

Patient-Aligned Care Teams

Primary Care Operations
Primary Care Services

Veterans Health Administration
Department of Veterans Affairs

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VA Northern California Health Care System

Enhancing the Way We Provide Care

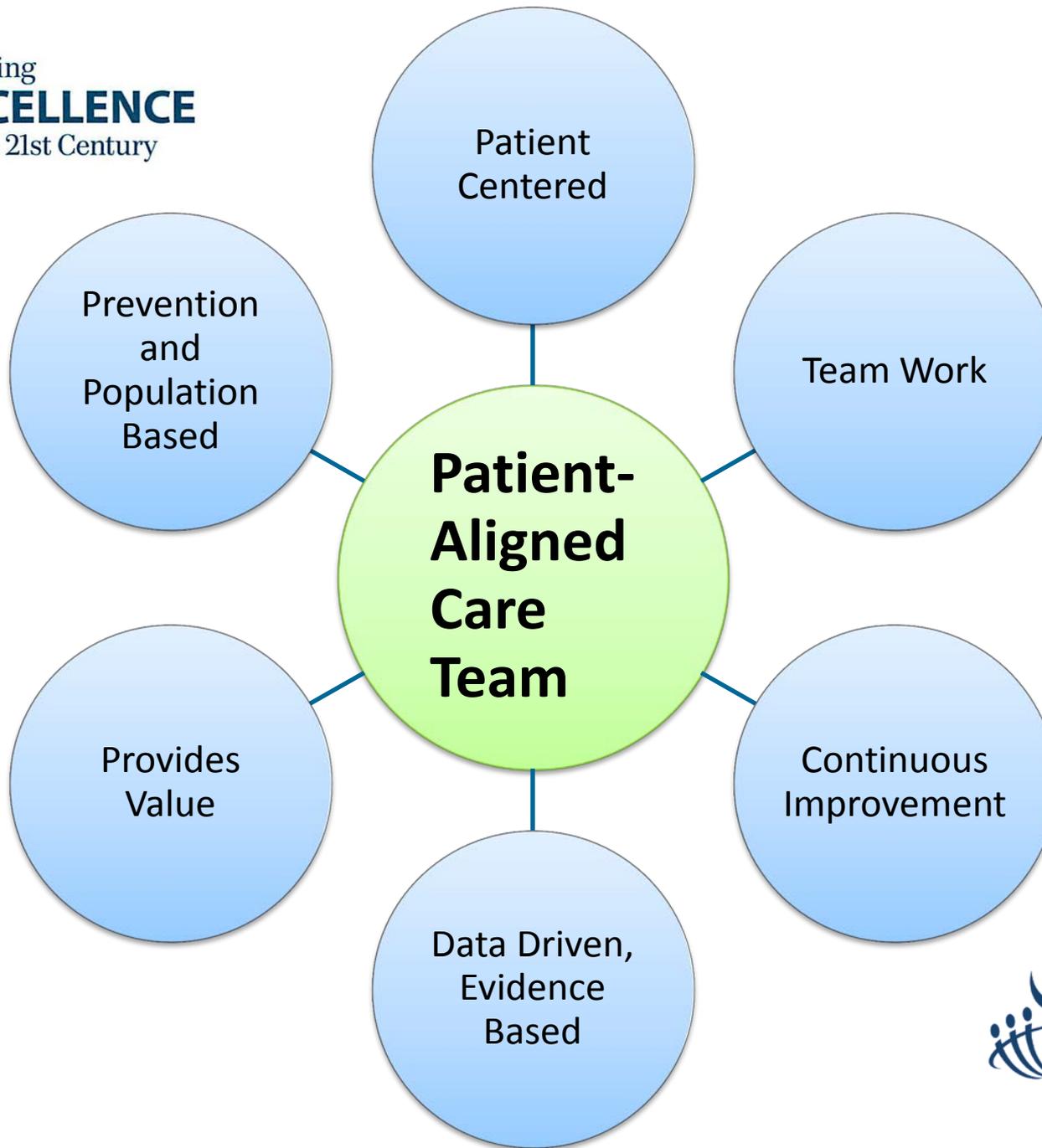
“We are creating a healthcare system that is, first and foremost, patient centered and characterized by team care...

We’re also striving, every day, for a healthcare system that is continuously improving, data driven, evidence based, and characterized by excellence at every level.”

Robert A. Petzel, M.D.
Under Secretary for Health
Department of Veterans Affairs

Changes in Primary Care

Past	PACT (Patient Aligned Care Team)
The patient has one provider	The patient has a team
Care delivered only by provider	Care delivered by team members
Focus on visits	Focus on overall health
Most care delivered by visits	New care delivery routes and tools
Virtual visits uncommon	Phone, telehealth visits, secure messaging common
Continuity inconsistent	Continuity consistent
High risk patients get routine care	Identify and manage high risk patients
Hospitalizations common	Hospitalizations less frequent
Care not well coordinated	Care coordinated throughout the system
Prevention not stressed	Prevention and health promotion essential



Other Team Members

Clinical Pharmacy Specialist: ± 3 panels
Clinical Pharmacy anticoagulation: ± 5 panels
Social Work: ± 2 panels
Nutrition: ± 5 panels
Case Managers
Trainees
Integrated Behavioral Health
Psychologist ± 3 panels
Social Worker ± 5 panels
Care Manager ± 5 panels
Psychiatrist ± 10 panels

Other Team Members

For each parent facility
HPDP Program Manager: 1 FTE
Health Behavior Coordinator: 1 FTE
My HealtheVet Coordinator: 1 FTE

Teamlet: assigned to 1 panel (±1200 patients)

- **Provider: 1 FTE**
- **RN Care Mgr: 1 FTE**
- **Clinical Associate (LPN, MA, or Health Tech): 1 FTE**
- **Clerk: 1 FTE**

Monitored via Primary Care Staffing and Room Utilization Data report in VSSC

Panel size adjusted (modeled) for rooms and staffing per PCMM Handbook

Patient

The Patient's Primary Care Team

Patient Aligned Care Team

Replaces episodic care based on illness and patient complaints with coordinated care and a long term healing relationship



