

Using Qualitative Methods to Understand and Inform the VA's PACT Initiative: The experience of Patient Aligned Care Team (PACT) members

George Sayre, PsyD

Health Science Researcher & Qualitative Resources Coordinator,
VA Puget Sound Healthcare System, Denver & Seattle HSR&D Center of Innovation

Clinical Assistant Professor, Health Services
University of Washington, Department of Health.

George.Sayre@va.gov

Purpose

- Introduce qualitative research methods as a useful approach to gaining a better understanding of PACT.
- Present two distinct examples of qualitative research methods used to study pact.

Poll: How would you describe your familiarity with qualitative research?

1. Not much, but interested enough to sign up for the webinar.
2. Read it and interested using it in the future.
3. Have collaborated on projects with qualitative researchers.
4. Have done some qualitative research, but not my regular research approach.
5. It is what I do most of the time.

Why qualitative research?

- Qualitative **research questions** tend toward the inductive; moving from specific observations to broader generalizations and theories.
- **Data** that lends itself to qualitative studies tends to be, complex, ambiguous or otherwise open to interpretation.
- The **purpose** of qualitative research is to explore, discover, and better understand the phenomena being studied and to give voice to participants' experience.

Poll Question

What is your involvement with PACT?

- 1) I am a member of a PACT teamlet
- 2) I am researching or evaluating PACT
- 3) I am an administrator implementing PACT
- 4) I am involved with PACT in another capacity
- 5) I am unfamiliar with PACT

Secondary data analysis

- We conducted a retrospective content analysis of open text “general comment” responses to the 2012 PACT survey fielded to all VHA Primary Care personnel.
 - “Is there anything else you would like us to relay to the VA leadership in Central Office?”
 - “Do you have any other comments or feedback on PACT?”
- A total of 6,467 surveys were returned, of which 3,868 included responses to one or both open-text questions .

Study objectives

1. Contribute to evaluation of the PACT initiative and the broader literature on PCMH by assessing respondents' experiences of implementing a PCMH model and becoming a teamlet.
2. Examine how the experiences of team members affect **work satisfaction** and PACT teamlets' **abilities to implement a model of patient-centered care**.

METHOD

- Responses were analyzed using simultaneous deductive and inductive content analysis. (Elo & Kyngäs, 2008).
 - Inductive content analysis consists of open/unstructured coding and allows for the identification of emergent previously unidentified or unexpected themes.
 - Deductive content analysis is more structured and consists of identifying “meaning units” (discrete phrases, sentences, or series of sentences which convey one idea or one related set of perceptions) that fit within pre-identified *a-priori* categories. *A-priori* codes included:
 - barriers and facilitators to PACT implementation
 - Job satisfaction
 - Burnout.
- Participants were 1,705 VHA primary care physicians, nurse practitioners, physician assistants, nurse care managers, clinical associates, and administrative clerks.

Findings

- We identified seven higher order categories:
 - *Holistic teamlet experience*
 - *Burnout of team members*
 - *Perceived effects on patients*
 - *Level of competency within teams*
 - *The unheard voices of team members*
 - *Unintended consequences of PACT*
 - *Respondents' suggested improvements for the PACT model.*

Findings (cont.)

- While respondents viewed PACT positively as a model, and reported it improved relationships with patients and increased patient satisfaction, they described multiple barriers to achieving functioning teamlets and unintended consequences, including:
 - reduced time with patients
 - increased participant burnout
 - decreased team efficacy due to low performing team members.
- A central theme related to staffing being insufficient for the new model.
- **Practice Implications:** Insufficient staffing of PCMH teams is a critical barrier to realizing the benefits of the new model. Frontline staff have concrete recommendations for other problems, such as using back-up teams to cover during absences, but that will require providing more opportunities for feedback from staff to be heard.

