

## **Guide to the VA PCMH (Patient Centered Medical Home) Rotation 2015--2016**

Welcome! During this year you will have the opportunity to spend some time during your PCMH/Quality rotation in what is a relatively new model for primary care in the VA, the Patient Centered Medical Home (now VA branded as PACT—the Patient Aligned Care Team). We recommend you read this guide prior to the start of your rotation—it will give you an initial flavor of what the Patient Centered Medical Home is all about, and what your experience will be during this portion of your PCMH/Quality rotation.

Our learning objectives for you during this rotation include:

1. Understanding the basic model of the PCMH, including its three central pillars:
  - a. Improved **Access** to care for patients
  - b. Improved **Care Coordination** and **Care Management**
  - c. Continuous **Practice Redesign**
2. Understanding the roles of the various primary care team members who support the care of the patient
3. Understanding the ways in which electronic medical records and patient care databases support the PCMH model
4. Understanding how the PCMH model benefits both patients and the health care system (including—we hope—understanding how this model of care could improve your future practice, whether it be in general or specialty medicine)

### **What is PCMH/PACT**

First, some terminology clarification: when the VA began implementing the PCMH model in Primary Care, it was quickly rebranded as “PACT” (Patient Aligned Care Teams). This was done for a number of reasons:

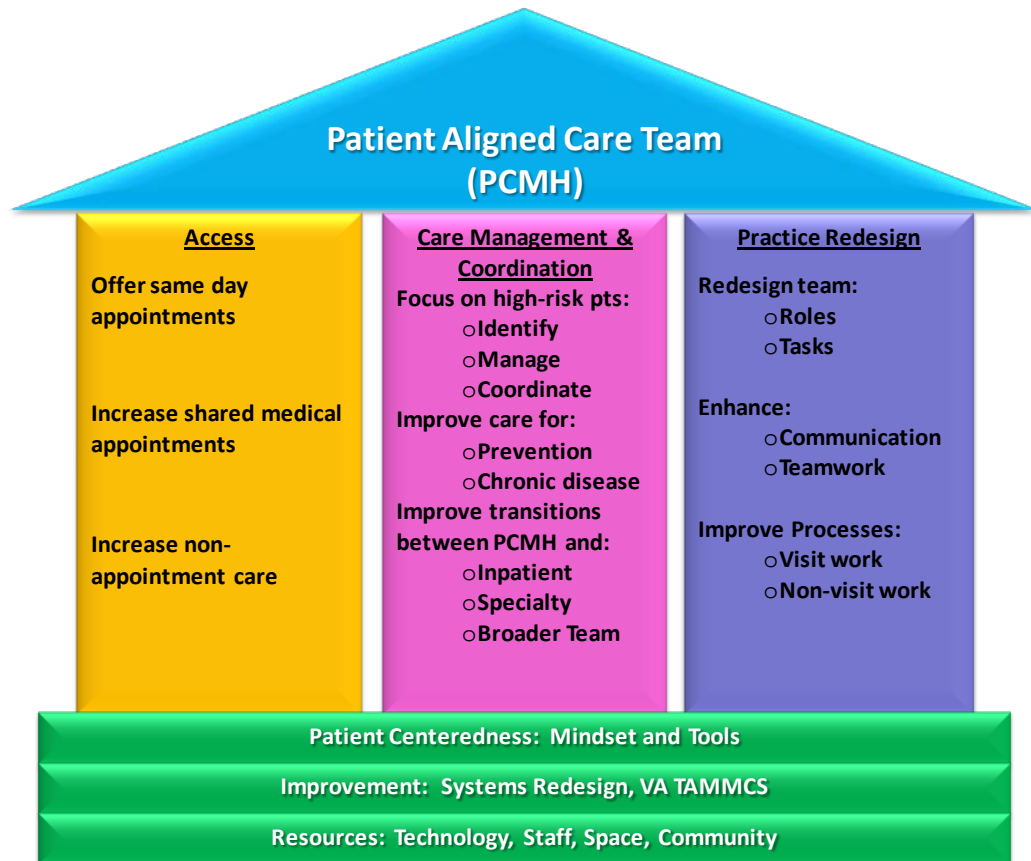
- The “Home” part of PCMH was confusing, and led many people to think this was a model of home care (we’ve heard this from our residents too).
- Everyone likes to place their own brand on a concept, and the VA is no different in this respect.
- Frankly, PACT is much easier to say than PCMH.

