

PACT in Academic Medical Center Primary Care Clinics: A Focus on Access and Continuity

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Outline

- Brief history of medical education in the VHA
- Project goals
- Methods
- Findings
- Implications
- Q&A

Poll Question #1

What is your role? (Please choose all that apply)

- Primary Care clinic administrator
- Primary Care clinician or staff
- VA researcher
- Non-VA researcher
- Other

History

Over a half-century ago in 1946, a “radical” strategy was proposed to achieve quality in health care: an academic partnership between the Veterans Administration, later to become the Department of Veterans Affairs, and academic medicine. This partnership has grown into the most comprehensive academic health system partnership in history.

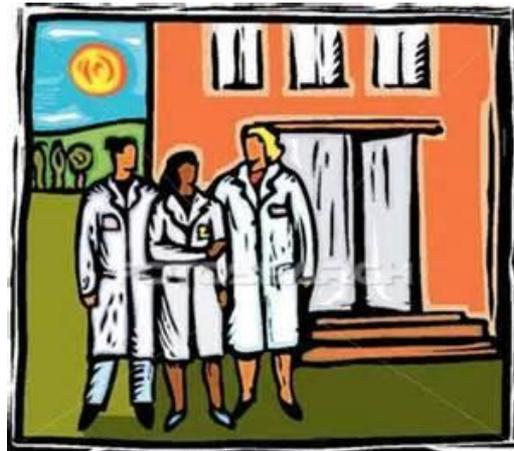


<http://www.va.gov/HEALTHPOLICYPLANNING/Vision2020.pdf>

Professional Education & Training

VHA conducts the largest coordinated education and training effort for health care professionals in the nation.

70% of physicians experience some portion of their training in VHA.



<http://www.va.gov/HEALTHPOLICYPLANNING/Vision2020.pdf>

Professional Education & Training

More than 76,000 health care professionals receive part of their clinical training in VHA facilities each year.

VHA trains health care professionals in the total care of the patient, because VA health care provides total care to eligible Veterans.



<http://www.va.gov/HEALTHPOLICYPLANNING/Vision2020.pdf>

VHA Vision

VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both **patient centered** and evidence based.

This care will be delivered by engaged, **collaborative teams** in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the nation's well-being through **education**, research and service in National emergencies.

Poll Question #2

Did you receive any portion of your training in a VHA facility?

- Yes, all of my training was in a VHA facility
- Yes, some of my training was in a VHA facility
- No, none of my training was in a VHA facility
- I am not a clinician

Project Origins

The VISN 11 PACT Demonstration Laboratory focused its efforts, in part, on understanding challenges to increasing access and continuity in academic Primary Care clinics implementing PACT.

This work started with a single case study that included semi-structured interviews with Primary Care physicians, residents, nurses, and clerks as well as observations of coaching sessions that were designed locally to help teams improve access and continuity.

Many challenges related to having part-time providers, both attendings and residents.

Project Goals

- Variation in features of academic Primary Care clinics
- How academic clinics approach coverage for same-day access, and factors that affect how successful they are at providing continuity and in meeting existing PACT access and continuity performance measures
- The positive and negative effects of these measures on care delivery
- Implications for revision of measures to better reflect and encourage clinic organization and processes that work to meet PACT goals.

Methods

- Semi-structured telephone interviews
- Members of Primary Care clinic leadership involved with residency program
- 19 VHA academic medical centers across 16 of 21 VISNs
- December 2013 – October 2014
- Interviews were recorded and transcribed verbatim

Analytic Approach

- Interview transcripts
- Comprehensive, structured summaries
- Matrix analyses to identify themes/patterns

Site Characteristics Varied Widely

- Total number of Primary Care patients (~9,000 - ~100,000)
- Percentage of patients with Resident PCP (2% - 43%)
 - Resident-only clinics vs. distributed throughout
- Number of attending physicians (5 – 40)
- Number of residents (16 – 144)
- Residency model (traditional, block, other)

Residency Models

Traditional ½ day of clinic per week (N=4)

Traditional, but changing to block (N=8)

Block (N=6)

Other (N=1)

Why Residency Models Are Changing

Scheduling

“...every month we have a problem with the scheduling...[and] there’s hardly any attendance at the pre-clinic conference”

[Site L]

Educational Experience

“It happened so residents could focus on out-patient medicine and in-patient separately, so they weren’t being pulled in various directions...We found that being able to focus on one or the other with the concentrated week has been preferable to both the residents and the faculty” [Site M]

