PATIENT CENTERED MANAGEMENT MODULE (PCMM) FOR PRIMARY CARE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes the guidelines and business rules for use of the Patient Centered Management Module (PCMM) (formerly known as "*Primary Care* Management Module"). PCMM is an enterprise application that enables users to (1) set up and define health care teams, (2) assign staff and their associated full-time equivalent (FTE) staff to positions within each team, (3) assign patients to the team, and (4) assign patients to specific team members. Following these guidelines and business rules will ensure that the data entered into PCMM is reliable and consistent across VA. For primary care (PC) this will enhance the ability of the Patient Aligned Care Team (PACT) to optimally manage health care for patients assigned to PACT, including all VHA PC clinical sites of care to include VHA owned, leased and contracted locations. PCMM capabilities include the management of PC (as defined by VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook), non-primary care (e.g., mental health, Operation Enduring Freedom-Operation Iraqi Freedom-Operation New Dawn (OEF-OIF-OND), etc.) and community care (non-VA) populations, in support of current or future program office guidance.

2. SUMMARY OF MAJOR CHANGES: This VHA directive provides updated guidance on the utilization of PCMM to support a team-based, patient centric approach to patient care.

a. Amendment dated April 16, 2026, corrects an error in Appendix E (Table 1. Adjustments in Modeled Panel Capacity for PACT Teamlet Support Staff) from 2.6-2.9 FTE to 2.6 to 2.99 FTE. ***NOTE:*** *There are no updates to the policy. This is an administrative change.*

b. Amendment dated April 10, 2025, changes language from "gender" to "sex" to comply with EO 14168.

c. Amendment dated April 17, 2024:

(1) Adds information regarding an April 2023 PCMM release which changes the auto-inactivation routine from 24-months to 36-months in Appendix G.

(2) Updates the stop codes in Appendix J.

d. As published June 20, 2017, this directive:

(1) Highlights the enhancement from a Veterans Health Information Systems and Technology Architecture (VistA) Graphical User Interface (GUI) software program to a VHA web-based GUI application to include a name change from Primary Care

Management Module to Patient Centered Management Module, utilizing the same acronym “PCMM”.

(2) Mandates the assignment of a National PCMM Coordinator and a Principal Facility Coordinator for PCMM.

(3) Ensures data validation occurs so the output is as refined as possible for executive decision making purposes.

(4) Identifies capabilities for PCMM utilization for managing non-primary care and community care (non-VA) populations.

(5) Describes the conversion of PCMM PACT assignment from pending to active when a qualifying teamlet encounter has been completed.

(6) Establishes PCMM as the authoritative source for PACT staffing, capacity, panel size, and exam room space.

(7) Enables the entry of PCMM surrogates who are routinely responsible for the PACT patient population during staff absences.

(8) Replaces the term “dual assignment” with “multi-PACT assignment” when referring to a primary care panel assignment status where a patient has been approved for assignment to more than one PACT.

3. RELATED ISSUES: VHA Handbooks 1101.10 and 1101.11(2).

4. RESPONSIBLE OFFICE: The VHA Office of Primary Care (11PC) in the Office of the Assistant Under Secretary for Health for Clinical Services is responsible for the contents of this directive. Questions related to Primary Care may be directed to VHA11PCPrimaryCareAction@va.gov.

5. RESCISSIONS: VHA Handbook 1101.02, dated April 21, 2009, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2022. This VHA directive will continue to serve as national policy until it is recertified or rescinded.

/s/ Poonam Alaigh, M.D.
Acting Under Secretary for Health

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PATIENT CENTERED MANAGEMENT MODULE (PCMM) FOR PRIMARY CARE

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes the guidelines and business rules for use of the Patient Centered Management Module (PCMM) (formerly known as “Primary Care Management Module”). PCMM is an enterprise application that enables users to (1) set up and define health care teams, (2) assign staff and their associated full-time equivalent (FTE) staff to positions within each team, (3) assign patients to the team, and (4) assign patients to specific team members. Following these guidelines and business rules will ensure that the data entered into PCMM is reliable and consistent across VA. For primary care (PC) this will enhance the ability of the Patient Aligned Care Team (PACT) to optimally manage health care for patients assigned to PACT, including all VHA PC facilities of care to include VHA owned, leased and contracted locations. PCMM capabilities include the management of PC (as defined by VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook), non-primary care (e.g., mental health, Operation Enduring Freedom-Operation Iraqi Freedom-Operation New Dawn (OEF-OIF-OND) and community care (non-VA) populations, in support of current or future program office guidance. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. Over time, VHA has developed a primary care system that balances productivity with quality, access, and personalized, proactive, patient-driven health care. Management of patient panels in PC through mandatory and consistent use of PCMM has supported this care delivery system, and allows facilities to track patients and their assigned PACT across the system. Additionally, PCMM allows for specific data entry of PACT teamlet FTE and their allocated exam room space. When data are entered in a standardized manner, the information is used to analyze Primary Care capacity, staffing, space and workload nationally, by Veteran Integrated Service Network (VISN), by VA medical center, and community-based outpatient clinic (CBOC). PACTs manage the overall care provided to a majority of Veterans in the Department of Veterans Affairs (VA) Health Care System. PACT workload capacity is an important factor in determining the total number of patients that can be cared for in the system. In response to the growing number of Veterans using VA health care services, there is a need to quantify the primary care capacity that is available, so that supply and demand can be aligned.

b. The PCMM application supports automated data collection for management metrics and analysis related to access, workload, and panel management.

c. PCMM management and oversight requires a national PCMM Coordinator, a VISN PCMM point of contact (POC), and a Principal Facility Coordinator (PFC) for PCMM to ensure adherence to policy and business rules, and for data management, education and training. These staff members will serve as subject matter experts (SME) to VHA staff members and ensure accuracy and data integrity of PCMM.

3. DEFINITIONS

a. **Actual PACT FTE.** Actual PACT FTE is the portion of the full-time equivalent employee available to support the PACT.

b. **Administrative Associate.** The Administrative Associate is the teamlet member who provides administrative support for the delivery of primary care services and operations management to a PACT (e.g., medical clerk (MC), health technician (HT)).

c. **Associate Provider.** Associate Provider (AP) is a designation in PCMM intended primarily for trainees who require supervision from a physician or faculty provider who is associated with academic affiliates. Health professionals in training (e.g., physician residents, Nurse Practitioner (NP) and Physician Assistant (PA) residents) are APs when they provide ongoing and comprehensive primary care in collaboration with a supervising practitioner for an assigned panel of patients (see VHA Handbook 1400.01, Resident Supervision, and VHA Handbook 1400.04, Supervision of Associated Health Trainees). Staff PAs and NPs may be designated as APs as determined by local facility policy or when assigned shared responsibility for a panel of patients with a supervising or collaborating physician, NP or PA. See VHA Handbook 1101.10, VHA PACT Handbook.

d. **Available Capacity.** Available capacity is the difference between the actual panel size and the defined panel capacity (modeled capacity or modeled capacity override).

e. **Clinical Associate.** A Clinical Associate is a Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) or unlicensed assistive personnel (e.g., certified nursing assistant (CNA), medical assistant (MA), HT). The Clinical Associate is a teamlet member. See VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook.

f. **Designated Women's Health Provider (DWHP).** A designated Women's Health Provider (DWHP) is a Primary Care Provider who is proficient in women's health. A designated WH PCP is preferentially assigned women Veterans within their primary care patient panels. See VHA Directive 1330.01 Health Care Services for Women Veterans.