Takes collective responsibility for patient care



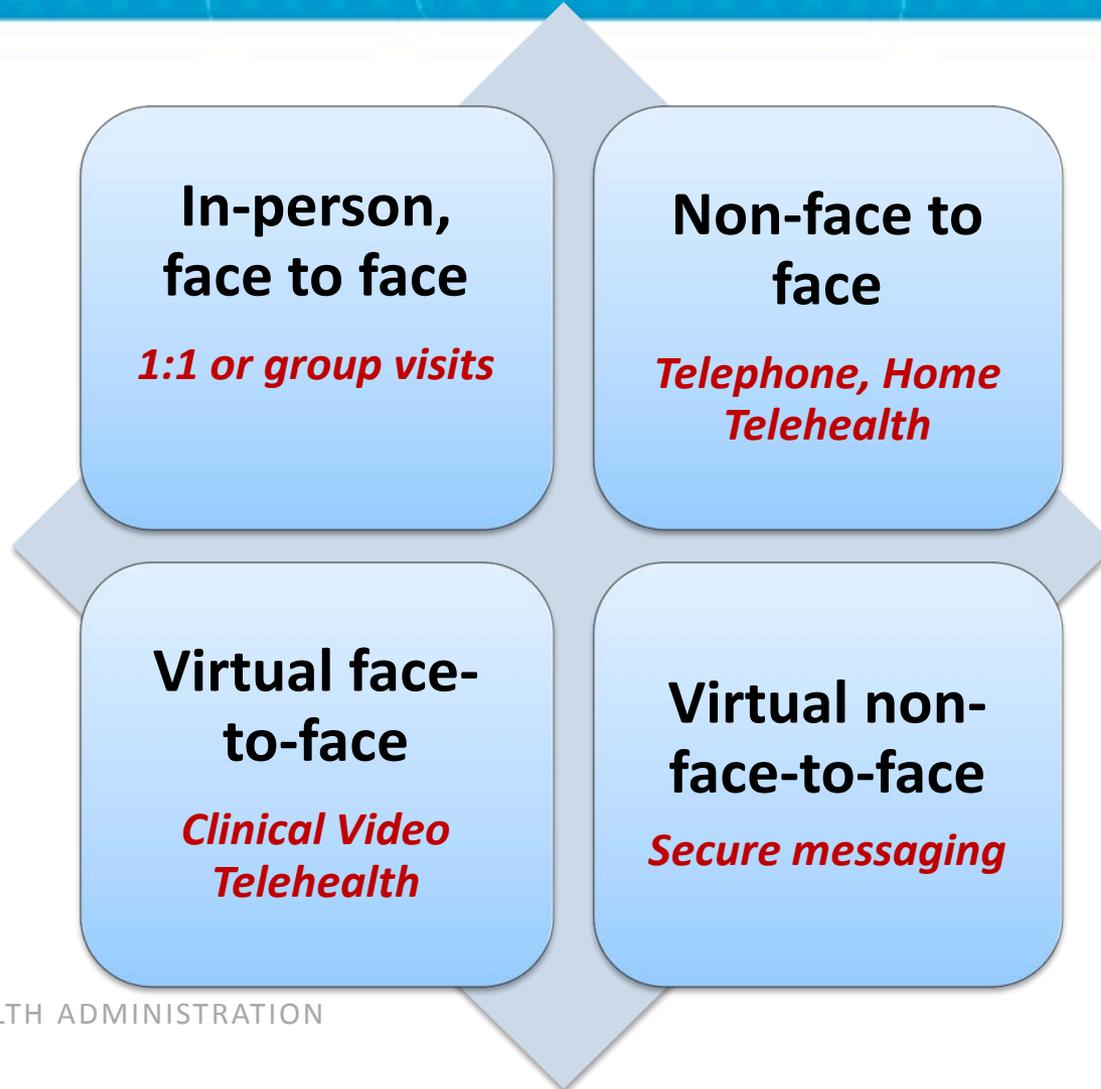
Is responsible for providing all the patient's health care needs



Arranges for appropriate care with other specialties

THE PRIMARY CARE TEAM

PACT Access and Care Delivery



PACT Implementation: Learning, Discovery, Continuous Improvement

Readiness Assessment Staffing Support

- ACP Medical Home Builder
- Primary Care Staffing

Training and Education

- PCMH Summit
- PACT Collaborative
- Transformation Initiative Learning Centers
- Consultation Teams

Demonstration Labs

Measurement: PACT Compass

- Access/Continuity
- Patient Satisfaction
- Coordination
- Panel Management

IT Improvements

- PCMM enhancements
- Secure Messaging

Communication

- Staff
- Patients
- Stakeholders

Centers of Excellence in Primary Care Education

PACT Implementation: Learning, Discovery, Continuous Improvement

Additional IT Improvements

- PCMM redesign
- High risk patient tracking tool (PCAS)
- PC Almanac

Guidance and Support

- PACT Handbook
- Workload capture
- Protocols

PACT Recognition

- Identify high functioning PACTs
- Reward early adopters

Specialty Integration

Performance Measures

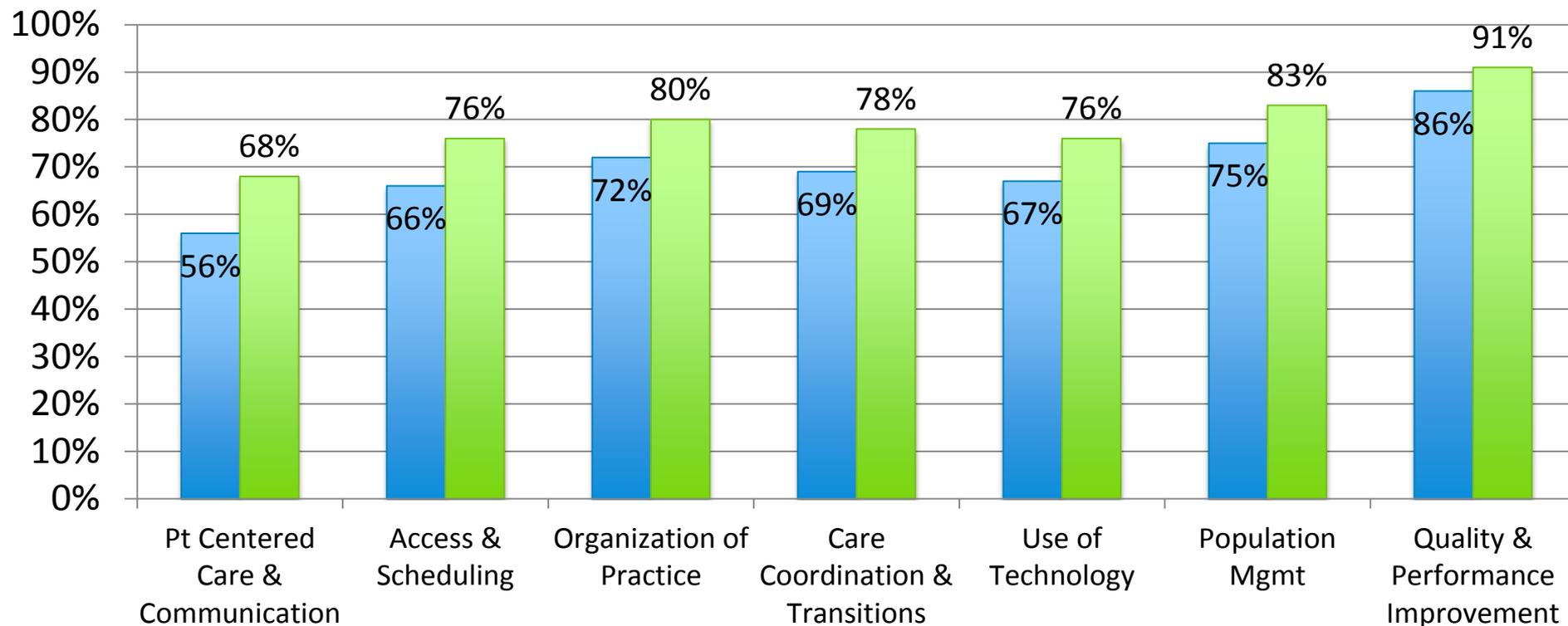
- Appts within 7 days
- Same-day access to PCP
- Continuity
- Phone utilization
- 2 day contact post-discharge

