a higher skill set than has been the case in the past
- LPN role also requires more diverse skills than in other clinic settings
- To help achieve these performance standards:
 - We've attempted to recruit more experienced RNs;
 - All team members are involved in interviewing candidates;
 - We've made aggressive use of feedback from providers to help develop performance plans, and followed up on them.

Teaching residents about PACT

Poll Question #2

Which best describes your facility?

We have developed new resident orientation practices to teach specifically about PACT...

- 1) A lot
- 2) A little bit
- 3) Not at all
- 4) Not sure

Teaching residents about PACT

- Resident orientation now includes expanded time devoted to:
 - Processes for communication, in team and with patients
 - Team function in managing chronic illnesses
 - All team members participate in orientation
- Ambulatory Curriculum overhaul led to development of practice management sessions for each +1 week
 - Team members participate in these sessions

Living the team approach

- During their first week in clinic, residents shadow the RNs and facilitators, to understand what they do
 - Shadowing repeated later in intern year, when residents are more experienced
- Evaluation of residents is done by all team members
 - More diverse feedback contributes to improvement
 - Very effective with some residents
- Time spent with residents on process issues like recall management and opioid management
- Orientation constantly reinforced in practice, in management and weekly large team debriefs

Challenges

- No huddles – full team is *never* all there
 - Response: Friday “debrief” with all clinic staff
- Access for routine chronic care management is excellent, BUT it’s rarely possible to achieve same day access with own provider
 - Access for acute care is in reality excellent – patients can get same-day/next day access with a member of team - but that does not count toward performance metric
 - Continuity scores likewise suffer
 - Possible response: develop new performance metrics to capture this dynamic?
 - The question remains: is this as good as being seen by your provider? This is not yet known.
- Poorly designed space and lack of sufficient space to achieve PACT goals and educational mission simultaneously

Concluding points

- Teams work better when residents have dedicated outpatient time with no other competing clinical duties
 - “3 +1” works in our setting; more than 3 weeks out of clinic would probably not work
 - Residents learn a lot more about full process of team-based care, using this approach
- An RN centric PACT model works better in our clinic staffed by multiple part time providers
- Creative structure to huddle sessions allows us to involve residents
- Nurses and administrative staff have to embrace the educational mission

Thank you

Interested in seeing our PACT training materials for residents?

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Educating Primary Care Residents about Primary Care Mental Health Integration within PACT

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Kristin Kopelson, MS, RN, NP, FNP-BC, ACNP

Susan Vivell, PhD

VISN 22 VAIL PACT Team

Objectives

- Why is it important for primary care residents to learn about Primary Care Mental Health Integration (PCMHI)?
- How have we changed our approach to teaching residents about PCMHI within PACT?
- Preliminary results of evaluation
- Challenges and opportunities

Resident Physicians in VA

- 65% of US physicians in training are educated within VA.
- They are an important part of the VA workforce.
- They carry what they learn in VA into their future careers within VA and beyond.

Behavioral Health in VA Primary Care

- Most mental disorders are treated in primary care.
- Mental disorders and health behaviors (including self-care) impact outcomes of medical illness.
- Patient Aligned Care Teams (PACT) and Primary Care Mental Health Integration (PCMHI) provide opportunities to improve the quality of behavioral health within primary care.
- Primary care residents can benefit from training to effectively collaborate with PCMHI to improve the behavioral health of their patients.

Previous approaches

Didactic Methods:

- One month psychiatry rotation for family medicine residents (Christiansen 2003, Tinsley 2000)
- Didactics (lectures, case conferences, games, skills training and practice, simulated patients) (Huzij 2005, Hottema 2012, Stein 2011)
- Psychiatry residents provide consultation & didactics in PC clinics (Servis 2000)

Content areas:

- General behavioral health
- Substance abuse (Alford 2009; Nigwekar 2006)
- Homelessness (Buchanan 2004, 2007)
- Brief interventions:
 - Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Hettema 2012)
 - Problem Solving Treatment (PST) for depression (Hegel 2004)
 - Motivational Interviewing (Triana 2012)
 - Enhancing patient self-efficacy (Jerant 2009)

Key principals for teaching adult learners

- Subject must be relevant to the learner's experience
- Active learning (“Learning by doing”)
- Learning within the context in which the knowledge will be applied
- Specific competencies as learning objectives

(Knowles 1990, Savory & Duffy 1995)

Our previous strategy for teaching PC residents about mental health

- One afternoon a week for 4 weeks
- Residents completed 2-3 psychiatry consults per week
- Limited opportunity for follow-up visits
- Resident evaluations:
 - High satisfaction
 - Residents liked practicing in-depth assessments and spending more time with patients
- However, later informal feedback from PC residents suggested that they did not often apply new skills and knowledge in their own PC practices.