Perceived Benefit of Block Models

Schedule Predictability: Block

“I think it’s extremely predictable and I can tell you today who’s going to be in clinic [one year from now]” [Site J]

Schedule Chaos: Traditional

“...every month we have a problem with the scheduling. The problem comes because patients are scheduled here and then the resident’s schedule doesn’t go with the schedule that we have for the patients...let’s say a resident has 6 patients scheduled...once the schedule for May comes out we find out that she’s not coming to clinic, so we have to cancel those patients or one of the attendings has to see those patients...we go through this every month...” [Site L]

PACT Continuity and Same-day Access Performance Measures

- Continuity and same-day access performance measures are focused on patient's usual PCP
- Continuity:
 - Proportion of in-person visits with the patient's usual PCP
- Same-day access:
 - Proportion of same-day or next-day in-person visits with the patient's usual PCP
 - Continuity built in to measure
- Generally, counts as assigned PCP if a patient sees either their usual resident or their usual resident's attending.

Coverage for Same-day Access: Residents

- **Academic Clinics Face Constraints in Providing PCP Continuity for Patients Seeking Same-day Access**

Residents have limited time in clinic

“for a patient to walk-in and see their provider [i.e., resident] on that same day...is virtually impossible in this system...they can see a team provider...seeing their own provider when the provider’s only here for one week out of five is very difficult.” [Site J]

Coverage for Same-day Access: Part-time vs. Full-time Attendings

- **Almost all sites had attendings who precepted part-time in clinic**
 - Had other patient care, research or administrative duties
- **More difficult to meet same-day access measure**
 - Limited time in clinic with their own patient panels
 - Less likely to be in clinic at the same time as their residents
- **Site that had full-time attendings who had time to see their residents' patients had no problem meeting the measure**

“Same day access is not a problem really...the attending will see the patient.” [Site L]

Coverage for Same-day Access: Most Sites Took a Team-based Approach

Site	1 st Choice	2 nd Choice	3 rd Choice
F	Resident's attending (RN if MD not needed)	n/a	n/a
L	Resident's attending	Attending's PA or resident	n/a
P	Team resident	Team NP Trainee	Team NP
G	Team resident	Team attending	Any open slot
H	Team resident	Team attending	Any open slot
M	Team PA	Team resident	Any open slot
Q	Team attending (RN if MD not needed)	Resident of team attending	Any open slot
N	Team resident	Any resident	Any NP or attending
D	Team resident	Any resident	
A	Team attending or resident	Walk-in clinic resident on ambulatory care rotation	n/a
S	Team attending	Walk-in clinic resident on ambulatory care rotation	Team resident
C	Any resident	Team attending	Any open slot
O	Any resident	Any attending	
J	Any resident	n/a	n/a
I	Walk-in clinic resident on ambulatory care rotation	n/a	n/a
B	Walk-in clinic resident or ambulatory care rotation or RN	Any PCP	
E	Walk-in clinic residents on ambulatory care rotation)	n/a	n/a
K	Walk-in clinic residents on ambulatory care rotation	n/a	n/a
R	n/a	n/a	n/a

Variation in Team-based Approaches

**Patient sees another team resident vs. resident's attending:
Reflect different training philosophies.**

Patients never see another resident, only an RN or attending “[walk-in patients] see the nurse or me...[residents'] panels are their own.” [Site F]

Team resident first in line to see an absent resident's patient “...if somebody really needs to be seen, they'll get seen by one of the other [team] residents who are there.” [Site G]

Incorporation of mid-level providers early in algorithm

- [the RN who's doing triage will] plug them in either with the PA, the physician assistant, which is the most common thing or sometimes... also plugged them into an open residents slots...each one of our PA's is assigned to one of the 4 PACT teams and then the residents are all spread out among the 4 PACT teams and so when, when convenient and possible they try to stick with the same PACT team for continuity” [Site M]

Varying Degrees Of Success In Providing Coverage That Promotes Continuity

The degree of formality and organization of coverage arrangements varied from...

Detailed algorithm for schedulers in the electronic scheduling system

“if you were to pull up CPRS...there’s an algorithm of who you would see. So if Dr. X is not here then his physician partner...If that physician partner...was not here...that nurse practitioner partner would see the patient...then the backup nurse practitioner would see the patient and if for like a freaky chance that still doesn’t work then there’s basically a same day appointment.” [Site P]

Varying Degrees Of Success In Providing Coverage That Promotes Continuity

...to simply hoping a team resident or attending would be available.