Holistic Teamlet Experience

- Overall satisfaction with teamlets in terms of the impacts they have had for their teams and patients. *“Because of our [team] huddles and constant communication with our PACT team, we have taken initiatives to improve patient care.”*
- Dissatisfaction with the implementation of PACT teamlets due to barriers such as under-staffing and limited resources. *“PACT model is awesome, but in order to make it work, each teamlet needs to be fully staffed. We are lucky that our team is staffed, but it’s not the same in every team and it really affects their measures and productivity.”*
- Inconsistent implementation across PACT teamlets within the same clinic. *“[different teamlets] functioned significantly differently. One is very efficient and organized and the other, not so much. We all had the same initial education. It is interesting to see the difference.”*
- Staffing Ratios and Resources. *“Ideally, PACT would be a good system; however, not realistic due to lack of staff and not enough hours in the day to complete the work that we are supposed to do.” “Space has been the most negative factor in implementing the PACT model ... there is not enough equipment, such as faxes [and] printers, available to send and get patient information” “Currently we are limping along putting out fires and becoming burnt out in the process. We were never given the tools to succeed.”*
- Training: *“It would be helpful if the training could take place before changes are mandated. It’s a little like being dropped in the middle of a lake and told to swim when you’ve never done it.” “[PACT is] a great idea but hasn’t been implemented properly, largely due to staffing shortages but also due to poor attitude and training of staff.”*
- Scheduling: *“We have to become serious about not seeing walk-ins or being a ‘by appointment only’ clinic. The walk-ins are overwhelming and they have not been reduced.” “The clinic is chaos. Running at crisis level virtually all day every day.” “No ability for the staff to adjust appointment times/slots to accommodate patients that need more/less time with the PCP.”*
- Distractions of Telephones and Computers. *“There is not enough time in the day to deal with appointments, calls, secure messaging, emails etc.”*
- Phone call volume: *“Currently phone calls are going into nurses’ office - all phone calls should be diverted to central line so that the phone is not ringing all day in the nurses’ office - clerical staff should be answering the phone calls.” “Care managers should not be spending so much time creating reports for facility leadership and manning a nurse call line but instead, providing care management to patients.” “Monthly PACT meetings interfere with patient care.”*
- Need for clear expectations for all team members, including leadership. *“I think there should be accountability of management for the fact that our staffing is such that PACT cannot be implemented. Our veterans are hurt by their lack of attention and leadership.”*

Burnout for All Team Members

- *“PACT has added many new duties without promised resources and has offered no new pay increases or incentives. It has brought on many inconsistencies from team to team and decreased job satisfaction.”*
- *“Burnout of my colleagues is a huge problem; I am worried we will lose some of our best providers.”*
- *“burning out rapidly.”*
- *“The biggest issue is if a Team Member is gone continuity of care becomes compromised and the workload may double or triple for at least one member of the team - usually the RN or LPN.”*

Perceived Effect on Patients

Positive :

“[patients] love [PACT]” and “feel more involved in their own care.”

“From the beginning of this PACT implementation, many veterans have really benefitted from it and they love the program [...] they can reach their teamlet, either through phone or secure messaging.”

“It really builds relationships with Veterans. And you get to really know them as you case manage them, and help them get their needs met sooner rather than later.”

“Most importantly, the veterans are very satisfied with the change.” “PACT has been very helpful toward patient care; however, it has overburdened the staff.”

Negative:

“Patients don’t understand PACT and how to be more responsible for something as simple as refilling medication. Many of the older vets don’t like using the telephone for reorders and prefer to have the PCP or Pharmacist reorder for them.”