g. **Discipline-Specific Team Member.** A discipline-specific team member is a health care professional designated to a PACT position who provides direct discipline-specific patient care, either in-person or through telehealth, to one or more panels of patients, but not to all primary care patients at the facility. Examples of discipline-specific team members are: Clinical Pharmacy Specialists, Registered Dietitian Nutritionists, Social Workers, Physical Medicine and Rehabilitation Services Therapists, Lead Coordinators, Primary Care-Mental Health Integration staff members. See VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook. ***NOTE:*** *Discipline-specific team members may also be referred to as expanded team members and may be included as part of a larger interdisciplinary team for complex care coordination and should be assigned in PCMM as appropriate.*

h. **Encounter.** An encounter is a professional contact between a patient and a provider with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in outpatient and inpatient settings (including Residential Rehabilitation Treatment centers). See VHA Directive 1082, Patient Care Data Capture.

i. **Examination Rooms.** Examination rooms are fully-equipped rooms in which providers and other staff prepare and examine patients.

j. **Expected FTE.** Expected FTE is a field in PCMM that allows the user to identify the expected FTE associated with the team position being established. It is to be used to identify the portion of a full-time equivalent employee required to support the team.

k. **Full-Time Equivalent.** An FTE is the hours worked by one employee on a full-time basis in a normal 80 hour pay period. The value usually ranges from 0.0 to 1.0. For example, a 1.0 FTE would work 80 hours in a pay period, while a 0.5 FTE would work 40 hours per pay period.

l. **Managerial Cost Accounting.** Managerial cost accounting (MCA) (formerly known as Decision Support System (DSS)) is an activity based cost allocation system that generates estimates of the cost of individual VA hospital stays and health care encounters. See VHA Directive 1750, Managerial Cost Accounting System (Decision Support System (DSS)).

m. **Modeled Panel Capacity.** The modeled panel capacity is the maximum number of patients a PACT is expected to care for when the baseline capacity, which is currently 1200, is adjusted by a formula that takes into account the current teamlet support staff, rooms, female veterans, intensity score, and PCP type.

n. **Modeled Capacity Override.** Modeled capacity override is the panel capacity set locally if primary care leadership chooses to use a panel capacity different than what the modeled panel capacity specifies.

o. **Multi-PACT Assignment.** A multi-PACT assignment (previously known as "dual assignment") is a primary care panel assignment status where a patient has been clinically approved for assignment to more than one PACT. For more information see VHA Handbooks 1101.10, VHA PACT Handbook and 1101.11(2), Coordinated Care for Traveling Veterans.

p. **Panel Management.** Panel management is the administrative process of using the PCMM application to assign and un-assign patients to a team, and to calculate, adjust, and monitor PACT panel capacity and size.

q. **Patient Aligned Care Team.** The PACT is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care. PACTs for special populations are designated by a specific indicator. See VHA Handbook 1101.10.

r. **PACT Assigned Total.** PACT assigned total is the sum of PACT assignments with an active and pending status.

s. **PACT Staff.** PACT staff is VHA staff designated in PCMM to a position in a PACT. See VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook.

t. **Panel Management.** Panel management is the administrative process of using PCMM software to assign and un-assign patients to a PACT, and to calculate, adjust and monitor panel size. ***NOTE:*** *Panel management is often confused with population management. Panel management refers to management of assigning patients to a panel and managing the panel size. Population management refers to the use of data to address the health status of a cohort of patients defined by specific parameters. See definition for population management.*

u. **Panel Size.** Panel size is a field in PCMM that displays the total number of currently assigned patients. For all PACTs, panel size is the total number of pending and active PCMM PACT assignments. For non-primary care and community (non-VA) populations, panel size is the total number of active assignments.

v. **Patient Centered Management Module.** PCMM is a VHA Web-based application that allows input of facility specific and PC panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes.

w. **Population Management**. Population management is a data-driven process for proactively defining a cohort of patients who might benefit from a health care plan or intervention. This approach allows the PACT to contact individual patients in the cohort to offer the right service at the right time, rather than waiting for the patient to self-identify and seek out health care. Population management activities enable identification of gaps in clinical care and use strategies for improving health care outcomes for the defined patient cohort. ***NOTE:*** *Population management is often confused with panel management. Population management refers to the use of data to address the health status of a cohort of patients defined by specific parameters. Population management of a patient panel means that population management strategies are used to assess and address the care needs of all patients assigned to the panel. Panel management refers to management of assigning patients to a panel and managing the panel size. See definition for panel management.*

x. **Principal Facility Coordinator.** The principal facility coordinator (PFC) is the facility's designated staff member who manages and maintains the access, data entry, and accuracy of PCMM.

y. **Primary Care Direct Patient Care FTE.** Primary Care Direct Patient Care (PCDPC) FTE is the time to prepare for, provide, and follow-up on the clinical needs of PC patients. This includes all time spent in reviewing patient data; discussions about the care with colleagues; contacting the patient, family or other surrogate decision-makers, or caregivers to discuss their concerns or needs; and collaborating with potential and actual community care (non-VA) health care institutions on patients' behalf.

z. **Primary Care Intensity Score.** Primary care intensity score is a measure that predicts primary care workload. The intensity score allows PCMM software to adjust primary care panel capacity to allow equilibration of PACT workload among teams despite differences in medical complexity of their patient panel. The primary care intensity score is computed at least yearly and typically explains over 40 percent of the total variation in PACT workload (including both face-to-face and telephone care). The model for determining the intensity score evaluates a wide-range of demographic variables including patient age, sex, priority group, insurance status, and number and severity of diagnoses to determine those factors most highly correlated with workload. These factors reflect a combination of complexity of illness and reliance on VHA.

aa. **Provider.** For the purposes of this directive, the term provider is interchangeable with the PCP.

bb. **Primary Care Provider.** Primary Care Provider's (PCP) are physicians, NPs, and PAs who provide primary care to an assigned panel of patients and in accordance with licensure, privileges, scope of practice or functional statement. The PCP is a teamlet member. See VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook. ***NOTE:*** *Other PACT teamlet or discipline-specific team members provide health care services, but are not considered to be providers for the purpose of this directive.*

cc. **Qualifying Encounter.** A qualifying encounter is an encounter by a PACT team member that triggers a PCMM status change from pending to active or maintains active status. See definition for encounter and appendix J for a list of qualifying encounters and stop codes.

dd. **Registered Nurse Care Manager.** The Registered Nurse Care Manager (RNCM) is a teamlet member who provides comprehensive and coordinated nursing care to an assigned panel of patients. The RNCM collaborates with both VA services and community services as appropriate to effectively meet the health promotion or disease prevention, acute, chronic, and long-term needs, based on the Veteran's goals and plan of care with a focus on self-management. See VHA Handbook 1101.10.

ee. **Pro-Rated Room Availability.** Pro-rated room availability is the total count of available exam space to provide patient care when clinic is in session. The total count should include the proportional amount of time the space is available for patient care. For example, if one exam room is equally shared by primary care and specialty care, primary care's pro-rated exam room count would be 0.5.

ff. **Station Modeled Capacity.** The station modeled capacity represents the total number of patients that should be assigned to a team based on its station, care type, intensity score and rooms available at the station.

gg. **Surrogate.** A surrogate is a specific individual in a similar role that is assigned to cover for the corresponding PACT staff-member during short-term or unplanned absences.

hh. **Teamlet.** A teamlet consists of a PCP, RNCM, clinical associate, and administrative associate who provides patient care, either in-person or through telehealth, to one entire panel of patients as assigned in PCMM. Generally, teamlet members are designated in PCMM to the following positions: PCP, Registered Nurse (RN), LPN/LVN/HT, and Clerk. Trainees may also participate in teamlets. Special population PACTs may have additional or other designated teamlet positions in PCMM. See VHA Handbook 1101.10.

