FEDERAL PATIENT CENTERED MEDICAL HOME (PCMH) COLLABORATIVE
Catalogue of Federal PCMH Activities as of October 2012

OPERATING DIVISION/DEPARTMENT:
Department of Veterans Affairs (VA), Veterans Health Administration

Respondents:
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PRÉCIS:
The VA is a leader in development and implementation of the PCMH. It has funded a national transformation of all primary care practices, to include pilot projects, training programs, and system improvements that promote a medical home model of care. The Department sees the PCMH as central to its mission to deliver direct care to veterans, and as such, has partnered with several agencies and regularly shares its experiences with interested stakeholders.

STRATEGIC GOALS OF THE OPERATING DIVISION/DEPARTMENT:
- *Strategic goals explicitly support advancing the PCMH*. The VA has developed agency-wide strategic goals and operational concepts that support movement towards a patient-centered model of care. The Secretary has developed a series of strategic goals called the “Transformation 21 (T-21) Initiatives”. VHA branded their medical home model as *Patient Aligned Care Teams (PACT)*. The VA’s vision is that primary care in their facilities will be accessible, patient-centered, coordinated, and team-based. PACT encompasses these values, which are all part of the PCMH concept. The VA has funded a variety of demonstrations, and training and research programs, indicating its commitment to advancing the PCMH model within its system.

PRIMARY AREAS OF PCMH ACTIVITY:

Direct provision of health care services or funding of care
- *Payment model reform for the Veteran’s Health Administration*. Primary care is foundational care in the Veteran’s Health Administration (VHA). The VHA budget is set by Congress and funds are allocated through a capitated payment model. The payment model, called Veterans Equitable Resource Allocation (VERA), is based on a Resource Value Unit (RVU) system that accounts for workload, complexity, and diagnoses of each service. Veteran Integrated Service Networks (VISNs), the VA’s networks of medical centers, veteran centers, and outpatient clinics offering primary and specialized care, are funded to provide patient care based in large part on this
model. To date, this payment model has been focused on highly complex patients, inpatient care, etc. which does not necessarily support the medical home model that the VA will use to provide primary care. The VA has made recommendations for ways to certify their facilities as medical homes so that they can receive improved funding to sustain the staffing level required to deliver a high quality medical home model of care. For example, it has recommended that the VERA calculation maximize the workload credit for care that is not face-to-face, which would provide patients greater opportunities to use telemedicine and access primary care services without travelling to see a provider. The revised allocation methodology will allow sites with PCMH practices to receive enhanced funding. This methodology is not unlike what the private sector is trying to address in funding medical homes.

Pilot or demonstration programs

- **Demonstration Labs.** The VA has created five demonstration labs and a coordinating center to coordinate the labs’ activities. The goal of the demonstration labs is to develop evidence that will guide PCMH implementation throughout the VA in real time. The demonstration lab projects will use robust research and program evaluation methodologies to evaluate specific topics related to the medical home, such as serving rural patients, using telemedicine and secure messaging, or structuring the care team. Initial results have been compiled and show positive outcomes for the PACT model. Process and outcome improvements include:
  
  - 30% of all encounters are conducted on the telephone, with a commensurate 4% reduction in face to face appointments.
  - 6% reduction in VHA acute admissions
  - 20% reduction in urgent care visits (patients being seen by their PACT for urgent needs)
  - 90% of Veterans get an appointment within 7 days
  - 70% are able to obtain an appointment on the same day if requested
  - 59% are able to obtain a same day appointment with their assigned primary care provider
  - Over 75% see their assigned primary care provider for their appointments (continuity)
  - Significant improvements in virtual care:
    - The number of Veterans opted in and using Secure Messaging has increased to over 380,000

Each lab works with the coordinating center to identify trends and system improvements. There are labs in each of the following five locations: (1) Los Angeles/San Diego/Loma Linda, CA; (2) Portland, OR; (3) Iowa City, IA/Minneapolis, MN; (4) Ann Arbor, MI; and (5) Philadelphia, PA. The coordinating center is located in Seattle, WA. The demonstration labs are grant funded and will receive $1 million a year for the next several years. The award was issued in 2010 and does not include
dissemination support.

- **Centers of Excellence in Primary Care Education.** Another area of focus for the VA is building and testing models for training students in patient centered medical home practices. The Office of Academic Affiliations has established five “Academic Centers of Excellence” for primary care education. These sites work with academic affiliate organizations in their area to develop training and practice models that promote the concepts of patient centered medical homes, including how to design residency programs, how to allocate staff in PCMH and team based care, etc. They award grants to academic medical centers to build models of training for staff and evaluate the effectiveness of each program. The selected sites are Seattle, Boise, San Francisco, Cleveland, and Connecticut. Working with academic medical centers has two benefits for the VA. First, it allows the VA to train medical providers in the PCMH model of care and encourages providers to promulgate the model in their community. Second, it is a recruitment tool that enables providers trained in a medical home model of care to gain exposure to and interest in working in the VA setting.

**Technical assistance, implementation assistance**

- **Increased staffing at primary care sites.** When the VA was initially exploring a PCMH model of care, it learned that many of the primary care sites weren’t adequately staffed for team-based care. Sites had a recommended staffing ratio of 2.5 support staff to every 1 provider. The VA recommended that PCMH and team-based care be delivered with an increased staffing ratio of 3:1. That is, for every provider, there should be one clerk, one LPN/medical assistant, and one RN. The VA refers to this group as a “teamlet,” and each teamlet is assigned to one panel of patients. The other members of the PCMH team, such as clinical pharmacists, social workers, and dietitians will be assigned to more than one panel, bringing the team total to 5-6 people. In addition, each facility has staffed one full time worker to implement secure messaging, that is, a system for providing electronic communications between patients and providers that keeps private information protected. Secure messaging has now been established in all VHA Patient Aligned Care Teams. The VA believes that infrastructure is very important and has focused most of its funding towards hiring and training the additional recommended staff at each primary care site; centers have begun to hire and slowly increase staffing levels. Support staff have increased 29%. VHA average teamlet staffing ratio per primary care provider is 3.03.

