PATIENT ALIGNED CARE TEAM (PACT) HANDBOOK

1. REASON FOR ISSUE: This VHA Handbook establishes the procedures for Patient Aligned Care Teams (PACTs) to provide Veterans with primary care that is patient-centered, data driven, continuously improving, team-based, accessible, timely, comprehensive, coordinated, and provides continuity of care over time.

2. MAJOR CHANGES: This Handbook establishes the procedures for the administration of PACTs in Primary Care Services.

3. RELATED ISSUES: VHA Directive 1101.02, Primary Care Management Module (PCMM).

4. RESPONSIBLE OFFICE. The Office of Primary Care (10NC3) is responsible for the contents of this VHA Handbook. Questions may be referred to 202-461-6259 or VHA10NC3Action@va.gov.

5. RESCISSIONS: None.

6. RECERTIFICATION: This document is scheduled for recertification on or before the last working day of February 2019.

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CONTENTS

VHA PATIENT ALIGNED CARE TEAM (PACT) HANDBOOK

PARAGRAPH **PAGE**

1. Purpose 1

2. Authority 1

3. Background 1

4. Definitions 1

5. Scope 7

6. PACT Principles 7

a. Patient-centered Care 7
b. Team-Based Care 8
c. Continuous Improvement 8
d. Data Driven Care 8
e. Population Health and Prevention 8
f. Access and Timeliness 8
g. Comprehensiveness 8
h. Care Coordination 8
i. Continuity of Care 9

7. PACT Members and Staffing 9

a. Patient 9
b. Personal Support Persons 9
c. PACT Staff 9

8. PACT Operations and Processes 14

a. Panel Management 14
b. Team Management and Function 14
c. PACT Quality Management and Quality Improvement 16
d. Access Management 18
e. Care Management 19
f. Care Coordination 20
g. Population Management 21

9. Examination Room Privacy Standards 22

10. Modalities of Health Care Delivery 23

a. Criteria for Usage of Health Care Delivery Modalities 23
b. In-Person Face-to-Face Care Delivery 23
c. Virtual Face-to-Face Care Delivery 24
d. Non-Face-to-Face Care Delivery 24
e. Other Health Care Delivery Modalities 27

11. PACT Services Required for Delivery of Comprehensive Primary Care 27

a. Chronic Care and Complex Care for Patients at High-Risk for Complications or Morbidity 27
b. Acute Care or Urgent Care 27
c. Emergent Assessment and Basic Cardiopulmonary Resuscitation (CPR) 27
d. Preventive Health Care 28
e. Mental Health Care 28
f. Health Education, Coaching, and Developing Health Care Partnerships 29
g. Military Health History and Unique concerns and health risks associated with deployment 29
h. Patient Comfort and Pain Management 30
i. Advance Care Planning 30

12. PACT for Special Populations 30

a. General Requirements for Special Population PACTs 30
b. Geriatrics PACT (Geri-PACT) 31
c. Home Based Primary Care PACT (HBPC-PACT) 33
d. Homeless PACT (H-PACT) 35
e. Infectious Diseases PACT (ID-PACT) 38
f. Post-Deployment Care Program PACT (PD-PACT) 40
g. Renal/Dialysis PACT (REN-PACT) 42
h. Serious Mental Illness PACT (SMI-PACT) 43
i. Spinal Cord Injuries and Disorders PACT (SCI/D-PACT) 45
j. Women's Health PACT (WH-PACT) 47

13. Specialty Care Services and PACT 49

14. VHA's Organizational Structure for Primary Care Implementation of PACT 51

a. VHA Primary Care Services 51
b. VHA Primary Care Operations Office 52
c. Primary Care Field Advisory Committee (PC-FAC) 52
d. Veterans Integrated Service Network (VISN) and Facility Primary Care Structure 52