ii. **Trainee.** A general term to describe undergraduate, graduate, and post-graduate students, interns, residents, fellows, and VA advanced fellows; and pre- and post-doctoral fellows whose time at a VA medical facility is spent in clinical or research training experiences to satisfy program or degree requirements. See VHA Directive 1400.09, Education of Physicians and Dentists, VHA Handbook 1400.08, Education of Associated Health Professions, and VHA Handbook 1400.07, Education of Advanced Fellows.

jj. **Trainee Full-Time Equivalent**. Although trainees are not considered employees for this purpose, trainee activities for supervised practice and other learning in primary care can be estimated assuming an 80-hour pay period. The estimated value usually ranges from 0.0 to 1.0. For example, a 1.0 trainee FTE would be present in the primary care setting for 80 hours in a pay period, while a 0.5 trainee FTE would be present in the primary care setting for 40 hours per pay period.

kk. **Traveling Veteran Coordinator.** A Traveling Veteran Coordinator (TVC) is a RN, PA, or NP who coordinates necessary or ongoing health care for Veterans on extended travel. See VHA Handbook 1101.11(2), Coordinated Care for Traveling Veterans.

ll. **User Permissions.** User permissions determine the actions an authorized PCMM user is allowed to perform within the PCMM application.

mm. **Vacancy FTE.** Vacancy FTE is the difference between PCMM expected and actual PACT FTE.

4. POLICY

a. It is VHA policy that PCMM be utilized by all PACTs for panel management. PCMM is used to identify the PACT assigned to care for each PC patient. Current primary care panel capacity can be measured using PCMM by determining the number of active primary care patients assigned to a PACT. Entry of PCMM assignments is done in a standardized way throughout the VA health care system in order to ensure accurate and meaningful network and national analysis of this information.

b. It is the expectation that Veterans will receive primary and/or specialty care at VA medical facilities, regardless of a PACT assignment in PCMM. Assignment to a PACT is not a prerequisite for receiving episodic care at a VA facility or VA-owned or contract community-based outpatient clinic (CBOC).

5. RESPONSIBILITIES

a. **VHA Executive Director for Primary Care Operations.** The VHA Executive Director for Primary Care Operations is the business owner of the PCMM application and is responsible for:

(1) Ensuring the overall technical functionality, development, and future enhancements of the PCMM application.

(2) Developing national guidelines for PCMM use for PACT.

(3) Developing and implementing the PCMM business rules for PACT to monitor data validity, reliability and variances to include, but not limited to panel sizes, actual capacity, modeled capacity, staffing, and examination rooms.

(4) Reviewing PCMM metrics for outliers or excessive data variability that require further evaluation to determine if PCMM business rules are being correctly implemented in conjunction with the national PCMM Coordinator.

(5) Appointing a national PCMM Coordinator.

b. **VHA Office of Academic Affiliations**. The VHA Office of Academic Affiliations is responsible for policies regarding trainee engagement in clinical care and education.

c. **National PCMM Coordinator.** The National PCMM Coordinator is responsible for:

(1) Serving as the technical authority of PCMM and its utilization throughout VHA.

(2) Overseeing the PCMM application to ensure expected functionality is optimized.

(3) Communicating PCMM business rules, operational impact, and functional development to VISN and facility coordinators and others, as needed.

(4) Providing technical support to field users through virtual mentoring, teaching, and instruction.

(5) Analyzing and evaluating the accuracy of PCMM data and working with VISNs to address compliance with PCMM business rules and variation in PCMM generated data which raises the possibility of data inaccuracy.

(6) Providing feedback to facility leaders regarding PCMM metrics, in conjunction with officials from VHA Primary Care Operations.

(7) Assigning PCMM user permissions to National and VISN staff.

d. **VISN Director.** The VISN Director is responsible for:

(1) Ensuring implementation of this directive at all VA medical facilities in the VISN where Veterans receive primary care.

(2) Ensuring that the VHA Web-based PCMM application is utilized within all primary care facilities across the VISN and the data is accurate and valid.

(3) Implementing the PCMM business rules for PACT, as described within this Directive, and monitoring data validity, reliability, and variances to include, but not limited to panel sizes, actual capacity, modeled capacity, staffing, and examination room space.

(a) Developing corrective action plans in collaboration with VHA Office of Primary Care Operations to address inappropriate variances or deficiencies.

(4) Identifying a staff member to serve as the VISN PCMM Coordinator with the following knowledge and skills:

(a) In-depth understanding of PCMM business rules, functionality, and clinical impact;

(b) Ability to validate PCMM utilization and data integrity across all VISN locations; and

(c) Ability to communicate with staff across all levels of the organization.

(5) Ensuring that the VISN PCMM Coordinator is actively involved with VISN-level PACT activities.

e. **VISN PCMM Coordinator.** The VISN PCMM Coordinator is responsible for:

(1) Completing VISN PCMM training activities and participating in national PCMM conference calls and discussion as needed.

(2) Participating in periodic conference calls with the National PCMM Coordinator to discuss the VISN PCMM Coordinator's role and to coordinate and support PCMM training for facility PCMM coordinators.

(3) Facilitating monthly and routine collaboration and communication with PFCs.

(4) Delegating PCMM user permissions for VISN and PFCs.

(5) Ensuring that PCMM expectations and business rules are communicated with VISN PACT leaders and PFCs, as needed.

(6) Ensuring that all VISN users and PFCs are familiar with this PCMM directive, the PCMM user guide, and other applicable reference materials.

(7) Ensuring accuracy and timeliness of PCMM utilization through analysis and evaluation to ensure compliance with VHA PCMM and PACT policies, guidelines, and business rules throughout the VISN.

(8) Serving as the VISN technical expert for PCMM with the ability to troubleshoot and resolve user issues.

(9) Reviewing PCMM metrics at facilities within the VISN to identify outliers or excessive data variability. Concerns will be shared with appropriate VISN and facility leaders, as well as the National PCMM Coordinator.

f. **VA Medical Facility Director.** The VA medical facility Director, or designee, is responsible for:

(1) Identifying a PFC, and a back-up PFC, who are organizationally aligned under Primary Care clinical leadership, with the following knowledge and skills:

(a) In-depth understanding of PCMM business rules, technical functionality, and clinical impact;

(b) Ability to ensure that PCMM is fully utilized at parent and all division locations where Primary Care is provided;

(c) Ability to validate PCMM utilization and data integrity throughout all facility Primary Care locations including timely data entry and oversight management; and

(d) Ability to communicate with staff across all levels of the organization.

(2) Ensuring the FTE allocation of the discipline-specific PACT members in PCMM accurately reflects PACT responsibilities (see VHA Handbook 1101.10) and is in alignment with MCA labor mapping (see VHA Directive 1750, VHA Managerial Accounting System (Decision Support System)).

(3) Ensuring that the data in PCMM accurately reflects the business rules for PACT, as described in this Directive, and monitoring data validity, reliability, and variances to include, but not limited to panel sizes, actual capacity, modeled capacity, staffing, and examination room space.

(4) Developing action plans to evaluate and correct unexplained deviations in PCMM data, as described above, in conjunction with the VISN Director.

g. **Facility Chief of Staff.** The facility Chief of Staff is responsible for:

(1) Determining the time allocation for each PCP dedicated to patient care and maximum panel expectations.

(2) Reviewing PCMM data related to efficiency, capacity, and staffing. The Chief of Staff may delegate this responsibility to service level officials accountable for PACT. At larger facilities where PC teams are in more than one clinical service (e.g., PC and SCI

Service), the Chief of Staff may designate this responsibility to more than one primary care clinical leader and/or practice manager.

(3) Overseeing PCMM multi-PACT approval/denial clinical review process to include the identification of approving POCs who are RNs or PCPs.