Telehealth

Secure Messaging

American College of Physicians Medical Home Builder

■ Oct-09 n=850 ■ Jul-11 n=846



VHA Average
Oct-09 **69%** Jul-11 **80%**

Measurement

- **PACT Compass**
 - Panel Management
 - Continuity
 - Access
 - Coordination
 - Engagement and Satisfaction
- **Patient Satisfaction**
 - CAHPS Patient Centered Medical Home Survey
- **Primary Care Almanac**
 - Diabetes
 - Hypertension
 - Congestive Heart Failure
- **Clinical Performance Measures**
 - Prevention
 - Chronic Disease Management
- **Employee Satisfaction surveys**
- **PACT Recognition Survey**
- **PACT Personnel Survey**

Homeless PACT

Launched January 2012

Over 4,000 enrolled

3,400 current patients:

- 8,600 primary care visits (2.3 visits/pt)
- 4,100 specialty care visits (1.2 visits/pt)
- >90% participation in homeless programs/mental health services
- **66% reduction in emergency department use** (compared with 6 months prior to enrollment)
- **35% reduction in hospitalizations** (compared with 6 months prior to enrollment)

Growing to 37 sites

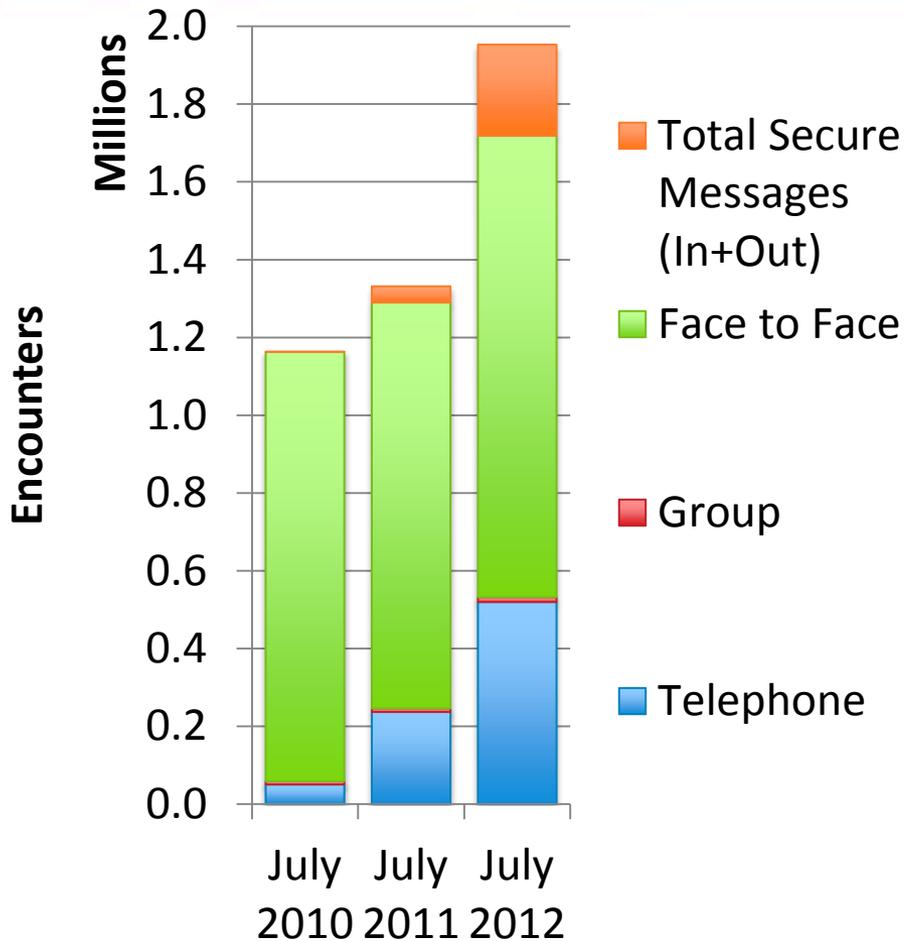
10,000+ enrolled by the end of FY13

National Changes since PACT Implementation (July 2010-July 2012)

Primary Care Uniques	↑ 7%
PACT Provider Staff	↑ 2%
PACT Support Staff	↑ 29%
Average Panel Size	↑ 4%
Primary Care Capacity	↑ 5%
PACT Encounters per 1000 unique patients	↑ 38%
Continuity	↑ 3%
VHA Acute Admissions per 1000 unique PC patients	↓ 6%
VHA ED Visits per 1000 unique PC patients	↑ 6%
VHA Urgent Care Visits per 1000 unique PC patients	↓ 20%

PACT patients enrolled in Home Telehealth	↑ 65%
PACT Group Visits	↑ 53%
PACT Telephone Visits	↑ 927%
PACT patients seen on desired date	↑ 8%
PACT patients seen within 7 days of desired date	↑ 5%
3rd Next Available Appointment in PACT clinics	↓ 13%
Same day appointments with PCP	↑ 35%
Patients contacted within 2 days after discharge	↑ 847%