Level of Competency within Team

- Burden of clerical work: *“I am an LPN but I feel like a glorified clerk most of the time. I do more clerical work than nursing.”*
- Working to level of training *“[I] will feel better once I have attended the PACT training. Teamwork has significantly improved with the PACT model and everyone is working to their highest training level.”*

The Unheard Voices of Team Members

- Feeling undervalued for their work and felt caught in a system without being heard. *“Listen to the concerns of the people in the trenches.”*
“When we have ideas to improve, leadership does not listen or work with us.”
- Disconnected leadership: *“[I] do not feel that upper management really understands what is going on in the clinics.”*
- Sense of powerlessness: *“There is a commanding and condescending tone when our leaders communicate with us. I feel as though we are not considered part of the process. One day we are simply told this is how we are doing such and such. We want more autonomy within our clinics.”* *“Decisions about how to do my job are made with no input from me, my questions go unanswered, and my requests for education are denied on frivolous grounds.”*

Unintended Consequences of PACT Implementation

- Within Team Conflict and the Effect of “Weakest Link”: *“This [teamlet model] will not work for a slacker.” “If one person isn’t doing what needs to be done it fails our whole team, and we need to be able to rely on each other!” “The success of the teamlet is limited by the weakest link.” “We need a full team, full time. We need enforcement and consistency of each staff level expectations. Clear expectations of all members across the board.”*
- Atmosphere of Anxiety: *“All [leadership] cares about is the number of patients to be seen in the clinic, not the quality of care.” “PACT seems to be too number-driven. [It] creates an atmosphere of anxiety. Teams [are] trying to improve numbers at the risk of good patient care and individual patient evaluation.” “We have been told that if we think we are working too hard that there are people waiting in line for our jobs.” “Since [the] PACT change, I have less interaction with the patients and feel ‘pushed’ all the time. I miss being with the patient.”*

Respondents' Suggested Improvements for PACT Model

- Increased Planning: *“The whole program should have been worked out entirely instead of a learn-as-you-go thing.”*
- Care Plans and Specific PACTs for Chronic Pain Patients: *“comprehensive pain program and living with chronic pain with all the specialists available and other resources not to be managed by primary care” and “a PACT team just to manage patients with chronic pain issues.”*
- Back-up Teams: [Back-up teams] *“could provide an extra hand” “There needs to be a sub system for call offs/vacations so that teams are not pulled apart to other staff areas.”*

Bibliography

- Ladebue A, Helfrich CD, Gerdes Z, Nelson K, & Sayre G. Primary care personnel experience of a Patient Centered Medical Home initiative. *Health Care Management Review*. (In press)
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x
- Sandelowski, Margarete. "Sample size in qualitative research." *Research in nursing & health* 18.2 (1995): 179-183.

Using Qualitative Methods to Understand and Inform the VA's PACT Initiative

Anais Tuepker, PhD, MPH

Core Investigator

Center to Improve Veteran Involvement in Care (CIVIC)

VA Portland Health Care System

VA HSR&D PACT Cyberseminar Series

11/19/2014



There is no one “best” approach to collecting and analyzing qualitative data.

Good choices often result from considering:

What *kind of* question am I trying to answer *now*?

What kind of question....

Trying to:

- improve a process?
- test a theory?
- understand a different perspective?
- explain how a situation developed?

Considering the purpose helps structure the questions to be asked, of whom, as well as where, when and how to ask them. Different theoretical approaches are suited to different types of questions.

What kind of question *now*?

The same qualitative data can often be used to investigate different kinds of questions – but you may want to change your methods of analysis.

Example:

VISN 20 PACT Demo Lab: Early and Later
Analyses

Early Analysis

- Data collected 12/2010-2/2013
- Framed as a needs assessment:
 - What were the barriers getting in the way of PACT implementation?
 - How could the effort be refined/improved?
- 15 participating clinics
- 32 focus groups (stratified by PACT team role)
- 21 interviews (clinic managers, and by request)
- Open-ended employee survey responses

Analytic Methods

- Hybrid approach to content analysis: inductive and deductive coding
- Double-coded, iteratively discussed for consensus
- Surveys not coded, used for “triangulation” only

Findings

Some overall themes (*Tuepker et al. 2014 JGIM*):

- Rift between PACT theory and reality
- Creating a well-functioning team comes first, faces challenges
- PACT requires greater primary care control within a supportive, well-aligned system
- Training is needed for specific PACT skills
- Facility and clinic leadership must champion employees and the PACT model

The **pervasive influence of performance measures** on PACT implementation, including unintended consequences, was a notable inductive theme (*Kansagara et al. JGIM 2014*).