(4) Ensuring allocated PACT examination room space is identified.

h. **Service Level Officials Accountable for PACT.** The service level officials accountable for PACT (i.e., designated facility PC, nursing, and administrative leader(s)) are responsible for:

(1) Ensuring service-level implementation of this Directive at all facilities of care administered by the VA medical facility where Veterans receive primary care. This includes special population PACTs, as defined in VHA Handbook 1101.10.

(2) Ensuring assignment of PACT team members and staffing are consistent with PACT staffing as outlined in VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook and are entered into PCMM accordingly.

(3) Ensuring that the PFC is notified of the required PCMM roles and identified staff during team setup in PCMM and as changes occur.

(4) Ensuring that validation of PCMM data is completed at least monthly and on a regular basis to ensure that definitions and decisions are subjected to ongoing evaluation and consistent interpretation.

(5) Identifying teamlet PCMM surrogates to enable the identification of PACT staff members who are responsible for covering the PACT teamlet when staff member absences occur.

(6) Identifying and validating the accuracy of the data related to number of rooms entered for each PACT.

(7) Validating the accuracy of the PCDPC FTE and maximum PACT capacity.

(8) Collaborating with the facility MCA Coordinator to ensure accuracy of teamlet PCMM FTE entry.

(9) Identifying PCMM positions, staff, and other information as needed for other non-primary care programs.

(10) Communicating any changes to staffing, staffing FTE, and pro-rated room availability to the PFC as they occur.

(11) Establishing local process/protocol to ensure PCMM PACT pending assignments are entered as soon as possible following the creation of the patient's first PACT appointment. ***NOTE:*** *Timely assignment of the patient allows for system-wide tracking of the patient's care, which is optimal for care coordination and in the best*

interest of the patient. It is also beneficial to the organization, as it allows for better tracking and monitoring of patient assignments, panel capacity, and staffing demands.

i. **Principal Facility Coordinator for PCMM.** The PFC for PCMM is responsible for:

(1) Ensuring the integrity of the VA medical facility's PCMM application, its functionality, utilization, and resulting data.

(2) Serving as the facility's technical expert for PCMM with the ability to troubleshoot and resolve user issues.

(3) Participating in monthly national calls with the national PCMM Coordinator to ensure alignment with national policy, receive updates, and share strong practices.

(4) Meeting regularly with facility primary care leadership and group practice managers to review provider panel management data, including access for face-to-face and telephone care.

(5) Delegating PCMM user permissions for facility staff members.

(6) Ensuring accuracy of PCMM through analysis and evaluation to ensure compliance with VHA PCMM and PACT policies, guidelines and business rules throughout the facility.

(7) Establishing and managing PCMM PACT position set up, staff and FTE assignment, as well as patient assignments for all primary care locations. Specifically, the PFC will electronically create or modify team and position settings, assign staff to positions, assign FTE to positions, identify set maximum panel capacity, program clinical notification levels, and establish preceptor to associate provider links.

(8) Ensuring that PCDPC data is entered for each PACT teamlet member in PCMM and entered as a portion of a FTE employee and is kept current and accurate.

(9) Completing multiple assignment/reassignment to move large groups of PACT populations to different teams, when changes become necessary.

(10) Managing automatic inactivations to ensure appropriateness and communication to PACT members.

(11) Maintaining oversight of the Multi-PACT approval disposition to ensure timely completion of active assignments.

(12) Assisting operating officials in implementing identified improvement actions and plans through participation in organizational improvement work through station programs such as Systems Redesign projects.

(13) Ensuring facility PCMM standard operation procedures (SOP) or Directives are in place and current; meeting all local requirements and stakeholder concurrence to meet VHA PACT PCMM goals and objectives.

(14) Completing comparative analysis of VSSC reports or data sets with local PCMM data to identify data variance and ensure data integrity.

(15) Participating in PCMM training activities and in national and/or VISN PCMM conference calls and discussion as needed.

(16) Ensuring that PCMM users are knowledgeable in PCMM functionality and utilization.

(17) Ensuring that PCMM PACT pending assignments are entered prior to the patient's first PACT appointment and no later than 24 hours from the creation of the patient's first PACT appointment.

(18) Collaborating and coordinating throughout all levels of the organization, including executive leadership and program leaders.

(19) Actively participating in PACT committees, workgroups, improvement projects and process development.

6. REFERENCES

a. VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook

b. VHA Handbook 1101.11(2), Coordinated Care for Traveling Veterans

c. VHA Handbook 1140.07, Geriatric Patient Aligned Care Team (GeriPACT)

d. VHA Directive 1330.01, Health Care Services for Women Veterans

e. VHA Handbook 1400.01, Resident Supervision

f. VHA Handbook 1400.04, Supervision of Associated Health Trainees

g. VHA Directive 1082, Patient Data Capture

h. VHA Directive 1063, Utilization of Physician Assistants

i. VHA Handbook 1400.07, Education of Advanced Fellows

j. VHA Handbook 1400.08, Education of Associated Health Professions

k. VHA Directive 1400.09, Education of Physicians and Dentists

l. VHA Directive 1750, Managerial Cost Accounting System (Decision Support System (DSS))

m. VHA Directive 2012-003, Person Class File Taxonomy, or subsequent policy issue.

PCMM USER PERMISSIONS

Access to Patient Centered Management Module (PCMM) will be granted by National and Veterans Integrated Service Network (VISN) PCMM Coordinators and Principal Facility Coordinators (PFC) through the PCMM User Permission option.

a. Required PCMM User Permissions are as follows:

(1) VISN PCMM Coordinator;

(2) PFC; and

(3) Traveling Veteran Coordinator.

b. PCMM is designed to help implement VA policy and will work best when access is limited to a small number of users. This assures data integrity. User access that allows PACT data entry to teams, staff, full-time equivalent (FTE), rooms, and patient assignments is to be limited to the PFC and their back-up. ***NOTE:*** *The PFC is responsible for the functionality, management and oversight of PCMM throughout the facility and its divisions; however,* community-based outpatient clinics (*CBOC) may also identify a local PCMM Coordinator or a PCMM Clerk to assist the PFC.*

c. PCMM users must be assigned a permission role based on expected PCMM utilization. For example, staff members who need to utilize PCMM's reporting functionality only, should be assigned a user permission role of "PCMM Reports Only". And executive leaders or staff members who need to view all PCMM data should be assigned the user permission role of "PACT Administrator – View ALL". ***NOTE:*** *Staff must be granted real Social Security Number (SSN) access by National Data Systems for viewing Veterans Health Administration (VHA) Service Support Center (VSSC) reporting in order to utilize the "PACT Administrator" permission.*

d. PCMM user permissions for contract CBOC staff members must be limited to patient assignment data entry only. Contract CBOC staff members should not be allowed access to enter or modify Patient Aligned Care Team (PACT) teams, staff, FTE, or room data in PCMM.

PACT TEAM AND STAFF ROLES IN PCMM

Patient Aligned Care Team (PACT) teamlet and teamlet surrogate roles for the Primary Care Provider (PCP)/Associate Provider (AP), Registered Nurse Care Manager (RNCM), Clinical Associate, and Administrative Associate must be designated in Patient Centered Management Module (PCMM) for all PACTs. Discipline-specific team members may assigned as appropriate to include Clinical Pharmacy Specialists, Registered Dieticians, Social Workers, Primary Care-Mental Health Integration staff. See VHA Handbook 1101.10, VHA PACT Handbook.

a. PACT teamlets are identified as staff that are located in the same primary care clinic location, or collaborating through telehealth, and are responsible for the same assigned panel of patients. The PCMM team entries for PACT teamlets have the following requirements:

(1) Each PACT is allowed only one PCP, even if the PCP is part-time.