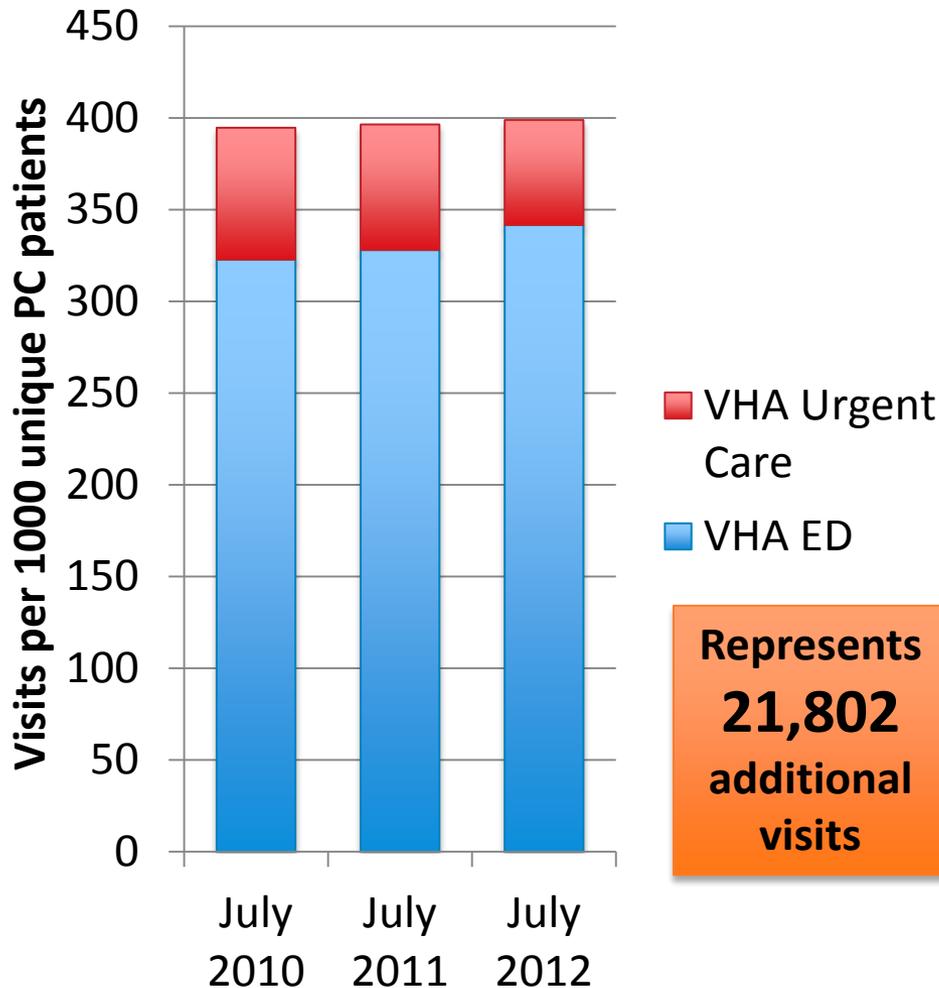
PACT Workload Trends



PACT Recognition, Summer 2011: PC encounters per year



Urgent/Emergent Care

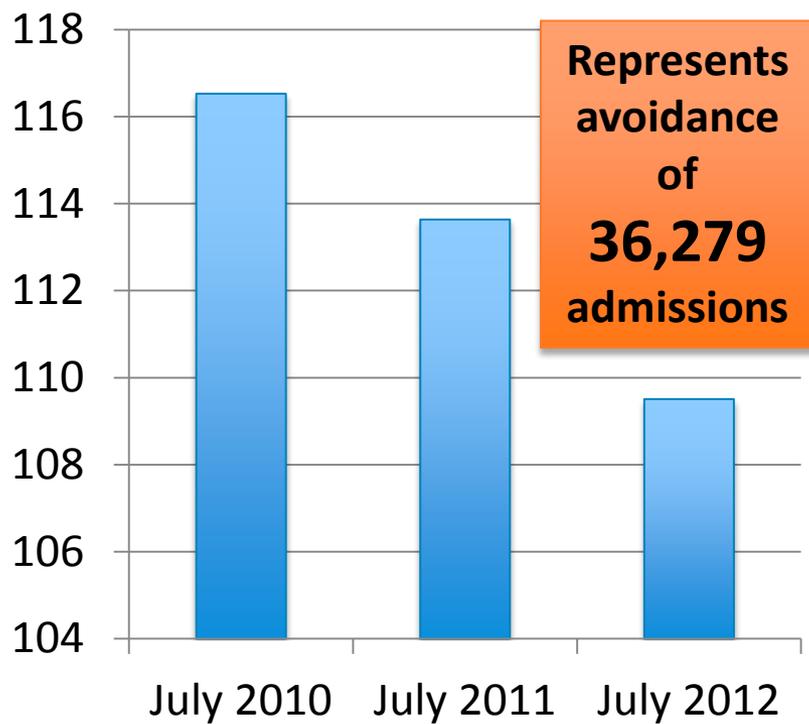


PACT Recognition, Summer 2011: ER/Urgent Care visits per 1000 unique PC patients



Admission Rates

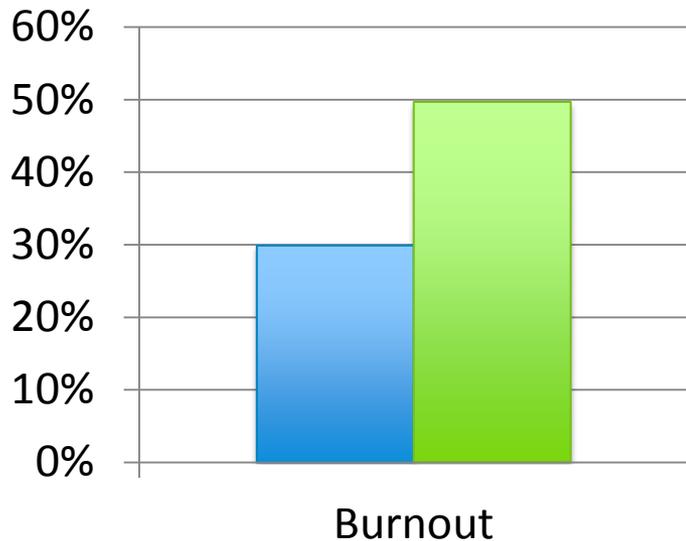
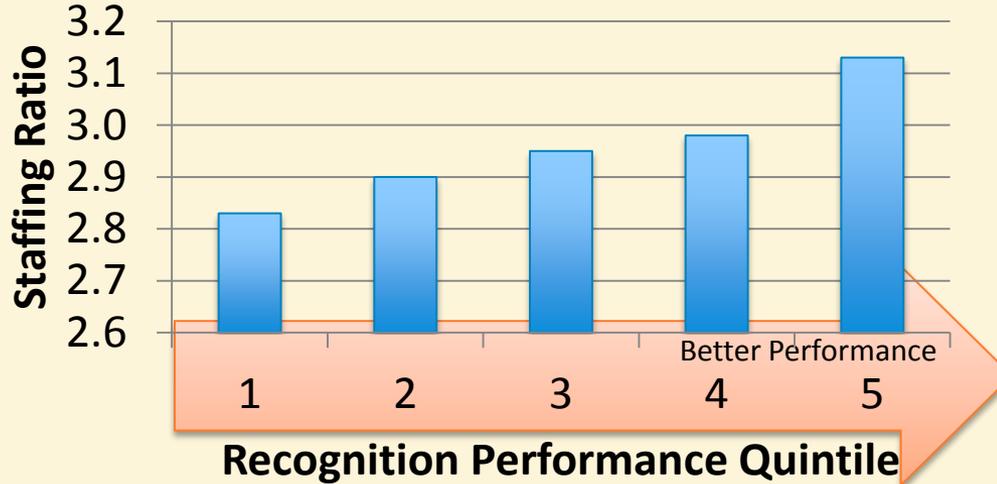
VHA Acute Admissions per 1000 unique PC patients