“we try to direct the residents to cross-cover for each other, but having said that...if the resident’s not able to, obviously an attending’s there, **the attending might be able to provide some support and then outside of that, it could potentially fall on...whomever’s available, I mean sometimes any of us in Primary Care are asked to help deal with a situation for a resident’s patient.**” [Site C]

Several Factors Affected Success

Predictability of resident and attending schedules

“P: ...when the resident’s not in clinic, they see their co-team resident and if no one on their co-team is available, then we put them in with any resident.

I: And how often do you think a co-team resident is there?

P: It’s just hit or miss because it’s so, it’s so up in the air” [Site D]

Ability to synchronize schedules of attendings and their residents

“their assigned physician is not always precepting them in clinic...[the] **assigned attending is on vacation or doing...whatever other hats they're wearing, so it’s just whoever the attending that happens to be in clinic that day...**”
[Site N]

Several Factors Affected Success

Availability of open slots

“P: 10 attendings that...all have interns and residents they all are in clinic today, no intern or resident is in clinic today.

I: Okay. So if a resident's patient comes in on a day where that resident's attending is there, is there any um, effort?

P: If the attending has access but 10 times out of 10 that attending doesn't have access.” [Site B]

Scheduler knowledge of coverage arrangements

Most Strategies for Providing Team-based Continuity Did Not Count Toward Meeting Measures

- **Coverage provided by a team member of the absent resident** (i.e., resident's attending, team attending, team resident, team mid-level provider, team RN).
- **Most of these arrangements didn't count toward meeting measures because:**

- **Attending in clinic not the absent resident's attending**
- **More than one associate provider part of the coverage algorithm:**
 - **Two or more residents, inter-professional trainees, mid-level providers**

“we can't put two associate providers in there at the same time...because the banner does not recognize a team. The banner is still very individual provider based...from the patient's perspective, they've been seeing one of the two team members and have no issue with the continuity but it's not being captured.” [Site G]

- **RN visits**

Positive Effects of Measures: More Attention Paid to Continuity

Matching walk-in patients with their resident's teamlet

“because of the metrics I think we've paid more attention to the continuity. We've tried to organize ourself within the PACT teamlets with a quarter of the residents on each teamlet and then **when urgent walk-in patients come in, we do make some conscious choice about trying to get them on the same teamlet and I think the metrics have led to that.**” [Site M]

Positive Effects of Measures: More Attention Paid to Continuity (cont.)

Synchronizing resident and attending schedules

“P: we try as much as possible for the residents to present to their attending when they’re available...And **then...talking to our university and saying, “We really would like these residents to come on the days that their attending is in clinic...**

I: do you think those things that you’ve done have improved patient care, or they just...trying to meet the metric?

P: **...I think that they have improved patient care...having that attending resident continuity is very helpful in teaching and leading the residents to become better doctors.”** [Site D]

Pressure to Meet Performance Measures

- **Pressure to meet existing measures varied widely**

High

“So the metrics, sure **there’s constant pressure on us to meet the metrics** and if I say to someone, ‘Well you know one of the reasons these metrics that [Site C] are a little different because we have a residency’, they’re like, ‘Oh, I don’t care, you’ve got to make the metric,’ I mean I’m oversimplifying a little bit but you see what I’m saying... that **the context of the metric is not the discussion, the discussion is the metric and meeting the metric.**” [Site C]

Pressure to Meet Performance Measures

Low

“our site has been consistently this is all about patient care and yes, the metrics matter, trust me if they heard me say they don’t matter, they would have a conniption. **It matters but we’re just to do our best. [I: Okay] But yeah, they haven’t given us a whole lot of grief on it, it’s been, they’ve understood the challenges and I've appreciated that.**” [Site O]

Primary Care Management Module (PCMM) Constraints

Not team-based

“PCMM does not recognize a team [of providers]. It is still very individual provider based”. [Site G]

Doesn't reflect reality

“I think we do a pretty good job of populating PCMM when it comes to the residents and matching them with an attending... where obviously PCMM starts to become more complex and difficult to manage is how you structure the rest of the team... because an individual can only be one FTE in PCMM and there's certain rules about how many teams you can even be on in PCMM... PCMM's very limiting because it doesn't really reflect the reality of clinical care” [Site C]