(2) Several part-time PCPs cannot be combined to form one full-time PACT PCP.

(3) Multiple APs are allowed on one PACT.

b. PCMM designations for each PACT teamlet role have the following requirements:

NOTE: *PACT teamlet members must be assigned to one or more patient panels in PCMM.*

(1) Primary Care Provider (PCP):

(a) PCPs are physicians, Nurse Practitioners (NP), and Physician Assistants (PA) who provide primary care to an assigned panel of patients and in accordance with licensure, privileges, scope of practice, or functional statement.

(b) Department of Veterans Affairs (VA) Trainees, such as Fellows or Advanced Fellows, may be designated as PCPs if they are licensed, have completed all required professional preparation, can be successfully appointed as a licensed independent practitioner or staff practitioner, and do not have a learning plan for their educational experience that includes advancement of clinical primary care skills.

(c) Locums providers may be designated as a PCP.

(2) Associate Providers (AP):

(a) All physician residents must be designated as an AP.

(b) Physicians who are not residents cannot be designated as an AP.

(c) Staff NPs and PAs may be designated as APs.

(d) NP and PA residents in primary care shall be designated as an AP when they are in residency or fellowship programs approved by VHA Office of Academic Affiliations.

(3) Registered Nurse Care Manager (RNCM):

(a) Registered Nurses (RN) must be designated as RNCMs.

(b) NPs cannot be designated as RNCMs.

(4) Clinical Associate: A teamlet member assigned in PCMM to one or more patient panels; trained and credentialed as a Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) or unlicensed assistive personnel including certified nursing assistant (CNA), medical assistant (MA), or health technician (HT).

(5) Administrative Associate: A medical clerk, patient services assistant, health technician or a medical assistant may be designated as an administrative associate.

c. Surrogate teamlet positions are to be populated with a specific individual in a similar role that is assigned to cover for the corresponding PACT staff-member during short-term or unplanned absences.

d. Discipline-specific team positions are not automatically created and can be added to a PACT by creating a position and identifying the specific team role (e.g., Clinical Pharmacy Specialist, Social Worker, Registered Dietitian Nutritionist, etc.).

(1) Clinical Pharmacy Specialists assigned to a PACT to provide comprehensive medication management services and team based care should be assigned appropriately in PCMM as PACT Clinical Pharmacist.

(2) Clinical Pharmacy Specialists who provide anticoagulation therapy management in a centralized anticoagulation clinic servicing one or more PC patient panels must be assigned appropriately in PCMM as Anticoagulation Clinical Pharmacist.

e. PACTs with a Designated Women's Health Provider (DWHP) should be designated as a Women's Health (WH) PACT, even if the assigned panel of patients is mixed in sex. See VHA Handbook 1101.10, PACT Handbook.

f. The following staff must not be entered in PCMM for PACT teamlet roles:

(1) Centralized telephone staff;

(2) Staff who are not consistently assigned to the same PACT or do not have regular engagement with other team members or patients on the panel; and

(3) Administrative staff (e.g., managers, supervisors, coordinators, etc.) or others for the purpose of administrative or clinical oversight.

g. Adding staff members to PCMM to support VHA Support Service Center (VSSC) access (i.e., Primary Care Almanac) is not permitted. ***NOTE:*** *Please refer to the VSSC home page to request social security number (SSN) and Protected Health Information (PHI) specific access requirements.*

h. Staff member names or initials must not be included in team names.

PACT FTE DATA ENTRY IN PCMM

Patient Centered Management Module (PCMM) requires an expected and actual full-time equivalent (FTE) be entered for each teamlet position. This is determined by calculating the portion of a full-time, 40-hour FTE employee that each teamlet member spends in managing care, known as Primary Care Direct Patient Care (PCDPC) FTE. PCMM will identify vacant FTE by calculating the difference between the expected and actual PACT FTE values.

a. PCDPC FTE is the time utilized by staff to prepare for, provide, and follow-up on the clinical needs of primary care (PC) patients. In the Managerial Cost Accounting (MCA), this time is allocated to PC departments in proportion to the time spent in each of these activities. See VHA Directive 1750, VHA Managerial Cost Accounting System (DSS). Trainee FTE is not counted in PCDPC FTE. The PCDPC activities will vary based on teamlet roles (e.g., PCP, AP, RNCM, etc.) and include, but are not limited to:

(1) Time with the patient, family, or other surrogate decision-makers or caregivers, in clinic and over the phone, to discuss their concerns or needs;

(2) Reviewing patient records and data;

(3) Documentation of patient care;

(4) Telephone care group clinics;

(5) Discussion of patient care issues with consultants and other staff members (e.g., care coordinators, etc.)

(6) Communicating and collaborating with community (non-VA) professionals, agencies, and facilities involved or potentially involved with patients' care;

(7) Time spent in patient care delivery with students in medicine, nursing and associated health professions;

(8) Precepting medicine, nursing, and associated health profession trainees while they deliver PC;

(9) Precepting or supervising staff NPs or PAs while they deliver PC.

b. Activities that are <u>not</u> considered PCDPC are the provision of specialty care to patients who are not assigned to the Patient Aligned Care Team (PACT) panel, inpatient hospital care (even for patients assigned to the PACT panel), administrative activities (including staff meetings), research activities, and educational activities. ***NOTE:*** *Administrative staff members do not have clinical time and therefore cannot be allocated PCDPC FTE.*

c. The data entry requirements for PACT FTE in PCMM are as follows:

(1) PACT FTE must not exclude annual leave (AL), sick leave (SL), work breaks or incidental time off.

(2) PACT FTE must be validated with the MCA to ensure accuracy and must be updated as changes occur.

(3) Expected FTE is the portion of time required to support a PACT patient panel. The requirements for expected FTE for PCMM data entry are as follows:

(a) Expected FTE for a full-time PACT is 1.0 and may be adjusted for part-time PACTs.

(b) Expected FTE will default to 1.0 in PCMM.

(c) Adjustments to expected FTE require a value greater than 0.00 but cannot be greater than 1.0.

(d) Total teamlet FTE is expected to reach a PCP support ratio of 3:1.

(4) Actual PACT FTE is the portion of time dedicated to providing care to the assigned PACT patient panels.

(a) Time spent performing the following activities are included in the actual PACT FTE:

1. Actions necessary to provide PACT-related clinical care;

2. Phlebotomy performed by the PACT on their own patients in the primary care clinic or in assigned exam rooms;

3. PACT huddles and meetings to discuss the care and management of specific patients;

4. Vital signs;

5. Primary Care appointment management check in/check out processes;

6. Patient education;

7. Nursing evaluations, procedures or injections;

8. Non-face-to-face-visits;

9. Population Management activities in support of care delivery;

10. Telephone, Secure Messaging, and other activities in support of non-traditional care delivery; and

11. PCMM surrogate coverage.

(b) Time spent performing the following activities must not be included in the actual PACT FTE:

1. Specialty or Inpatient care (non PC);

2. Administrative functions in support of specialty or inpatient care (non PC);

3. Responsibilities in support of PACT administrative, management, or oversight functions, medical center or VISN committees, or any activities not related to PACT care delivery;

4. Centralized, remotely-based, and non-PACT located telephone duties including clerk, nursing, or pharmacy;

5. Centralized phlebotomy;

6. Support for health care providers not assigned to a PACT; and

7. Business office enrollment functions.

(5) Associate Providers FTE is required.

(a) Trainee FTE is not included in PCDPC expected, actual and vacancy FTE reporting nor is it included in the modeled capacity formula.

(b) Non-physician staff AP FTE is included in PCDPC expected, actual, and vacancy FTE reporting and is included in the modeled capacity adjustments.

(6) Surrogate FTE is not required.