New Model

- During PC continuity clinics medical residents come to a central conference room for supervision from medical attendings.
- Psychiatry attendings are now present during that time to provide:
 - Information about behavioral health resources
 - Supervision of residents' management of behavioral issues (e.g., uncomplicated depression, anxiety, substance misuse, health behaviors)
 - Same-day consultation for complicated or urgent mental health concerns

Overall Goals

- Improve resident skills, knowledge, and confidence related to behavioral health in primary care
- Improve access to and quality of mental health care in primary care

Measures

- Resident/Attending satisfaction
- Resident Pre-Post Knowledge Assessment (pilot)
- CPRS data
 - Number of consults generated
 - Number of completed consults

PDSA cycle 1

- Implement model
- Obtain formative feedback from attending physicians
 - Mostly positive
 - Wanted medical attending involved in the discussion of behavioral management of the patient
 - Suggested use of educational materials and possibly didactics

PDSA cycle 2

- Implement modifications
- Develop educational materials
 - Depression
 - Anxiety
 - Substance abuse
 - Motivational interviewing
- Develop CPRS outcome measures
- Pilot test knowledge survey

Outcomes: Resident Satisfaction

- Resident satisfaction
 - How helpful with care of patients (3.3/5)
 - How much did you learn (3.2/5)
 - How much did you enjoy learning (3.2/5)
 - Suggestions for improvement:
 - “Doing a great job. Keep it up!”
 - “Enjoyed the experience; very convenient to have mental health in our office during PACCC”
 - “More support. We don’t really have too much interaction with MH providers.”

Outcomes: Resident Knowledge and Attitudes Assessment (pilot test)

	June 2012 N=22	June 2013 N=13
	% (N)	
Definitely or probably need to improve how you manage depression	67% (14)	54% (7)
Very or somewhat skilled in using antidepressants	33% (7)	62% (8)
Behavioral problems adversely affect medical outcomes in my patients (moderately or a lot)	80% (16)	62% (8)
Major Depression vignette		
Assess but not treat	41% (9)	38% (5)
Personally prescribe medication	55% (12)	62% (8)
Personally counsel	59% (13)	62% (8)
Refer to MH specialty	60% (14)	85% (11)

Pilot Resident Survey (continued)

	June 2012 N=22	June 2013 N=13
	% (N)	
Moderately or frequently do the following when talking to patients about depression		
Encourage positive thinking	36% (8)	54% (7)
Increase pleasurable activities	41% (9)	70% (9)
Reframe or clarify problems	50% (11)	70% (9)
Discuss how depression affects medical illness	41% (9)	62% (8)
Correctly identify medications that interact with antidepressants	38% (8)	54% (7)

Process of Care Outcomes

Consults from WLA PACC to WLA Mental Health Integrated Care Team	8/ 1 /11 – 5/31 /12		8/1 /12 – 5/31 /13		Change from 8'11-5'12 to 8'12-5'13
	NUMBER	PERCENT	NUMBER	PERCENT	
MHIC Consults from WLA PACC Clinics: TOTAL	559		505		-10%
Consult Requestors					
Attendings	362	64.8%	258	51.9%	-29%
IM Housestaff	90	16.1%	120	23.4%	33%
NPs & PAs	107	19.1%	127	24.8%	19%
Consult Status					
Completed	385	68.9%	412	81.7%	9%
Cancelled or Discontinued	174	31.1%	73	14.2%	-63%

Process of Care Outcomes (con't)

WLA PACC Consult Requestors	8/1 /11 – 5/ 31 /12		8/1 /12 – 5/31 /13		Change from 8'11-5'12 to 8'12-5'13
	NUMBER	PERCENT	NUMBER	PERCENT	
MHIC Consults from WLA PACC Medicine Attendings: TOTAL	362		258		-29%
Completed	259	71.5%	213	82.7%	-18%
Cancelled or Discontinued	103	28.5%	34	13.2%	-67%
Scheduled	0		11	4.1%	
Consults from WLA PACC IM Housestaff: TOTAL	90		120		33%
Completed	57	63.3%	97	80.8%	70%
Cancelled or Discontinued	33	36.7%	22	18.3%	-42%
Scheduled	0		1	0.1%	
Consults from WLA PACC NPs & PAs: TOTAL	107		127		19%
Completed	69	64.5%	102	80.3%	48%
Cancelled or Discontinued	38	35.5%	16	12.6%	-60%
Scheduled	0		9	7.1%	

Challenges

- Buy-in for addressing behavioral health issues when clinic is busy
- Finding opportunities for formal teaching
- Temptation of PCMH providers to take over care themselves rather than supervising residents in providing the treatment
- Tracking PCMH provider workload
- Changes in PCMH and PACT implementation and staffing in the clinic overall

Preliminary Lessons Learned

- New model appears to have increased:
 - Number of patients referred by residents to mental health
 - Proportion of those patients completing a MH assessment
 - Self-reported likelihood to treat depression (including use of antidepressant medication and personal counseling)
- However:
 - Lower resident satisfaction than with previous model

Next Steps

- Psychiatry lectures to be added to PC resident didactics
- Improve orientation for PC attendings and residents
- Increasing PC resident and attending involvement in program design
- Improve uptake of knowledge & attitude survey
- Producing tool-kit:
 - Educational materials
 - CPRS templates for notes, consults
 - Resident knowledge survey
 - Satisfaction assessments
 - Outcome measures
- Dissemination to other sites



Questions?

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