- **PACT Compass and quality measurement.** In 2010, the VA created a PACT Compass to enable teams to view their progress on a host of data points thought to be important to PACT implementation. The PACT Compass combines the myriad of care quality measures already in use into a one-stop shopping experience in which a user can easily evaluate the patient centered medical home. The PACT Compass includes measures for panel size, capacity, and staffing; patient and employee satisfaction
scores; care continuity; access; admissions; communication following discharge; employee satisfaction, etc. Associated clinical data tools include the Primary Care Almanac (PC Almanac) and Care Assessment Needs Score (CANS). The PC Almanac is a registry tool that displays subpopulation clinical and demographics for population management. The CANS tool identifies patients at risk for a morbidity/mortality event based on a VA validated set of parameters. These tools provide specific patient level data so teams can proactively manage patient care.

VHA PACT Educational Plan:

- **PACT Learning Collaborative.** The VA has developed a plan to train and educate providers to work as a team. The VA kicked-off its educational plan in April of 2010, and 3,600 people came together for 90 presentations on topics related to the medical home. Early adopter teams were identified and invited to participate in the PACT Collaborative where five regional learning networks were established to educate a total of 250 primary care teams in six collaborative and experiential learning sessions alternating with action periods over the course of 18 months. These collaborative sessions were completed in early January 2012. In the Collaborative, the clinical staff work together to redesign their systems. Each learning session was concentrated on key implementation concepts for system redesign known as the PACT Pillars. These include patient centeredness, teamwork, roles & function, access to care, and care management and coordination.

- **Transformation Initiative Learning Center.** Five regional Learning Centers of Excellence (COEs) were established in 2010 to train all Patient Aligned Care Teams (PACTs) in the implementation of PCMH. Content areas of Access, Care Coordination, Care Management, Practice Redesign, and Team Effectiveness were highlighted during (3-day) face-to-face training sessions throughout FY2011. This approach was modified in FY 12 to meet changing training mandates, and participant expectations. This resulted in a more dynamic, cost effective, longitudinal training model that also integrates training priorities of other transformational initiatives.

  The updated training model contains five sessions over 9-12 months, using a combination of:
  
  - Virtual training methods
  - Facility-based, face-to-face workshops (for team interaction and group learning)
  - Coaching support between sessions
  - Integrated curriculum encompassing other transformational initiatives
    - More than 1,000 primary care teams per year participate in this training initiative, and will expand in FY13 with the inclusion of specialty care teams. Each of these changes requires greater participation and partnership with facilities.

- **Consultation teams.** The VA has created five teams of one provider (MD, PNP, or PA), one nurse, and one administrator to be deployed for facilities that are having
problems or request additional help and guidance on implementing the medical home. The consultation team has been in the field since December 2010 and will continue to work onsite with the requesting facility. The teams continue to be available for consultation at least through FY2013.

- **Mini-residency in specialty care for primary care providers.** The VA has created mini-residency programs for primary care providers to rotate through selected specialty clinics to become familiar with specialty care services and create linkages between primary and specialty care.

- **Telemedicine.** The VA is emphasizing telemedicine as a way to reduce the travel barriers that would inhibit access to care. My HealtheVet, the VA’s patient portal, has introduced secure messaging that enables patients to communicate with their health care team, eliminating the needs for phone calls and visits. The system will also let them view appointments, lab results, and access health records. In addition, providers can conduct electronic consults for visits that do not require face to face contact. The VA is piloting programs similar to the Project Echo videoconferencing initiative in New Mexico at several sites across the country.

- **Computerized Patient Record System (CPRS) enhancements:** The VA is enhancing its existing Computerized Patient Record System (CPRS) by reconfiguring the data collection templates. It is also using health record data to identify patients at high risk for admission and target prevention strategies to patient needs. This tool is known as the Care Assessment Needs Score (CANS) (see PACT Compass and quality measurement section). A Health Risk Assessment tool, to be completed by the Veteran, is also being developed to provide comprehensive health recommendations to both patient and provider.

**Research (includes evaluation)**

- Both Demonstration Laboratories and Centers of Excellence in Primary Care Education are involved in evaluation and described above under “Pilot or demonstration programs.”

**MATERIALS:**

**Policies and Guidelines**

- **Internal Materials.** There are a variety of plans and materials that have been developed for internal use. The VA is currently working to implement the plans and prepare materials for sharing with external stakeholders.

- **PACT Handbook.** The handbook is expected to be published in December 2012.

**ACTIVE PCMH COLLABORATIONS WITH FEDERAL PARTNERS:**

- **Department of Defense.** VA and DOD have a natural shared mission to provide health care for veterans. They also have a similar structure for care delivery and budgeting, which creates a natural partnership. The two departments have been working together to smooth the transition from active duty to veteran care. One
new initiative looks at existing architectural plans and building space recommendations for new facilities and recommends design changes needed to accommodate expanded PCMH teams.

OTHER PCMH COLLABORATIONS:

- **Patient Centered Primary Care Collaborative (PCPCC).** The VA has been involved with the PCPCC for several years. They have shared their work, met stakeholders, and learned from the work of others involved in PCMH implementation.

- **American College of Physicians (ACP).** The VA uses ACP’s medical home builder to evaluate readiness as they began their transition a PCMH model.

- National Healthcare Group, Singapore.