Healthcare 2 (2014) 245–250

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/hjdsi

Implementing a patient centered medical home in the Veterans health administration: Perspectives of primary care providers

Samantha L. Solimeo [a,b,*], Kenda R. Stewart [a,b,c], Gregory L. Stewart [a,b,d], Gary Rosenthal [a,b,e,f]

[a] US Department of Veterans Affairs, VISN 23 Patient Aligned Care Team Demonstration Lab, Iowa City VA Health Care System, Iowa City, IA 52246, United States
[b] US Department of Veterans Affairs, Center for Comprehensive Access & Delivery Research and Evaluation, Iowa City VA Health Care System, 152, Iowa City, IA 52246, United States
[c] US Department of Veterans Affairs, Veteran Rural health Resource Center Central Region, Iowa City VA Health Care System, Iowa City, IA 52246, United States
[d] Tippie College of Business, University of Iowa, Iowa City, IA 52242, United States
[e] Division of General Internal Medicine, University of Iowa Carver College of Medicine, Iowa City, IA 52242, United States
[f] Department of Health Management and Policy, University of Iowa College of Public Health, Iowa City, IA 52242, United States

ARTICLE INFO

Article history:
Received 22 October 2013
Received in revised form
26 June 2014
Accepted 15 July 2014
Available online 13 August 2014

Keywords:
Patient-centered care
Primary health care
Leadership
Qualitative research
Veterans health
Health care quality, access, and evaluation
Organizational culture
Telemedicine
Empanelment
Patient aligned care team

ABSTRACT

Implementation of a patient centered medical home challenges primary care providers to change their scheduling practices to enhance patient access to care as well as to learn how to use performance metrics as part of a self-reflective practice redesign culture. As medical homes become more commonplace, health care administrators and primary care providers alike are eager to identify barriers to implementation. The objective of this study was to identify non-technological barriers to medical home implementation from the perspective of primary care providers. We conducted qualitative interviews with providers implementing the medical home model in Department of Veterans Affairs clinics—the most comprehensive rollout to date. Primary care providers reported favorable attitudes towards the model but discussed the importance of data infrastructure for practice redesign and panel management. Respondents emphasized the need for administrative leadership to support practice redesign by facilitating time for panel management and recognizing providers who utilize non-face-to-face ways of delivering clinical care. Health care systems considering adoption of the medical home model should ensure that they support both technological capacities and vertically aligned expectations for provider performance.

Published by Elsevier Inc.

1. Introduction

The Patient Centered Medical Home model is designed to improve patient outcomes and primary care provider satisfaction through practice redesign that challenges primary care providers in multiple ways.[1,2] To be successful, primary care providers practicing in medical homes must simultaneously develop strategies to provide patient-centered, preventative, acute, and chronic disease care in an accessible way.[3–6]

In 2010, the Veterans Health Administration (VHA) began implementing the medical home model throughout its primary care clinics.[2,7] VHA's initiative represents the nation's largest effort to fundamentally redesign the delivery of primary care. In VHA, medical homes are organized around "Patient Aligned Care Teams" also known as "PACTs" that are comprised of a primary care provider who leads the team, and a clerical associate, registered nurse, and licensed practical nurse. PACTs function independently, but multiple PACTs have shared relationships with specialist physicians and other health care practitioners, including social workers and pharmacists.

Within the PACT model, primary care providers are accountable for patient outcomes and for identifying ways to improve access and other quality performance metrics. When administrative leadership enables teams to shift time from direct patient care, primary care providers are assumed to be able to create processes to improve quality of care and patient satisfaction, provide greater patient access, and reduce costs.[8,9] Ideally, PACTs acquire time to complete this work by utilizing team members to the top of their skill set through: (1) delegation, and (2) by utilizing "encounterless encounters"[10] (e.g. telephone visits, secure messaging) to provide patient care in lieu of traditional face-to-face visits. Nonetheless, in many clinics primary care provider workdays remain structured around face-to-face encounters, and facility variation in the interpretation of nursing scope of practice can limit primary care provider within-team delegation.[3,8,11–13]

As part of a larger project studying team function we conducted qualitative interviews with members of 22 teams implementing PACT as part of a pilot launch. In the current manuscript we report

* Corresponding author at: US Department of Veterans Affairs, VISN 23 Patient Aligned Care Team Demonstration Lab, Iowa City VA Health Care System, Iowa City, IA 52246, United States. Tel.: +1 319 338 0581x7637.
E-mail address: Samantha.Solimeo@va.gov (S.L. Solimeo).

http://dx.doi.org/10.1016/j.hjdsi.2014.07.004
2213-0764/Published by Elsevier Inc.

on data collected from primary care providers in these teams, whose role as team leaders is accompanied by responsibility for PACT implementation. As VHA primary care providers practice in settings already equipped with an integrated pharmacy, secure messaging, multiple telehealth platforms, and an electronic medical record, our objective was to identify non-technological challenges to providers' transition to the medical home care model.