(7) PCMM will identify vacant FTE from the difference of Expected and Actual PACT FTE values.

(8) Validation of FTE is required during team and position creation, staff assignments, and when changes occur.

NOTE: *For additional guidance on PACT FTE data entry in PCMM, see Appendix I, "Example Scenarios for Identifying PACT Teamlet Full-Time Equivalent".*

PRO-RATED ROOM AVAILABILITY DATA ENTRY IN PCMM

Pro-rated room availability consists of the total count of exam rooms utilized by Patient Aligned Care Team (PACT) for the provision of patient care. The data entry requirements for pro-rated room availability in Patient Centered Management Module (PCMM) are as follows:

a. Pro-rated room availability must be listed in the “Room” section of PCMM.

b. Individual rooms are to be identified by a unique room number and name.

c. Expected use of rooms is entered by identifying the portion of time the room is utilized.

d. Several PACTs may use a portion of the room during regular and extended hours.

e. PACTs that rotate through generic space should be assigned to each room for the average amount of time utilized.

f. Examination room counts used for calculating modeled panel capacity will be automatically prorated based on the team expected FTE.

PACT PANEL CAPACITY

The baseline capacity for a full-time Patient Aligned Care Team (PACT) is 1,200 patients. Panel capacity for general PACTs will vary from facility to facility depending on patient characteristics and level of system support. For PACTs with a patient population reflecting the norms for disease severity and reliance on VHA and who have current norms of 3.0 teamlet support staff and 2.0 exam rooms per Primary Care Direct Patient Care (PCDPC) full-time equivalent (FTE) provider, an average panel would be 1,200 patients. After adjustment for the factors identified, panels for PACT providers largely fall in the range of 1,000 to 1,400. Associate Providers' capacity and assignments are considered subtotals of the PCP's capacity and panel size.

a. Special Population PACTs may have a smaller panel, as they serve a patient population with specific, substantial health care complexity, including Geriatrics, Home Based Primary Care, Homeless, Post-Deployment Care Program, Serious Mental Illness, Spinal Cord Injuries and Disorders, and Women's Health (see VHA Handbook 1101.10, VHA PACT Handbook). Academic PACTs may also have smaller panel sizes, as they include trainees operating under the supervision of PACT providers.

b. PCMM will automatically display the Station Modeled Capacity (aggregate), Modeled Team Capacity, PACT Assigned Total and Available Capacity. Modeled capacity adjustments at the team level is based on 1) teamlet support staff, 2) examination rooms, 3) primary care intensity score, 4) women Veteran population, and 5) provider type. The Modeled Team Capacity may be adjusted by manually entering a Modeled Capacity Override value to account for special circumstances.

(1) **PACT Teamlet Support Staff.** The PACT teamlet is designed to provide optimal support for the patient. The PACT teamlet includes the Primary Care Provider (PCP), Registered Nurse (RN) (designated Registered Nurse Care Manager (RNCM)), the Clinical Associate, and the Administrative Associate. All PACT teamlet staff roles should have equal FTE; for example if the provider is part-time at 0.5 FTE to support half a panel of patients then all PACT teamlet staff roles would be set at 0.5 FTE. The expected PACT teamlet support staff ratio is 3:1 per provider's PCDPC FTE. Adjustment in panel size from the baseline of 1,200 for levels of teamlet support staff should be made based on the ranges shown in Table 1. ***NOTE:*** *Low PACT staffing levels may reduce the productivity of individual providers. A teamlet support staff ratio greater than 3:1 may lead to further improvements in productivity and are encouraged. Additionally, some special population PACTs have separate recommendations for teamlet support staff configurations. For example, GeriPACT teamlets should include a Social Worker and a Clinical Pharmacy Specialist, and Women's Health PACTs should include access to a chaperone, as described in VHA Handbook 1101.01, PACT Handbook.*

Table 1. Adjustments in Modeled Panel Capacity for PACT Teamlet Support Staff.

Teamlet Support Staff per PCDPC FTE	Panel Capacity Adjustment
< 2.6	- 10%
2.6 - 2.99	- 5%
3.0 - 3.45	No adjustment
3.46 -3.9	+ 5%
> 3.9	+ 10%

NOTE: *In PCMM Web, only one PCP, one RN, one Clinical Associate, one Administrative Associate, and one Clinical Pharmacy Specialist are included in the modeled PACT teamlet support staff calculation. Additional teamlet members or surrogates may be entered into PCMM; however, they are not included in the modeled teamlet support staff calculation for PACT.*

(2) **Examination Rooms.** Examination rooms are fully-equipped rooms in which providers and other staff prepare and examine patients. Levels of 2.5 examination rooms per 1.0 FTE provider have been recommended as a minimum for VHA. Adequate space should also be provided for trainees. Adjustments in panel capacity for room availability for a baseline panel of 1,200 are shown in Table 2.

Table 2. Adjustments in Modeled Panel Capacity for Examination Room Availability.

Exam Rooms per PCP FTE	Panel Capacity Adjustment
< 2.0	- 5%
2.0 - 2.5	No adjustment
> 2.5	+ 5%

(3) **Primary Care Intensity Score.** Using the data in the VHA visit file for primary care clinics, a model has been developed that predicts the average number of primary care face-to-face and telephone visits an identified primary care population is likely to make, given its patient characteristics. This predicted number of visits is compared to the VHA average, providing a primary care intensity score. A primary care intensity score of 1.0 represents the standard for VHA. A score above 1.0 indicates a patient population that is sicker or more reliant on VHA than the VHA average and a higher number of PC interactions are expected. A score below 1.0 indicates that the patient population has a lower burden of illness or less reliance on VHA than the VHA average.

Intensity scores reflect workload (both face-to-face and telephone visits) of the entire PACT. Adjustments in panel capacity for patient intensity are shown in Table 3.

Table 3. Adjustments in Modeled Panel Capacity for Intensity Score.

PC Intensity Score	Panel Capacity Adjustment
≤ 0.89	+ 10%
0.90 - 0.94	+ 9%
0.95 - 0.96	+ 8%
0.97 – 0.98	+ 5%
0.99 -1.01	No adjustment
1.02 – 1.03	- 3%
1.04 – 1.06	- 4%
1.07 – 1.19	- 5%
≥ 1.20	- 16%

(4) **Women Veteran Population.** The complexity of primary care issues for women Veterans results in increased number of visits, and therefore the panel capacity for the proportion of the panel comprised of women Veterans is reduced by 20 percent. The adjustment in panel capacity for female Veterans is shown in Table 4.

Table 4. Adjustments in Modeled Panel Capacity for Women Veterans.

Women Veterans Adjustment	Panel Capacity Adjustment
X=Y-0.2(Z)	X=modeled panel capacity adjustment for number of women veterans; Y=panel capacity unadjusted for women; Z=number of women veterans assigned.

(5) Provider type. To allow primary care providers who are non-physician providers sufficient time to manage a panel of patients, their panel capacity is adjusted to contain 75 percent of a physician's unadjusted capacity. The adjustment in panel capacity according to provider type is shown in Table 5.

Table 5. Adjustments in Modeled Panel Capacity for Provider Type.

Provider Type	Panel Capacity Adjustment
Non-physician provider	75% of physician's unadjusted capacity

c. Manual adjustment (override) to modeled team capacity is allowed to account for special circumstances. Examples include, but are not limited to:

(1) Complex cohort patients with complex issues such as congestive heart failure, liver disease, frail elderly, physically disabled, sensory disabled, cognitively impaired, etc.