Recommendations for PM Modification

Current PMs viewed as ill-fitted to academic clinics

“there should be acknowledgement of that there are differences between academic and non-academic PACTs...that just **putting all PACT teams...under the same rules...might not be appropriate because of the different complexities within each facility**...a CBOC is held under the same rules as a complex highly affiliated academic PACT program.”
[Site A]

Team-based metrics a better fit with on-the-ground efforts to provide urgent access and continuity

“...we need to have metrics that accommodate [trainees] and we know... there’s going to be some discontinuity...**we’ve strongly promoted teams and I think Veterans are getting better care because of the teams and that we should be measuring team continuity on all aspects of that, with the trainee providers and the RNs, the LVNs, and the clerks.**” [Site P]

Recommendations for PM Modification

Teams of Physicians

“it’s impossible for a resident to be in clinic the way an attending provider would be in clinic if they have other competing responsibilities, **somehow have continuity measured in a way that allowed for flexibility...somehow having a team of doctors taking care of one patient would still count as continuity.**” [Site D]

Include RN

“I think that it should include **nurses...the whole concept of having PACT teams is that you’re co-managing patients with your RN care manager...I think that their contribution should be included within all of the metrics, not just like the 2-day post discharge metric.**” [Site A]

Include Extended Team Members

“if the point is that the patient is taken care of by a team and my resident knows that they're going to be on nights next month and he then sets up a visit for the patient...with **our PACT RN or the PACT pharmacist to follow-up on his diabetes or his blood pressure, etcetera, that seems to me that should count as continuity.** [Site O]

Reasons for Wanting Team-based PMs

1) Reflect and Incentivize team-based care as envisioned in the PACT model

2) Give RNs credit for the work they do

“There’s so much shared decision-making within the teams themselves...[it’s] unfair to nurses to deny them...credit for what they’re doing” [Site F]

3) Encourage all teamlet members to take ownership of patient care, i.e., understand that their actions affect patient care and contribute to meeting measures.

4) Teaching mission

“we’re going to have academic medical centers and they’re going to be training trainees because we feel like it’s a mission of the VA. Then we need to have metrics that accommodate that.” [Site P]

Unintended Consequences: Job Satisfaction

Attendings

“...a lot of internists really enjoy the diversity in their job description, but that diversity makes it very challenging for them to meet measures in all of those different venues and it makes it hard to maintain continuity for the patients that they have. So, we’re definitely recognizing that and leadership is really brainstorming different ways to try to keep providers happy and interested in the job that they’re doing, but that we’re also meeting our measures or improving upon our measures” [Site S]

Residents

“It’s really sad because I think it’s easier to get rid of the academic PACTs if you only put them on one team because then you can cut the arm off, but if you have them everywhere on the team then the work is spread out...then it’s harder to get rid of, just get rid of the trainees”. [Site P]

Unintended Consequences: Tension

“...there are two issues in academic PACTs. One is the educational component, the ability to teach our house staff not only the principles of PACT, but issues such as population health, issues such as panel management, issues such as working within teams, and also performance improvement, that I think there has to be some sort of attention placed on that because you need the formal didactics to also help with the experiential learning that you get within clinic. From the operations perspective, just having some sort of clarity in terms of, it's not really the metrics that drive everything. It's how you organize yourself and the metrics will follow. **But, clearly there are some metrics that are not congruent with having team participation**”.

[Site A]

Despite Unintended Consequences...

- They promote patient-centered, team-based care
- They're passionate about providing a robust educational experience
- They're creative in the face of complexity
- They're trying to structure their clinics to align patient care and teaching missions

Academic Clinics Are Worth It

Teaching Mission

“I really feel strongly that the VA...has done a great job rolling out PACT and it’s excellent for residents and it’s really what we need, we’re obligated to teach them these things and allow them to hone their skills before they complete their...Internal Medicine residency...”
[Site S]

Part-time PCPs Valuable

“I think there’s a tendency at the VA to see part-time people as more complicated and not to necessarily want part-time people...I look at our part-time providers and I honestly think they're some of our strongest providers...they're doing teaching...doing homeless shelter work...so that **yes, they're more complicated in terms of the scheduling and making sure we have adequate coverage but I think they bring a really important perspective to clinic that we wouldn't have otherwise.”** [Site O]

Implications

As performance measures are revised:

- **Take into account constraints imposed on academic clinics by residency programs as performance measures are revised**
 - Work toward flexibility – academic clinics not one size fits all
- **Identify and avoid potential unintended consequences**
- **Revision of measures important for both patient care and training missions.**

Questions/Comments?

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