15. Responsibilities of VHA Chief Consultant for Primary Care Services 54

16. Responsibilities of VHA Executive Director of Primary Care Operations 54

17. Responsibilities of VISN Director 55

18. Responsibilities of VISN Chief Medical Officer 55

19. Responsibilities of VHA Primary Care Field Advisory Committee (PC-FAC) 56

20. Responsibilities of Medical Facility Director 56

21. Responsibilities of Facility Clinical Executives 57

22. Responsibilities of Service Level Officials Accountable for PACT 58

23. Responsibilities of PACT Staff 60

24. Responsibilities of Primary Care Provider (PCP) 60

25. Responsibilities of PACT RNCMs and PACT Staff Assigned to the RN Position in PCMM 61

26. Responsibilities of Clinical Associate or PACT Staff Assigned to the LPN/LVN/HT Position in PCMM 62

27. Responsibilities of Administrative Associate or PACT Staff Assigned to the Clerk Position in PCMM 62

28. Responsibilities of Discipline-Specific Team Members 63

29. References 64

APPENDICES

A Engaging Veterans in the PACT A-1

VHA PATIENT ALIGNED CARE TEAM (PACT) HANDBOOK

1. PURPOSE: This Veterans Health Administration (VHA) Handbook establishes the procedures for Patient Aligned Care Teams (PACTs) to provide Veterans with primary care that is patient-centered, data driven, continuously improving, team-based, accessible, timely, comprehensive, coordinated, and provides continuity of care over time.

2. AUTHORITY: Title 38 United States Code (U.S.C.) 7301(b), Title 38 Code of Federal Regulations (CFR) 17.38.

3. BACKGROUND:

a. VHA is authorized to provide health care to eligible Veterans under 38 U.S.C. 7301(b). Section 17.38 of 38 CFR, is the regulation that authorizes the provision of the medical benefits package to enrolled Veterans. The medical benefits package is available to patients requiring clinically indicated health care that is needed to promote, preserve, or restore the health of the Veteran (as those terms are defined in § 17.38(b)) and is also in accordance with generally accepted standards of medical practice. VHA uses these authorities to establish PACT as its model for delivery of comprehensive primary care.

b. Recognizing the need for a highly developed, efficient and integrated health care system, VHA authorized a team-based primary care model in 1994 that emphasizes provision of care that is accessible, timely, coordinated, continuous, comprehensive, and compassionate. This change transformed VHA from a health care delivery system that revolved around the hospital into a health care delivery system with primary care as the foundation of health care delivery.

c. In early 2009, the Department of Veterans Affairs (VA) Universal Services Task Force Report, Veterans Health Care: Leading the Way to Excellence, recommended the formal adoption of a team-based model of care featuring the three major principles: patient-centered care, coordination of care, and access to care. To apply these principles more completely within Primary Care, VHA adopted and customized the patient-centered medical home model of care, and branded VHA's patient-centered medical home model as the Patient Aligned Care Team (PACT). The model was developed and launched in October 2009 as part of the Veterans Health Administration Transformational Initiatives. The patient-centered medical home model of care has been outlined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and the American Osteopathic Association (AOA). This Handbook builds on previous team-based strategies for providing health care and establishes new policy on PACT for delivery of comprehensive primary care to Veterans.

4. DEFINITIONS:

a. **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)).

b. **Associate Provider.** Associate Provider (AP) is a designation in Primary Care Management Module (PCMM) intended primarily for trainees who require close supervision and oversight from a physician provider. Health professionals in training (e.g., interns and 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). Advanced practice nurses may also be designated as APs when required by facility policy or state licensure. Physician assistants may be designated as APs when required by facility policy, when assigned shared responsibility for a panel of patients with a supervising PCP or when functioning in an accessory, supportive, or collaborative role to the patient's assigned PCP. (See definition of PCP for Physician Assistant role as PCP.)

c. **Care coordination.** Care coordination is the administrative process that facilitates integration of health care services and navigation through complex health care systems. Care coordination involves working across care settings, accessing health care providers, and other services such as community programs, when appropriate.

d. **Care management.** Care management is the process by which components of a patient's personal health plan (e.g., patients' ability to perform self-care) are assessed, analyzed and optimized for a patients' desired health and well-being. Care management is the oversight and management of a personal health plan for an individual patient or a cohort of patients.

e. **Case management.** Case management is a specialized and highly-skilled component of care management. Case management emphasizes a collaborative process that assesses, advocates, plans, implements, coordinates, monitors, and evaluates health care options and services so that they meet the needs of the individual patient. Case management services are provided to individuals who require a higher level of care management services. These individuals may include the Veteran, the Veteran's family, and the Veteran's caregiver. (See VHA Handbook 1110.04, Case Management Standards of Practice).

f. **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.