(2) Newly established PACTs or newly hired PCPs;

(3) New PCP taking over an established PACT;

(4) Teaching responsibilities; and

(5) Special Population PACTs.

d. The model for the Primary Care Intensity Score is not designed to account for such highly-specialized PACTs. It is recognized that panel capacity for special population PACTs may be smaller than typical PACTs. The maximum panel capacity for these PACTs needs to be determined locally, incorporating guidance from national programs, where available. ***NOTE:*** *When specialists provide PC to a PACT that is not a special population PACT, no panel capacity adjustment is expected.*

e. Additional clinic rooms are needed when residents, students, and trainees participate in clinical activities in PC. In some cases, such as in larger trainee clinics, additional discipline-specific (extended) team members, may be needed, as well. The educational mission of VHA is critical, and provision of the appropriate clinic environment is a necessity for this mission. ***NOTE:*** *Within VHA as a whole, the presence of trainee clinics is associated with larger panel sizes for their PCP faculty, since trainees' patients are counted in their PCP panels per current VHA policy. However, due to the great variation in the nature and scope of training programs, general guidance on adjustments for these activities is not provided. Whether and how much a facility needs to adjust panel capacity when staff is supervising trainees should be determined locally.*

f. Newly-hired providers who are building a panel of new patients may take 12 to 15 months to achieve a full panel equal to that of an established provider. For the purposes of pro-rating capacity, maximum panel capacity for such providers may be set at 50 percent of a fully-established provider for the first 6 months, at 75 percent for the second 6 months, and then at 100 percent at 12 months. Specific panel capacity recommendations for new providers are customized for each facility as appropriate by the Chief of Staff or designee.

PACT PATIENT ASSIGNMENTS IN PCMM

Patient Centered Management Module (PCMM) assignments occur between the patient and the Patient Aligned Care Team (PACT).

a. Each patient must have only one active PACT assignment within the VA system unless there is a compelling clinical need for multiple primary care providers (PCP) managing the patient. Multi-PACT assignments (previously known as "dual assignments") in PCMM should be avoided since they inflate the number of patients present in each provider's panel, resulting in increased workload for PACT staff and increased risk for error.

(1) Exceptions may be approved under two circumstances:

(a) Veterans with Spinal Cord Injury & Disorders (SCI&D) who are receiving highly-complex dual care (such as in a "hub and spokes" system of care) may be assigned two PCPs at the two facilities of SCI&D care. These Veterans may be assigned to a Primary Care team at both the SCI referral center (Hub) and at their own local VA medical facility or associated community-based outpatient clinics (CBOC) (Spoke).

(b) If a Veteran receives care between two facilities of residence (i.e., south in winter, north in summer) and requires complex PC management (as assessed by the PC clinical leader, or designee, at the patient's preferred facility), the Veteran may be assigned an identified PACT at each of the geographically distant residences.

b. A new PCMM assignment must occur before the PACT appointment occurs.

c. When a new PCMM assignment is entered it will have an assignment status of "Pending".

d. PCMM will automatically evaluate pending assignments enterprise-wide to determine if an active PACT assignment exists in another 3-digit code station.

(1) If it is determined that the patient has one or more active PACT assignment(s) at other 3-digit code stations, the system will automatically generate a Multi-PACT Request [previously known as Dual Assignment Request] for the current pending PACT assignment.

(a) The system will send out an actionable PCMM alert to any stations holding an active PACT assignment and the station with pending assignment. ***NOTE:*** *An actionable PCMM alert is not a Computer Patient Record System (CPRS) alert, but rather a notification within PCMM.*

(b) The actionable PCMM alert is sent to the Traveling Veterans Coordinators (TVC) at both the active and pending assignment locations requesting Approval or Denial of Multi-PACT Request.

e. Multi-PACT approval from active (current) and pending (future) assignment locations must be completed in PCMM. PCMM will initiate evaluation of qualifying encounter (see Appendix J for a list of qualifying encounters and stop codes) at the time the assignment is made. After the patient has had a qualifying teamlet encounter and the Multi-PACT assignment is approved, the assignment will convert from pending to active status at the receiving facility. See appendices C and D in 1101.11(2) VHA Handbook 1101.11(2), Coordinated Care for Traveling Veterans for the process used for reviewing and approving multi-PACT assignments for traveling Veterans.

(1) When multiple PACT assignments are requested, the clinicians currently and potentially caring for the patient or their clinical designee are responsible for determining whether there is compelling clinical need for Multi-PACT assignments.

(2) The Multi-PACT request for an additional PACT assignment at another facility will require a clinical decision by a Physician, RN, PA, or NP or other clinical designee. The Traveling Veteran Coordinator1101.11(2), or designee, will then enter the approval/denial within PCMM. The Traveling Veteran Coordinator is often well positioned to facilitate this function. ***NOTE:*** *The role and responsibilities of the Traveling Veteran Coordinator are described at length in VHA Handbook 1101.11(2), Coordinated Care for Traveling Veterans.*

(3) Local processes must be in place to assure care coordination with the assigned PACT occurs until the patient is able to receive care at the new location. See VHA Handbook 1101.11(2), Coordinated Care for Traveling Veterans.

f. If it is determined the patient does not have an active PACT assignment at another 3-digit code station or there are Multi-PACT approvals, the system will identify a qualifying encounter by any teamlet member [including AP] and convert the assignment status from pending to active. See Appendix J of this Directive for a list of qualifying encounters and stop codes. ***NOTE:*** *A qualifying encounter does not include encounters completed by surrogates.*

g. If it is determined the patient already has an active assignment and is reassigned to another PACT within the same 3-digit code station, the patient must be assigned using the “Assign” button in PCMM. The patient should <u>not</u> be manually unassigned from the active PACT teamlet. PCMM will automatically initiate evaluation of qualifying encounter (see appendix J for a list of qualifying encounters and stop codes) at the time the assignment is made. The patient will be assigned as pending until a qualifying encounter by a teamlet member converts the assignment to active. This will automatically inactivate the previous active assignment. VHA considers this a “warm handoff” from one PACT team to the other and is ideal to optimally manage and coordinate health care for patients assigned to PACT.

PATIENT ALIGNED CARE TEAM (PACT) PATIENT CENTERED MANAGEMENT MODULE (PCMM) INACTIVATION

PACT PCMM assignments are to be inactivated for patients who permanently discontinue Veterans Affairs (VA) health care.

a. Automatic inactivation of PCMM assignments occur automatically in the following cases:

(1) The patient expires. This function is automated to occur when a date of death is annotated in the Registration package, but may also be completed manually when notification of a patient death is received and verified.

(2) Newly assigned patients (either newly-enrolled patients or patients who have been re-assigned to a different provider) who have not had a qualifying clinical encounter by an assigned PACT team member and 12 months have passed since the time of assignment to that team will be automatically inactivated due to inactivity. This provides every teamlet a 1-year grace period for seeing patients added to their panel (either newly-enrolled patients or patients transferred from a different panel) before they are inactivated. Patients must be encountered by their PACT teamlet within 12 months of being assigned, or they need to be inactivated from the primary care provider's (PCP's) panel.

(3) Active PACT assignments that have not had a qualifying encounter in the past 36 months will be considered inactive and the assignment will be automatically inactivated. See Appendix J for a list of qualifying encounters and stop codes. ***NOTE:*** *In April 2023, a PCMM release updated the auto-inactivation routine from 24-months to 36-months for assignments in an "Active" status. After the update, any "Active" status assignment that has not had a qualifying encounter in the past 36-months are automatically inactivated. Additionally, this release removes the functionality that allows a one-time 6-month extension for assignments identified for automatic inactivation. Without a qualifying encounter in the past 36-months, an "Active" status assignment will be scheduled for inactivation.*

(a) Scheduled inactive assignments dates are identified in PCMM and include an icon to reflect the number of days before the automatic inactivation. The scheduled inactivation date ranges are listed in PCMM and will occur as follows.