Results shared with clinics and leadership and included in synthesis of Demo Lab findings, with potential to influence future PACT refinements.

Later Analysis

- Shift from formative needs assessment to summative (or long-term formative) evaluation
- Differences between clinics emerging as a focus – why did PACT play out so differently in different places?
- Difficulty in distinguishing between the intervention and its (measurable) outcomes at the clinic level ruled out some appealing methods (like Qualitative Comparative Analysis)

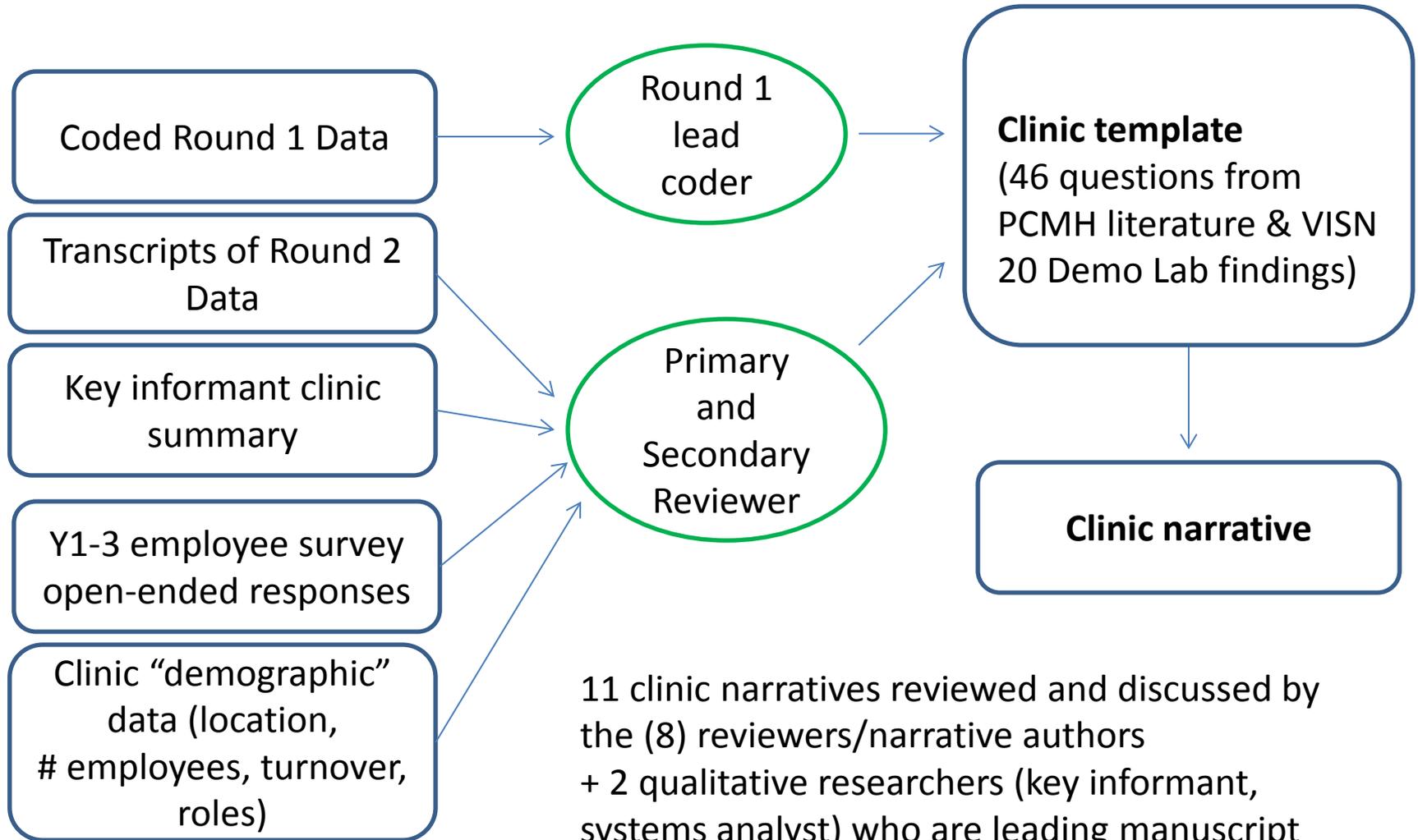
Realist (Evaluation) Approach

- “What works, for whom, under what circumstances?” (*Greenhalgh et al, 2009*)
- Understanding the dynamic that drives action/change (“context-mechanism-outcome” interaction)
- Unique contexts generate thought/theory about dynamics, in turn generating abstract/generalizable knowledge

Changes to 2013-2014 data collection

- More directed enquiry in focus group and interview guides, to themes found in earlier data collection
- Scaled back to 11 clinics
- 10 focus groups (1 per site), still stratified by role
- 21 interviews, but shift in recruitment to focus more on engaged employees
- 1-3 transcripts per site
- Creation of key informant summaries

Clinic narrative creation process



11 clinic narratives reviewed and discussed by the (8) reviewers/narrative authors + 2 qualitative researchers (key informant, systems analyst) who are leading manuscript development

Preliminary Findings

Common themes:

- Structural barriers continue to predominate
- Siloing (lack of communication/feedback/shared goals) often a strong negative influence, along with “top-down” implementation
- PACT making progress as an accepted cultural change within primary care

Diverging experiences:

- Challenges to staffing are not “one size fits all” (rural locations, “gateway” locations, and turnover cycles are all factors that may require different policy/practice solutions)