PACT Recognition, Summer 2011: Acute Admissions per 1000 unique PC patients

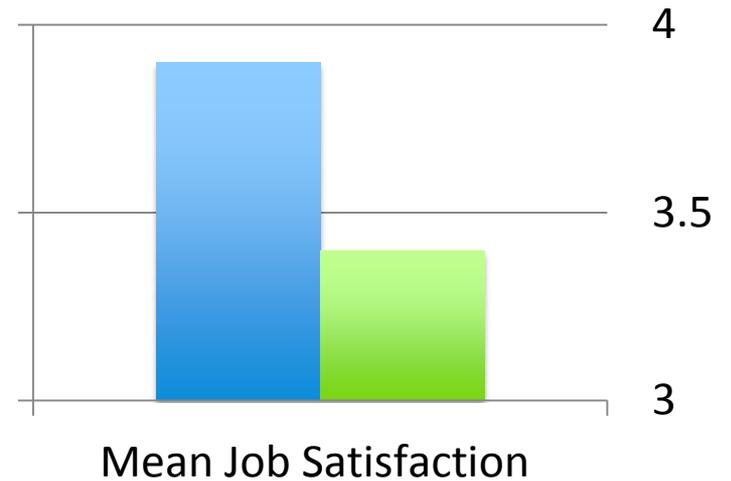


PACT Recognition, Summer 2011

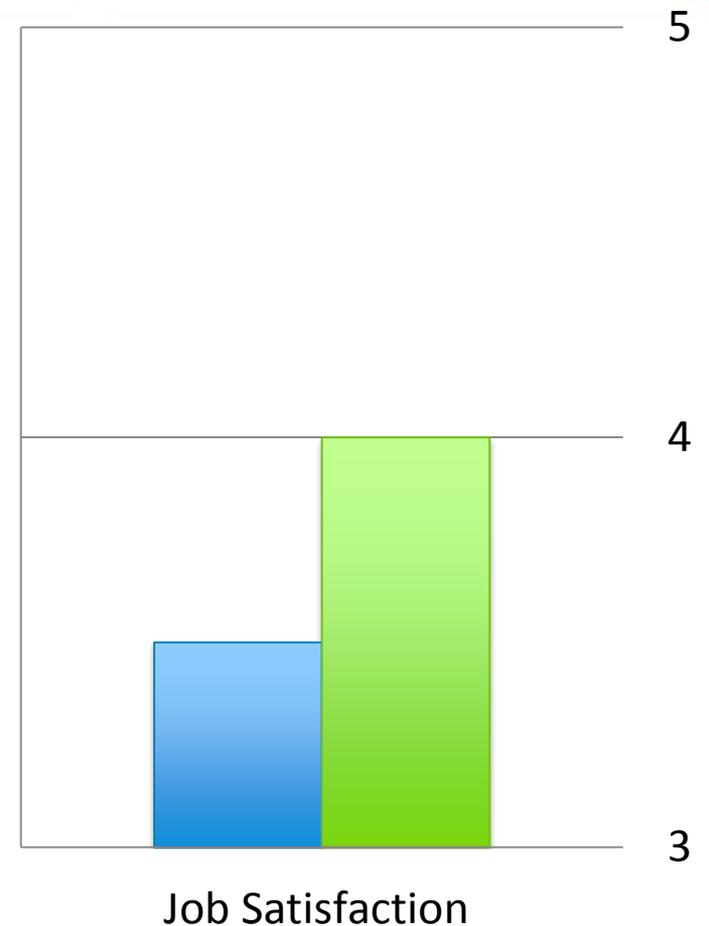
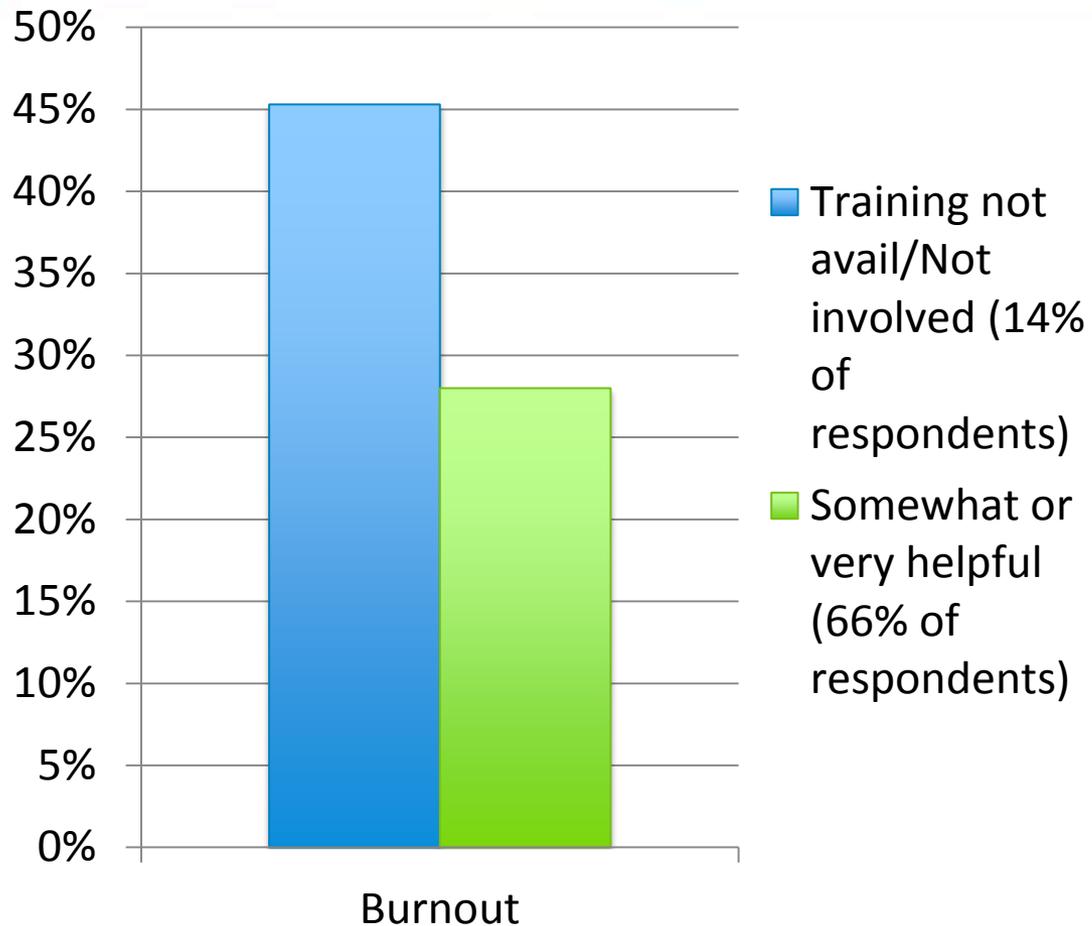