g. **Clinical Video Telehealth.** Clinical Video Telehealth (CVT) is defined as the use of real-time interactive video conferencing, sometimes with supportive peripheral technologies, to assess, treat, and provide care to a patient remotely. Typically, CVT links the patient(s) at a clinic to the provider(s) at another location. CVT can also provide video connectivity between a provider and a patient at home. (See the VA Telehealth Services Website at http://www.telehealth.va.gov and the VHA Telehealth Services Website at http://vaww.telehealth.va.gov. ***NOTE:*** *The VHA Telehealth Services Website is an internal VA WebSite that is not available to the public.*)

h. **Discipline-specific team member.** A discipline-specific team member is a health care professional designated to a PACT position in Primary Care Management Module (PCMM) who provides direct discipline-specific patient care 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 Dietitians, Social Workers, Primary Care-Mental Health Integration staff.

i. **Facility Primary Care Service.** For purposes of this Handbook, the term Primary Care Service for a facility refers to the facility organizational structure that is accountable to VHA Primary Care Services and the Office of Primary Care Clinical Operations regarding management and outcomes of primary care provided to patients. Unless specified in this Handbook, local policy or local service agreement, a facility's Primary Care Service is not usually accountable for primary care delivered by Special population PACTs (with the exception of Women's Health Special Population PACTs, which usually falls under the primary care service line).

j. **Health Coaching.** Health coaching is an evidence-based method for working with patients to enhance their well-being and achieve their health-related goals. Health coaching is a patient-centered, highly collaborative method that applies principles and methods derived from health education, health promotion, and health behavior change research. Health coaching includes: assessment of patients' educational needs, concerns, values, preferences, and past experiences; information sharing; goal setting; action planning; skill building; problem solving; and arranging a follow-up plan. (See VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements).

k. **Health Education.** Health education, as defined in VHA Handbook 1120.04, Veterans Health Education and Information Core Program Requirements, para.3.a. and the National Task Force on the Preparation and Practice of Health Educators as "the process of assisting individuals, acting separately collectively, to make informed decisions about matters affecting their personal health and that of others." In VHA, Veterans health education encompasses patient education, and is defined as any combination of information, education, and other strategies designed to help Veterans to enhance their quality of life through health promotion and disease prevention, actively partner with their providers and health care teams, engage needed family and social support systems, develop self-management and coping skills, and access and appropriately utilize VHA health care resources across the continuum of care.

l. **Home Telehealth.** Home Telehealth is defined as a program into which Veterans are enrolled that applies care and case management principles to coordinate care using health informatics, disease management, and telehealth technologies to facilitate access to care and to improve the health of Veterans. The goal of Home Telehealth is to improve clinical outcomes and access to care while reducing complications, hospitalizations, and clinic or emergency room visits for Veterans in post-acute care settings and high-risk patients with chronic disease. (See http://www.telehealth.va.gov and http://vaww.telehealth.va.gov.)

m. **Huddle.** A huddle is a brief (less than 10 minutes, and typically 3-5 minutes) meeting of the teamlet and appropriate discipline-specific team members to communicate information about the patient care work for a specified period of time (usually a clinic session).

n. **Motivational Interviewing.** Motivational Interviewing (MI) is an evidence-based clinical method that involves guiding patients to make healthy choices by eliciting and supporting their own motivation to change. MI is employed when patients are unsure about change or have difficulty following through with recommended health behaviors. (See VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements).

o. **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 (see VHA Handbook 1101.02, Primary Care Management Module (PCMM)). ***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.) Panel sizes for PACT teamlets may vary; see VHA Handbook 1101.02 and paragraph 7 of this Handbook.*

p. **Patient Aligned Care Team.** The Patient Aligned Care Team (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 definition for Special population PACT.)

q. **PACT staff.** PACT staff are VHA staff designated in PCMM to a position in a PACT.

r. **Personal support person.** A personal support person is an individual authorized, either orally or in writing, by the patient to be involved in the patient's health care. Some examples of personal support persons are family members, caregivers, surrogates, friends, faith-based advisors, cultural leaders, and acquaintances. ***NOTE:*** *See VHA Handbook 1605.1, Privacy and Release of Information, for requirements to complete VA Form 10-5345, Release of Information, permitting VHA providers to disclose individually identifiable personal health care information to others, Patients can designate a Health Care Agent by executing a Durable Power of Attorney for Health Care (see VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives.*

s. **Personalized, proactive, patient-driven health care.** Providing Veterans with personalized, proactive, patient-driven health care is a VHA strategic goal. Personalized care refers to a dynamic adaptation or customization of recommended education, prevention and treatment that is specifically relevant to the individual user, based on the user's history, clinical presentation, lifestyle, behavior, and preferences. Proactive refers to acting in advance of a likely future situation, rather than just reacting; it includes taking initiative to act rather than just adjusting to a situation. Patient-driven is the engagement between a patient and a health care system where the patient is the source of control, ensuring that their health care is based on their needs, values, and life preferences. The delivery of personalized, proactive, patient-driven care is based upon the development and nurturing over time of strong relationships between the patient and health care team.