- Realistic expectations and phased implementation may have more sustainability than stellar effort without adequate structural support
- PACT culture, PACT “success,” and better employee morale may go together as a triad, but not always as a dyad

Reflections on methods

- Truly team-based approach to analysis enhances validity of findings.
- The end result has fewer quotes, more systems-level analysis, than much qualitative health services research.
- The creation of clinic narratives helps avoid a false “pre-post” framing, emphasizing instead the feedback loops of clinic experience.

Conclusion

- Identifying mechanisms of change is hard, as other realist evaluators (*Greenhalgh 2009*) have pointed out.
- This multi-step approach to consolidating data sources using an iterative, team-based approach to analysis proved to be a useful method within a realist evaluation framework.

Resources and References

Greenhalgh G, Humphrey C, Hughes J, Macfarlane F, Butler C, Pawson R. How do you modernize a health service? A realist evaluation of whole-scale transformation in London. *Milbank Quart.* 2009; 87 (2):391-416.

Kansagara D, Tuepker A, Nicolaidis C, Skaperdas E, Joos S, Hickam D. Getting performance metrics right: a qualitative study of staff experiences implementing and measuring practice transformation. *J Gen Intern Med.* 2014; 29 (2): 607-613.

Tuepker A, Kansagara D, Skaperdas E, et al. “We’ve not gotten even close to what we want to do”: a qualitative study of early Patient-Centered Medical Home implementation. *J Gen Intern Med.* 2014; 29 (2): 614-622

Comments/Questions?

Contact information:

George Sayre, PsyD

VA Puget Sound Healthcare System

Denver & Seattle HSR&D Center of Innovation

George.Sayre@va.gov

Anais Tuepker, PhD, MPH

Center to Improve Veteran Involvement in Care (CIVIC)

VA Portland Health Care System

Anais.tuepker@va.gov

tuepker@ohsu.edu