2. Materials and methods

2.1. Sample

Twenty-two primary care providers participating in a PACT Learning Collaborative organized by the VA Midwest Health Care Network (VISN 23) located in the upper Midwestern United States, were eligible for the study. Primary care providers were recruited to participate by e-mail in a voluntary, confidential, one-on-one semi-structured interview six months after the initial Learning Collaborative. Twelve primary care providers agreed to participate in the initial interview; nine of these agreed to participate in a second interview one year later. Detailed description of the larger evaluation[14] and the Learning Collaborative are reported elsewhere.[12]

2.2. Data collection

In order to balance our desire for respondents to speak about issues that they felt were important with our need to have standardization across interviews, we used a semi-structured interview format.[15] Interview topics were informed by: (1) review of published literature on medical home implementation, which identified a number of key concepts related to medical home implementation (e.g., enhanced access, care coordination, continuity of care, role of practice facilitators); (2) review of PACT training materials, which emphasize team function, delegation, and practice redesign; and (3) the research team's interest in understanding the within-team processes driving team function, such as role negotiation, delegation, and job satisfaction. Draft interview questions were developed, reviewed for face validity by the VISN 23 PACT Demonstration Lab leadership, and then revised for clarity and feasibility. See Fig. 1. All interviews were audio-recorded and designed to be completed in 30–60 min.

2.3. Analysis

The interviews were transcribed by experienced transcriptionists, audited for accuracy, and imported to a qualitative data software platform (MAXQDA[16]) to facilitate analysis. Pairs of trained qualitative analysts coded transcripts to an 80% agreement benchmark, facilitated by the software to enhance coding reliability. The initial codebook was written using deductive parameters derived from the literature and interview guide. The research team developed additional codes through inductive review of the interview transcripts. The lead investigator (SLS) adjudicated disagreements.

To understand primary care provider perceptions of PACT implementation demands, two anthropologists (SLS and KRS) analyzed interview data coded for primary care provider role, enhanced access practices, panel management, chronic disease management, data quality, and implementation barriers. Each anthropologist reviewed these coded data and independently developed a list of the effects of implementation on primary care provider practice and perceived implementation barriers. After the initial list development, the anthropologists met and identified broad themes to characterize primary care providers' implementation experience. A majority of respondents' discussion of non-technological barriers to implementation were encompassed by two domains: (1) primary care utilization of virtual encounters; and (2) the integration of performance metrics into team operations. Coded data for these two domains were then reviewed independently, refined, and exemplar passages selected for comparison. After comparison and further refinement, the anthropologists reviewed the primary care provider interviews at one-year follow up to assess change and sustainment.

3. Results

Table 1 summarizes participant characteristics. A majority ($n=7$) of participating primary care providers had worked at their current practice site for less than five years. Interviews ranged in length from 30–75 min. Despite being scheduled during providers' administrative time, interviews were frequently rescheduled to accommodate patient appointments or otherwise interrupted, underscoring the ubiquity of time pressures.

3.1. Primary care providers generally positive towards PACT

Overall, respondents described enthusiasm for the model and expressed their buy-in as a result of being allowed to provide care in a way that they had long desired:

> "*I think that because I'm used to this and this honestly is how I've always wanted to work, but the one glitch was always: 'How do I clear a schedule when, if you do that somebody's going to think you don't want to see the patient?' So now with this PACT I'm where I can delegate. My LPNs call back when I need call backs. They all give me information*" (Primary Care Provider 1).

Despite an expressed enthusiasm, a majority of respondents related concerns regarding the challenge of bringing clinical practice into alignment with the ideals of the PACT model. Of particular note were primary care provider observations that VHA's emphasis on bottom-up, team driven implementation (as opposed to centrally directed mandates) was a positive feature. However, some participants explained that being directed to innovate was intrinsically at odds with the scale of implementation and led them to question the ability of VHA to sustain PACT implementation efforts over time. Some participants also discussed the importance of having VHA leadership provide clear communication of PACT implementation goals and endpoints.

In the context of implementation, primary care providers reported a sense of increasing expectations to provide more services to each patient, while assuming responsibility for a larger patient panel. Discussion of increasing panel size was connected to respondents' belief that implementation increased administrative leadership's scrutiny of their performance. Providers reported concerns with the ability of existing metrics to accurately reflect primary care provider performance and workload. These concerns constituted two primary themes common to the primary care provider interviews: (1) "mixed messages" primary care providers received regarding encounterless encounters; and (2) using performance metrics to redesign practice. A brief description of the overall trends within each theme as well as subtle differences in primary care provider perceptions between the initial and follow-up interviews follows.

3.2. Providers cannot embrace enhanced access strategies if rewarded for a full schedule

Once PACTs had been formed, their first practice redesign efforts focused on improving access. While some providers