■ Fully staffed

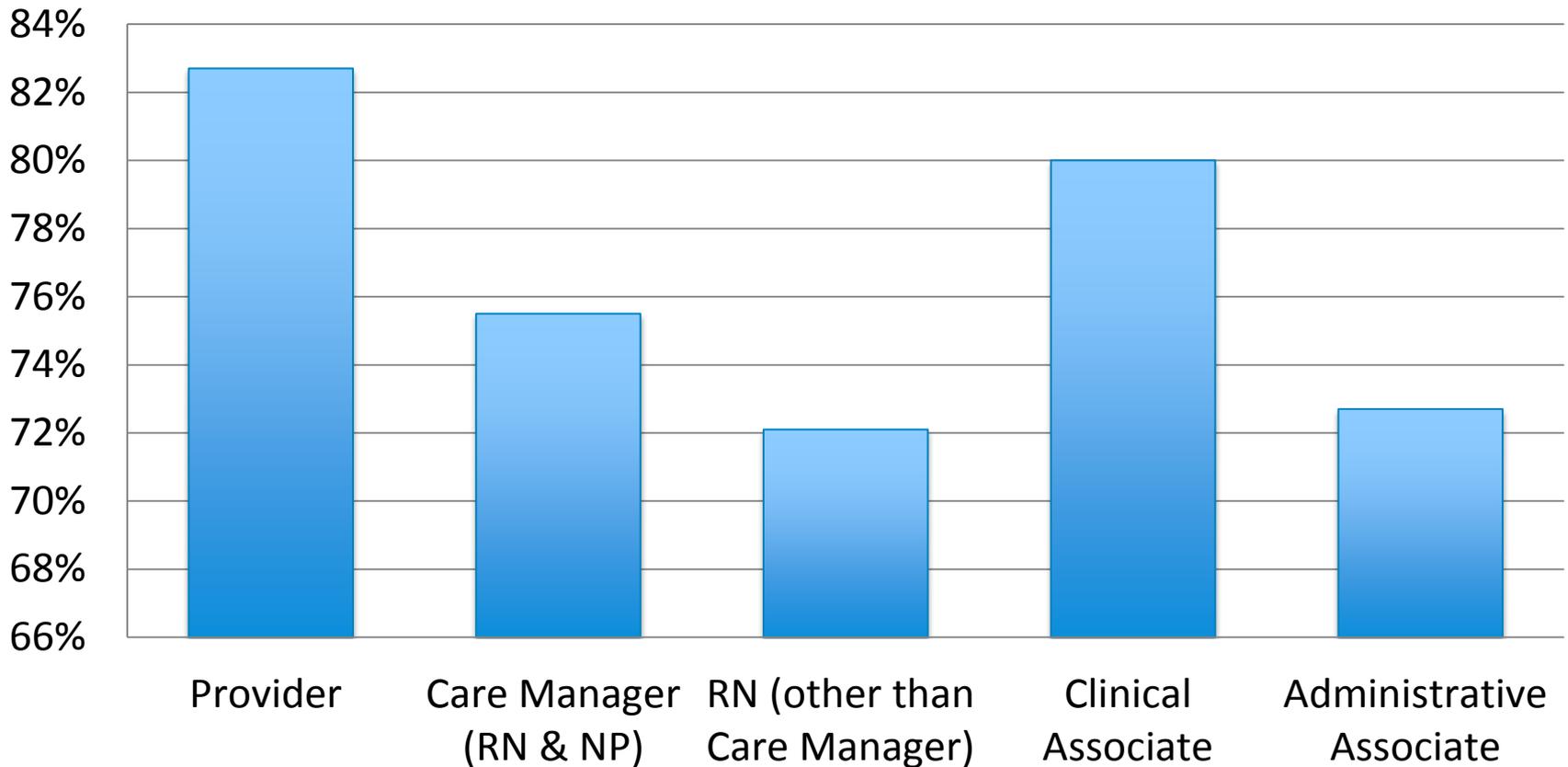
■ Not fully staffed



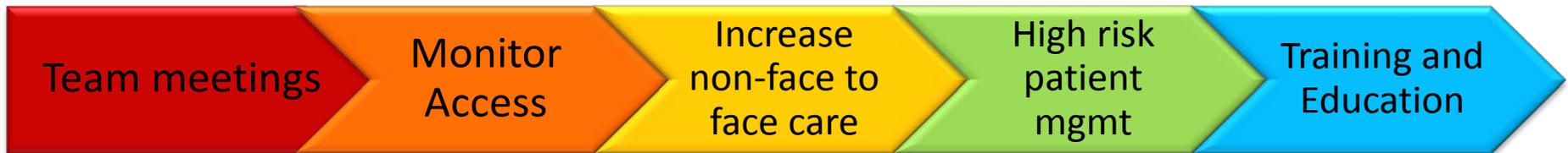
PACT Training, Burnout and Job Satisfaction



More than half my time is spent each week on work that could be done by someone with less training



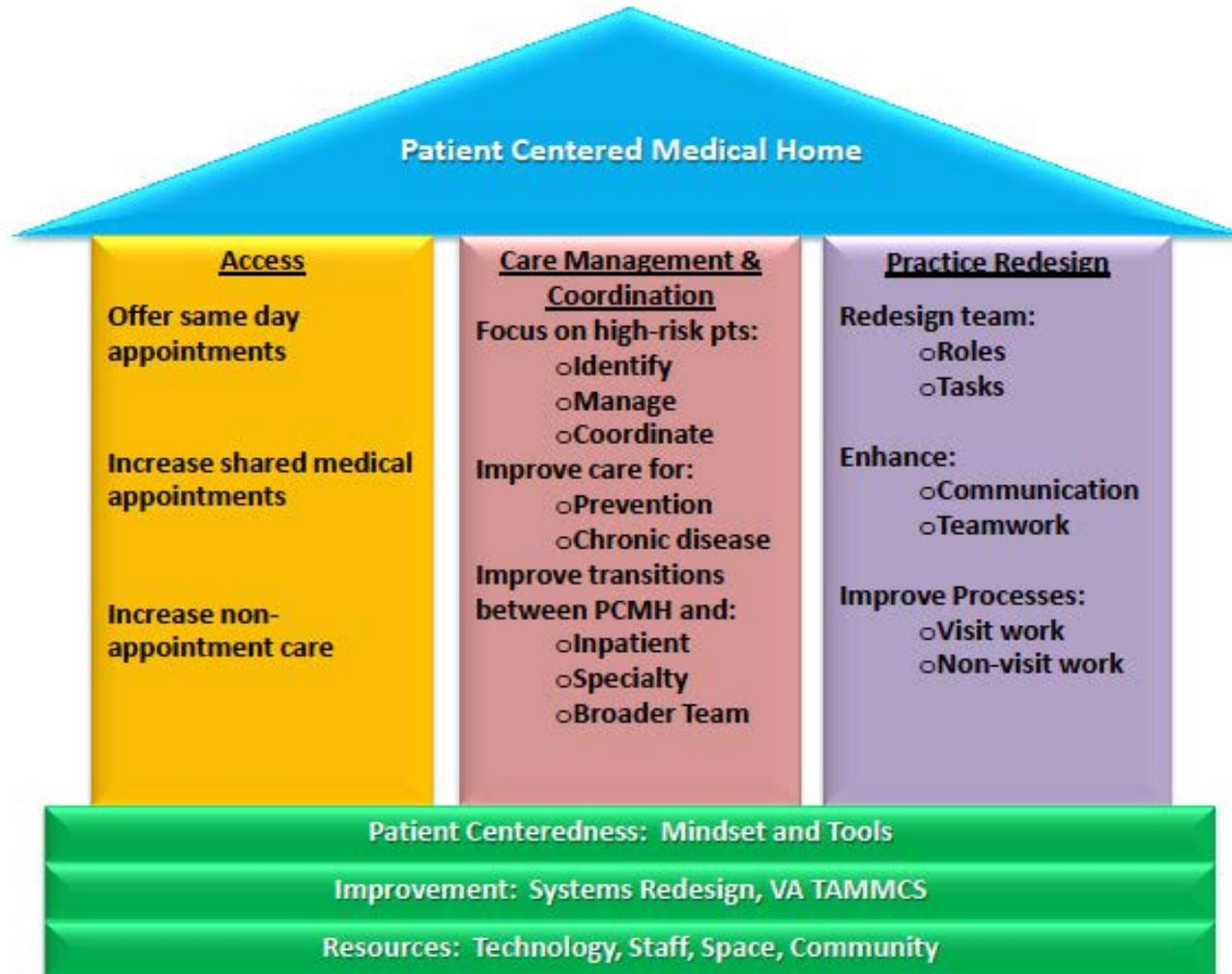
Gradually Change Functions



The Approach to PACT at VANCHCS

- Kick-off meeting with all involved in Primary Care – May, 2010
 - Explained the model as rolled out nationally
 - Asked for volunteer pilot teams – selected teams (21 teamlets) at 6 sites
 - Team vs. Teamlet
- Added staff
 - 11 nurses, 2.5 LVNs, 14 clerks, 6 pharmacists, 7 social workers, 3.5 dieticians
- Series of Collaborative meetings with the pilot teams
 - Systems redesign of access, office practice, and care management
 - Sharing of lessons learned
- Expanded to all teams – Summer, 2011
 - Staff shifted to cover additional teams
 - Continued collaborative learning approach
- Data collected on key measures