t. **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.)*

u. **Preventive Health Care.** Preventive health care is, among other things, the provision of health education and certain clinical preventive services as defined in 38 U.S.C. 1701(9). Health education services are defined in VHA Handbook 1120.04, Veterans Health Education and Information Core Program Requirements, paragraph 3.a. Veterans health education spans the continuum of care from the skills and information needed to promote health and prevent disease, to the patient education needed to cope with and manage acute and chronic conditions. Clinical preventive services are delivered for the primary prevention of disease, or for the early detection of disease in persons who are asymptomatic for the target condition, with the goal of preventing or minimizing future morbidity and mortality. Clinical preventive services include: screening for treatable diseases, conditions or health risk behaviors (e.g., cancers, mental health conditions, tobacco use); immunizations; health education (e.g., education, counseling regarding tobacco use, physical activity, nutrition, promoting health and wellness); and preventive medications (such as prescribing statins for subclinical heart disease, etc.).

v. **Primary care.** Primary care is the provision of integrated, accessible health care services by health care professionals accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to: diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education.

w. **Primary Care Management Module (PCMM).** PCMM is a Veterans Health Information Systems and Technology Architecture (VistA) application that allows input of facility-specific and panel-specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes (see VHA Handbook 1101.02, Primary Care Management Module (PCMM)). PCMM supports set up and definition of the health care team, assignment of staff to positions within the team, and assignment of patients to the PACT.

x. **Primary Care Provider.** Primary Care Provider's (PCP) are physicians, advanced practice registered nurses, and physician assistants 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. Physician assistants may be designated as PCPs, but must function as agents of a supervising physician specified by scope of practice and facility

policy, consistent with state licensure requirements, and therefore must function in a collaborative relationship with a physician. ***NOTE:*** *Physicians in Fellowship programs may be PCPs if they are Board Eligible.*

y. **Primary Care Service Chief.** As used in this Handbook, the Primary Care Service Chief is the senior clinical leader in the facility accountable for management and operations of the facility's Primary Care Service. Facility organizational structures may use different titles for the person fulfilling this role.

z. **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.

aa. **Same-day access.** Same-day access is the ability to schedule an appointment within one business day of when the patient contacts the facility.

bb. **Secure Messaging.** Secure Messaging is the authorized means for VA staff and patients to communicate electronically with one another. This e-health service, provided through MyHealth***e***Vet, enables Veterans and their healthcare teams to exchange non-urgent health-related information, attend to administrative needs, and in some cases communicate in lieu of an office visit or telephone call.

cc. **Self-care.** Self-care includes all the choices a person makes on a daily basis that affect their physical, mental, and spiritual health. Self-care includes activities to maintain, improve, or restore health, as well as, to treat or prevent a disease.

dd. **Special populations.** Special populations are cohorts of patients who meet VHA national or local approved and published qualifying criteria for receiving comprehensive primary care and additional specialized care (i.e., care that is tailored to the needs of the cohort of patients, usually directed by VHA national program directives, programmatic requirements or published guidance) from a Special population PACT. Examples of special populations include: Geriatric (GERI), Home-based Primary Care (HBPC), Infectious Disease (ID), Post-deployment Care (PD), Renal/Dialysis (REN), Serious Mental Illness (SMI), Spinal Cord Injuries and Disorders (SCI/D), and Women's Health (WH).

ee. **Special population PACT.** A special population PACT, such as GERI-PACT, is a team designated by specific nomenclature in PCMM that provides comprehensive primary care and additional specialized care to a special population.

ff. **Specialty care.** Specialty care is the provision of specialist or sub-specialist advice and treatment. Specialty care provides Veterans with clinical advice, diagnosis, and treatment related to the special training and expertise of the provider.

gg. **Team meeting.** A team meeting is a regularly scheduled meeting of PACT staff for the purposes of team management (e.g., performance improvement, continuous improvement, team building), oversight (e.g., PCMM panel management, population management), and care coordination. Team meetings are usually 30-60 minutes in duration.