Therefore, throughout the rest of this document, and in the VA Primary Care Clinics, you will hear this model referred to as PACT, though the extensive literature on this model primarily uses the PCMH term.

The PACT model is not something newly invented by the VA—the PCMH concept was first developed in the 1960’s by pediatricians, and slowly refined over the past few decades, but did not really begin to catch on in primary care until the past decade, when frustrations of both patients and primary care providers with the current care model led to renewed interest in a transformed model of primary care. Growth of this model has benefited from the general dissatisfaction with our health care system in the U.S., as well as the support of business leaders (frustrated with the cost of care), medical professional societies (including the ACP, AAFP, AAP, AMA, and others) and government (Medicare is funding demonstration projects in PCMH). The model is also supported by a growing body of literature demonstrating its benefits in terms of both medical outcomes and possibly medical costs.

The PACT model constitutes a more patient-centered approach to primary care utilizing teams of health care providers who provide improved access to care, care coordination and disease management . This

pictorial representation demonstrates the three core pillars of PACT built on a foundation of patient centeredness, systems improvement tools and appropriate resources.



We are hoping that you will get a flavor of the nuts and bolts of PACT by joining one of our primary care “teamlets” and working with them as they deliver patient care in the PACT setting. Each teamlet consists of a provider, RN, LPN, clerical associate and an assigned panel of primary care patients.

You will also have the option to spend time with members of the larger primary care team (Clinical Pharmacy, Behavioral Health, Social Work) who support our individual teamlets. While some of your experience will be observational (primarily when you don’t have the skills or experience to provide those aspects of care), we have strived to make this an active learning experience where possible.

**Individual Schedule Elements:**

**Teamlet Huddles and Weekly meetings:**

The teamlet huddles briefly as a group on most days to

- review the patient schedule for either that day or the next day, determining any special patient needs/interventions

- review the previous day's inpatient discharges and ER visits to determine and assign follow-up tasks (phone calls, patient appointments, other care coordination)
- review other active patient issues and assign tasks
- (on some teams) review the patient schedule a week or more ahead to "scrub" the schedule for unneeded patient appointments (duplicate visits, appointments that can be converted to telephone visits)

The teamlet meets weekly to focus on process improvements in the team or to work on chronic disease management or high-risk patient management projects.

### **Clinic with Attending/Women's Health Clinic**

You will work in clinic with your attending and with Dr. Grewal, participating in direct patient care in the PACT setting, seeing both scheduled patients and walk-in/urgent patients. The objective will be to consider use of PACT resources in caring for those patients and developing your management plans. You will also have the opportunity to observe and participate in telephone visits with your attending's patients.

### **Evaluation Process**

Your evaluation will be completed by your precepting attending with input from the other members of your PACT teamlet (RN, LPN and clerical associate) and additional PACT team members, using the standard online form provided by the housestaff office. The most important aspect of your performance will be your active participation in the rotation.

### **Additional Resources:**

[http://www.acponline.org/running\\_practice/delivery\\_and\\_payment\\_models/pcmh/understanding/](http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/) (an excellent general resource to better understand the patient-centered medical home model, with additional links)

<http://vawww.infoshare.va.gov/sites/primarycare/mh/pcmhinfo/default.aspx> (VA PCMH site, has a wealth of links to other PCMH resources; this site is available only within the VA intranet)



12-16-09 The Evidence for PCMH.ppt (PowerPoint summarizing some of the evidence supporting the PCMH model)



PCMH Concept Paper 10-1-09.pdf (VA description of the PCMH concept, as planned for implementation in VA)

**Reviewed by Dr. Langenberg and Dr. Kaul 6/1/16**