The Vision of “How”



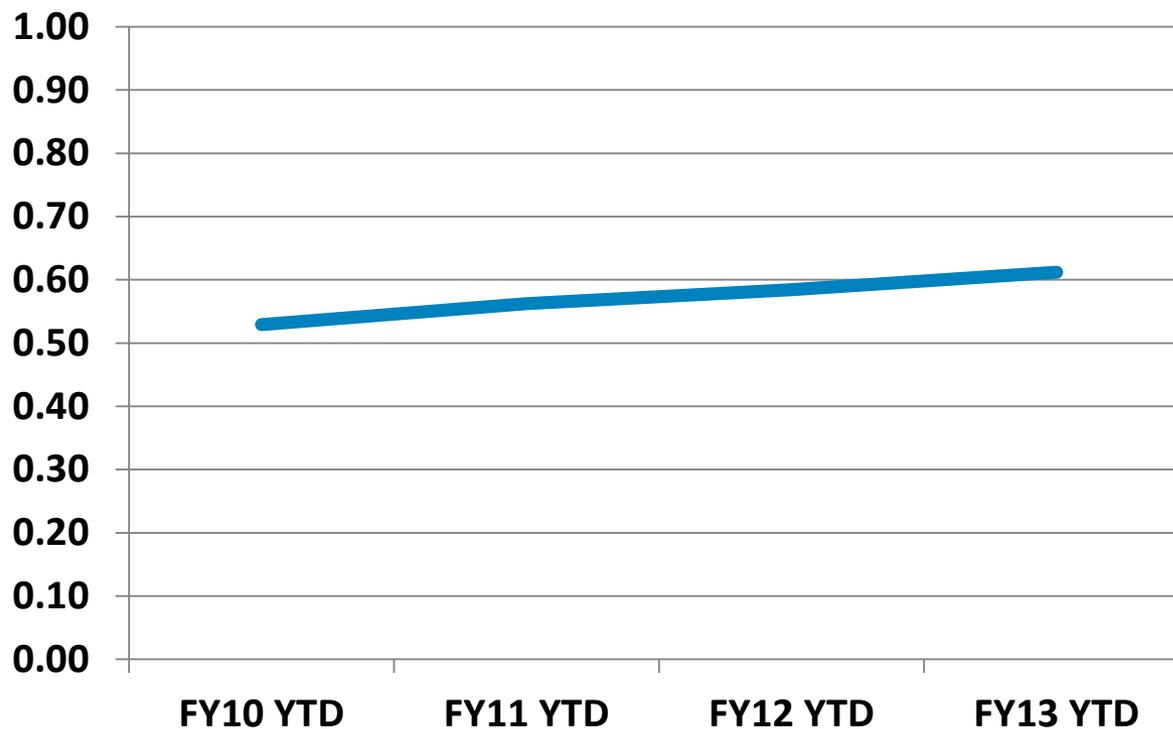
The Approach to PACT at VANCHCS – Team Results

Measure	VANCHCS – Jan FY13	Target – FY13
2-Day Post-Discharge Contact	59.4%	75%
7 Day Access	88.2%	92%
Continuity with the PCP	73.8%	77%
Phone Encounters	21.3%	20%
Same Day Appointments	37.1%	70%