hh. **Teamlet.** A teamlet consists of a PCP, RNCM, clinical associate, and administrative associate. The teamlet is the subset of PACT staff to which one entire panel of patients is assigned in PCMM. Generally, teamlet members are designated in PCMM to the following positions: Provider, RN, LPN/LVN/HT, and Clerk. Special population PACTs may have additional or other designated teamlet positions in PCMM.

ii. **Telehealth.** Telehealth uses new information and telecommunications technologies to change the location where health services are routinely provided, supporting Veterans' preferences to live in the least restrictive settings possible. VHA Telehealth Services divides telehealth into three basic modalities allowing for its use in the most appropriate setting: 1) Clinical Video Telehealth, 2) Home Telehealth and 3) Store-and-Forward Telehealth. (See http://www.telehealth.va.gov and http://vaww.telehealth.va.gov).

jj. **Telehealth Clinical Technician (TCT).** Telehealth Clinical Technician's (TCT) are typically generalist HTs or LPNs that have received specialized training to operate and troubleshoot telehealth technology to support and manage telehealth primary and specialty care clinical encounters. The TCT typically supports the telehealth encounter as a technician and a telepresenter for CVT, as an imager for Store and Forward Telehealth applications, and also provides health technician support for Home Telehealth. (See http://www.telehealth.va.gov and http://vaww.telehealth.va.gov).

5. SCOPE: It is VHA policy that Veterans receiving VA primary care are assigned to a PACT for continuity of care over time, and are offered services and benefits for which they are eligible as established in this Handbook and as set forth in 38 CFR 17.38. This Handbook applies to all PACTs that practice under the local Primary Care organizational structure (e.g., Primary Care Service, Managed Care Service, Ambulatory Care Service, Medicine Service) and to all PACTs under the direction of VHA programs accountable for providing comprehensive primary care to special populations of Veterans.

6. PACT PRINCIPLES: PACT principles establish the foundation for high-quality primary care for Veterans and apply to all PACTs.

a. **Patient-centered Care.** Patient-centered care starts with the Veteran. Patient-centered care is personalized, proactive, and patient-driven health care. Patient-centered care focuses on discovering the Veteran's vision of living life fully and his or her goals for health. The PACT, including the Veteran and personal support persons, come together as partners to create the Veteran's plan for health. The team helps Veterans acquire the skills and resources they need to engage in self-care and self-management and provides Veterans with ongoing support and coaching needed to succeed in making and sustaining changes in their health. The intended result of health coaching is to ensure that every Veteran has explored and developed their life goals, values, and preferences as they relate to their health and that the PACT captures these in a

personalized plan of care. Whether the Veteran is fundamentally healthy, or whether the Veteran is in the end stages of life, patient-centered care begins and ends with the Veteran. Ensuring that the voice of the Veteran is heard and is incorporated into PACT is essential for relationship-building and successful implementation. (See Appendix A. Engaging Veterans in the PACT).

b. **Team-Based Care.** Team-based care embraces the strong practice of teamwork among members dedicated to achieving the common goal of excellent comprehensive primary care for Veterans. The synergistic efforts of an effective team surpass the ability of any single individual to meet the health care needs of a panel of patients.

c. **Continuous Improvement.** PACT staff employs continuous improvement strategies and active learning to improve the team's function, increase efficiency, encourage standardization, improve health outcomes and optimize the quality of care they deliver.

d. **Data Driven Care.** Quality of care is based on the highest level of evidence available at the time, which may include data, expert opinion, consensus, and professionally accepted standards for the practice of care.

e. **Population Health and Prevention.** Population health refers to the "health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Institute of Medicine's Working Definition of Population Health (Kindig and Stoddart, 2003)). It is an approach designed to improve the health of an entire population of patients, and can also be applied to the subset of patients managed by a health care team, or to the patients cared for by a clinic or facility. Population health management is an important approach to improve the health of the targeted population using data-driven processes to ensure that every individual within the selected cohort receives the right care at the right time. Population health management has particular relevance for prevention, ensuring that every patient is offered appropriate preventive health care interventions, including education in self-care, with the goal of preventing or minimizing future morbidity or mortality.

f. **Access and Timeliness.** Access and timeliness are essential components of high quality customer service and support VHA's goals to provide prompt and appropriate treatment for Veterans' health concerns. PACT staff works as a team to provide the right care at the right time in the right place by the right person.