1. Between 91 and 120 days.

2. Between 61 and 90 days.

3. Between 31 and 60 days.

4. Between 1 and 30 days.

(b) Scheduled inactivations occur on the 15th and the last day of the month.

(c) Veteran Integrated Service Network (VISN) or local standard operating procedures must be in place for notifying patients when their PACT assignment in PCMM is at risk of being automatically inactivated.

b. It is strongly recommended that the assigned PACT team performs outreach to the Veteran if not encountered by the assigned PCP in more than 20 months to ensure a primary care qualifying appointment is scheduled to update the care plan and remain assigned to the team/location. A return to clinic order or clinical review is not necessary to schedule the Veteran and should be scheduled at the Veteran's convenience. The intent is to have a face-to-face, clinical video Telehealth or VA Video Connect visit at least every 3 years. A phone visit does not reset the 3-year clock.

NON-PRIMARY CARE AND COMMUNITY CARE (NON-VA) ASSIGNMENTS IN PATIENT CENTERED MANAGEMENT MODULE (PCMM)

Non-Primary Care teams in PCMM may be established and used to ensure appropriate management and tracking of non-primary care and community care (non-VA) patient populations. In these cases the:

1. The Principal Facility Coordinator for PCMM provides overall technical oversight for PCMM utilization.

2. The identified National Program Office or initiative sponsor is responsible for the development of the business rules governing management, use, and oversight of PCMM for non-primary care and community care (non-VA) populations.

EXAMPLE SCENARIOS FOR IDENTIFYING PATIENT ALIGNED CARE TEAM (PACT) TEAMLET FULL-TIME EQUIVALENT (FTE)

This appendix describes potential staffing scenarios and the subsequent PACT teamlet full-time equivalent (FTE) identification. This list of scenarios is not all inclusive and only serves as a guide to assist Veterans Integrated Service Networks (VISN) and facilities with the selection of PACT FTE for accurate patient centered management module (PCMM) data entries.

1. A Primary Care Provider (PCP) works solely as a full-time VA staff physician at a community-based outpatient clinic (CBOC) and has no other clinical or administrative responsibilities (e.g., PCP does not provide specialty or inpatient care, does not manage any programs, serve on committees/workgroups, or conduct educational programs or research, etc.) What is the PCP's actual Primary Care Direct Patient Care (PCDPC) full-time equivalent (FTE)? What is the PCP vacancy FTE? The PCP's actual PCDPC FTE is 1.0 and the PCP vacancy FTE is 0.0.

2. A full-time PACT Registered Nurse Care Manager (RNCM) temporarily covers two PACTs equally, during recruitment for a full-time RN. What is their actual PACT FTE? What is the RN's vacancy FTE? The RNCM's actual PACT FTE is 0.5 for each PACT that the RNCM covers. The vacancy FTE for each PACT is 0.5 FTE for the RNCM role.

3. A clinical associate works full-time for one PACT. What is their actual PACT FTE? What is the vacancy FTE? The clinical associate's actual PACT FTE is 1.0 and the vacancy FTE is 0.0.

4. A full-time administrative associate is responsible for supporting a full-time PACT 60 percent of the time and a specialty clinic 40 percent of the time. What is their actual PACT FTE? What is the vacancy FTE? The administrative associate's actual PACT FTE is 0.6 and the vacancy FTE is 0.4.

5. A full-time physician serves in the administrative role of Associate Chief of Staff (ACOS) and spends 10 percent of their time as a PCP following a panel of patients. And the physician's team capacity is 10 percent of a full-time PACT. What is their expected and actual PCDPC FTE? What is the PCP vacancy? The PCP's expected FTE is 0.10, the actual PCDPC FTE is 0.10 and the PCP vacancy is 0.0.

6. A PCP spends 80 percent of the time providing primary care to a panel of patients and the remainder of his/her time lecturing medical students and conducting administrative tasks associated with educational duties (e.g., developing curriculum, planning schedules, attending meetings at the medical school, etc.). What is the PCP's expected and actual PCDPC FTE? What is the PCP vacancy? The PCP's expected PCDPC FTE is 0.80, the actual PCPDPC FTE is 0.8 and the PCP vacancy is 0.0.

7. A full-time PACT has a PCP who sees patients 1 day per week and the remaining 4 days per week are spent on research activities. What is their expected and actual PCDPC FTE? What is the vacancy FTE? The PCP's expected PCDPC FTE is 1.0, the actual PCDPC FTE is 0.20 and the vacancy PCDPC FTE is 0.80.

8. A telephone care RN is located outside of Primary Care and is responsible for answering all incoming calls for all locations. What is their actual RN FTE? As this RN is not a member of a PACT, this RN cannot be included in PCMM.

9. A float RN is responsible for assisting all PACTs as needed. What is their actual RN FTE? As this RN is not a PACT member, the float RN cannot be included in PCMM.

10. A full-time Clinical Associate is assigned to draw blood in the centralized lab at the CBOC every morning for a total of 20 hours per week. What is their actual PACT FTE? What is the vacancy FTE? The Clinical Associate's actual PACT FTE is 0.5 and the vacancy FTE is 0.5.

11. A VA Medical Center (VAMC) has seven CBOCs. Should the VAMC and each CBOC have a separate Principal Facility Coordinator (PFC) for PCMM? No. PCMM is designed to implement VA policy and will work best when access is limited to a small number of users. Each VA facility is to have one PFC who is responsible for PCMM throughout the facility and its divisions. The CBOCs may identify a PCMM Coordinator or a PCMM clerk to assist the PFC.

12. A VAMC has provided all scheduling clerks with access to PCMM so they are able to enter PCMM assignments. Is this recommended? No. To assure data integrity, PCMM responsibilities are to be limited to a small number of users.

13. Several staff members would like to utilize PCMM's reporting functionality. Is this allowed? Yes. The VISN PCMM Coordinator will assign these staff members with a user permission role of "PCMM Reports Only".

14. Executive leaders would like access to PCMM in order to view all PCMM data. Is this possible? Yes. The VISN PCMM Coordinator will assign this staff the user permission role of "PACT Administrator – View ALL". ***NOTE:*** *Staff members assigned the permission of "PACT Administrator – View ALL" must have social security number (SSN) and Protected Health Information (PHI) specific access in VHA Support Service Center (VSSC) to utilize this permission.*

QUALIFYING ENCOUNTERS

1. Patient Centered Management Module (PCMM) evaluates all encounters and considers only those encounters that are completed by the assigned primary care provider (PCP), assigned associate provider or assigned surrogate PCP. A qualifying encounter must have one of the following primary stop codes and anything in the secondary/credit stop code.

a. 322 (Comprehensive Women's and Gender Diverse Primary Care Clinic).

b. 323 (Primary Care Medicine).

c. 326 (Telephone Geriatrics).

d. 338 (Telephone Primary Care).

e. 348 (Primary Care Shared Appointment).

f. 350 (GeriPACT).

2. Anything with a primary stop code not listed above must have one of the following secondary/credit stop codes.

a. 322 (Comprehensive Women's and Gender Diverse Primary Care Clinic).

b. 323 (Primary Care Medicine).

c. 350 (GeriPACT).

3. QUALIFYING ENCOUNTERS CERNER/ORACLE

PCMM evaluates all encounters and considers only those encounters that are completed by the assigned PCP, assigned associate provider or assigned surrogate PCP. A qualifying encounter must have one of the following primary stop codes.

a. 22A (SCI).

b. 215 (SCI Home Care Program).

c. 310 (Infectious Disease).

d. 313 (Renal/Nephrology (Except Dialysis)).

e. 322 (Comprehensive Women's and Gender Diverse Primary Care Clinic).

f. 32A (Primary Care Medicine).

g. 350 (GeriPACT).