The Approach to PACT at VANCHCS

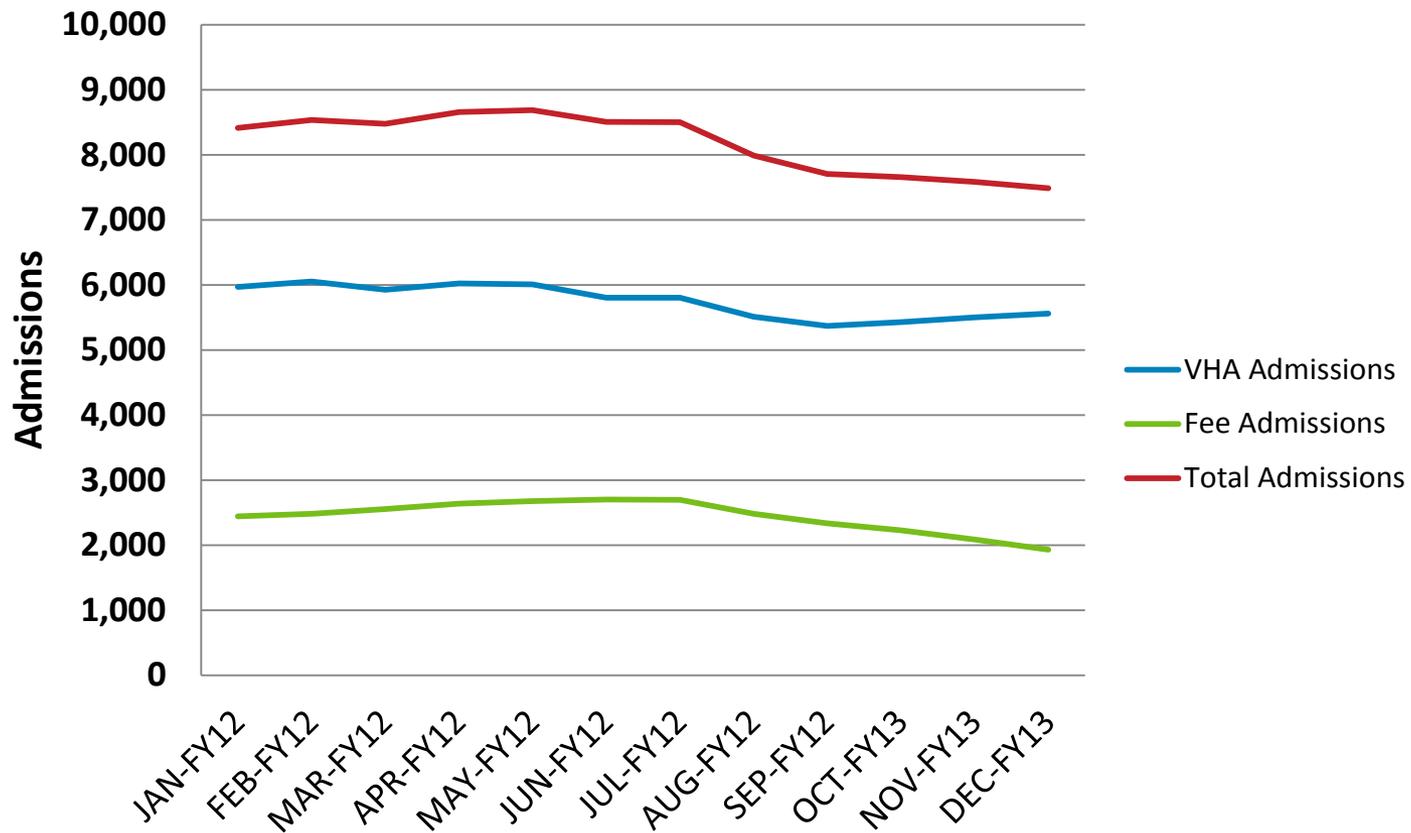
ED/Urgent Care Visits

**VANCHCS Total ED/Urgent Care Visits per
PACT Panel Patient per Year**



The Approach to PACT at VANCHCS - Admissions

Admissions from PACT Teams in CY 2012



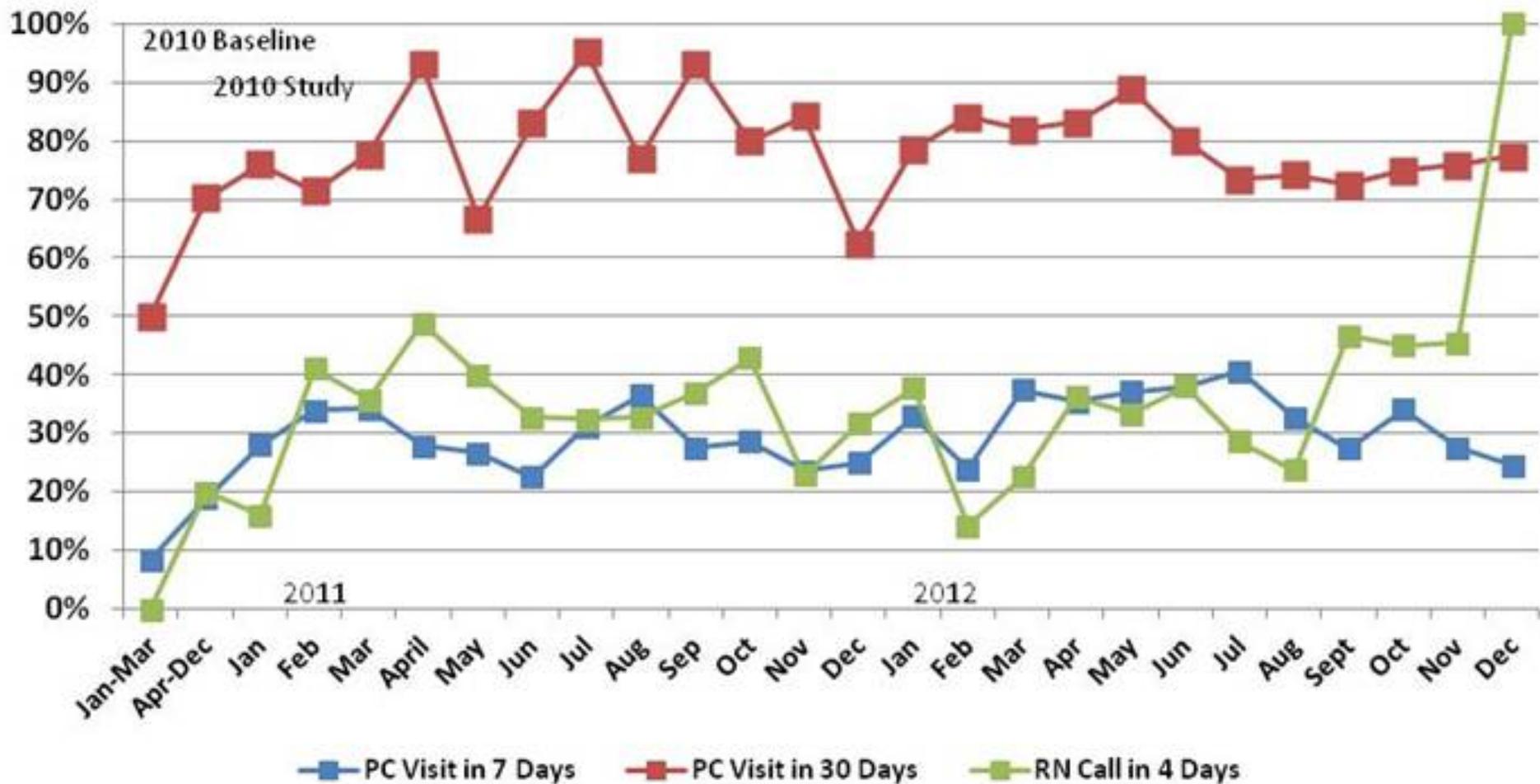
The Approach to PACT at VANCHCS

Avoidable Days of Care and Readmission Rates

Avoidable Days of Care	2011		6-Year Average Improvement	
	VA	Medicare	VA	Medicare
National	36%	24%	2.8%	6.0%
VANCHCS	11%	22%	15.1%	4.2%

VANCHCS Risk-Adjusted Readmission Rate FY12 = 17.2, > 2SD below VA mean

MD Visits and Care Manager Calls (post D/C)



Improvements – CHF 2010 - 2012

	Baseline	STUDY		
	2010	2010	2011	2012
	Jan-Mar	Apr-Dec	Jan-Dec	Jan-Dec
LOS	3.8 days	4.1 days	3.75 days	4.27 days
*30-Day ED Visits	14.5%	12.3%	13.9%	18.6%
*30-Day Readmissions	23.3%	17.4%	14.7%	13.92%

*N excludes inpatient deaths

The Approach to PACT at VANCHCS

Homeless PACT (H-PACT)

- Enrollment began May, 2012
 - 314 patients enrolled (2nd largest H-PACT in VA)
 - Only H-PACT to go to community locations
 - 90% receiving mental health services
 - 13% diagnosed with PTSD
 - 35% diagnosed with Depression
- 6-Month pre/post admission study (N = 53 Veterans)
 - Primary Care encounters increased 673%
 - 87% of all appointments with an H-PACT provider
 - 59% decrease in ED visits
 - Annualized to >\$250,000 in ED visits avoided for the current panel

Continuing Implementation Plan:

Continue to explore accreditation/certification through outside organizations such as the Joint Commission

Continue and enhance emphasis on relationship-based care (NUKA model)

Begin deployment of a patient Personal Health Inventory which their PACT will use to identify risks and customize health recommendations

Expand the incorporation of Home Telehealth and Secure Messaging into PACT practices

Expand specialty care support to PACTs

Lessons Learned

**Change is not easy
Change takes time**

**Leadership,
leadership,
leadership, leadership**

**Involve everyone,
even if you think they
are not interested**

**There are competing
priorities**

**Balance authority and
flexibility**

**Well staffed teams
perform better and
enjoy their work**

**Participation in
training improves
PACT processes and
outcomes**

**A good training
experience is
associated with a
better job experience**

**Keep in mind why
you are doing this in
the first place...**