g. **Comprehensiveness.** Comprehensiveness in primary care ensures that patients are offered all necessary and appropriate health care and are provided care in a manner consistent with the patient's (or surrogate's) treatment preferences and wishes. To the extent possible and appropriate, care should also be delivered in a manner that meets the patient's personal needs and preferences.

h. **Care Coordination.** Care coordination by the PACT facilitates integration of health care services and navigation through complex health care systems. It involves working across care settings and accessing health care providers and other services, such as community programs to help patients receive the care they need and want without unnecessary duplication of services or avoidable inconvenience. Care coordination involves open communication among health care

providers, legally permissible exchange of health care information, and logistical integration of desired care encounters.

i. **Continuity of Care.** PACT staff establishes a caring longitudinal relationship with Veterans and personal support persons that persists beyond a single episode of care. Continuity of care means that one team is the point of contact for coordinating their patients' current and future VA health care.

7. PACT MEMBERS AND STAFFING: PACTs comprise the patients, the patients' personal support persons, and the PACT staff designated in PCMM to provide health care to an assigned panel of patients.

a. **Patient.** The central member of the PACT is the patient. Each eligible Veteran receiving primary care from VHA is assigned to a PACT, which includes a single PCP or AP linked with supervising PCP. Veterans are assigned to only one PACT, except when multiple assignments are permitted by VHA Handbook 1101.02. Procedures for coordinating dual care, (i.e., the patient has an assigned PCP in VA and also uses a community PCP) are established by existing VHA policy on dual care. (See Appendix B.)

b. **Personal support persons.** Personal support persons augment and strengthen the PACT by serving as advocates and caregivers for patients. Personal support persons frequently provide important communication and coordination links with PACT staff, particularly when patients' care plans are complex and/or their conditions require, or may require, multiple or frequent care encounters (e.g., frequent hospitalizations). PACT staff encourages patients to involve personal support persons in their health care and encourages patients to complete relevant forms related to disclosure of health information to these support persons. Individually-identifiable health information may be provided to persons involved in patients' health care when authorized by the patient. (VHA Handbook 1907.01.)

c. **PACT Staff:**

(1) **Staffing.** PACT staffing must be sufficient to ensure that all patients assigned to the patient panel receive appropriate and desired health care. The teamlet staffing ratio recommendation is at least 3.0 Full Time Equivalent (FTE) staff to 1.0 FTE PCP for a teamlet assigned a full-time panel of patients receiving comprehensive primary care. Exact staffing models for PACTs may vary by facility; however, staffing decisions must optimize PACT function. ***NOTE:*** *VHA Handbook 1101.02 provides procedures for determining and adjusting panel sizes, determining Primary Care Direct Patient Care time and prorating of support staff FTE based on dedicated primary care clinical activities.*

(2) **Teamlet.** Teamlets consist of staff designated in PCMM to each of the following positions: Provider, RN, LPN/LVN/HT, and Clerk. A typical teamlet generally consists of a PCP, RNCM, Clinical Associate, and Administrative Associate. Special population PACTs may designate additional or other positions to the teamlet. Teamlet members collectively take responsibility for ongoing care of all of the patients assigned to a single patient panel. Once designated in PCMM, teamlet membership needs to remain consistent over time; individual

members may temporarily rotate among different PACTs for purposes of staff coverage. Additionally, individual team members may occasionally be assigned to different PACTs for optimal team function. The goals of providing team consistency and effective team work should be considered when assigning and reassigning team members.

(3) **Discipline-specific team members.** Discipline-specific team members are designated in PCMM for one or more PACT(s). Discipline-specific team members provide continuity of direct discipline-specific care to all patients assigned to PACT(s) for which the team member is designated. Staffing ratios may be adjusted locally or according to national guidance from relevant program offices. The following are suggested staffing ratios of select discipline-specific team members:

(a) One PACT clinical pharmacy specialist (CPS) for every three patient panels;

(b) One anticoagulation CPS for every five patient panels;

(c) One registered dietitian for approximately 6,000 patients; and

(d) One social worker for every two patient panels.

NOTE: *This list is not exhaustive and only includes some of the most common discipline-specific team members.*

(4) **PCMM configuration for PACT.** (See Diagram 1.) ***NOTE:*** *This sub-paragraph supersedes similar content on PCMM configuration for primary care teams in existing VHA Handbook 1101.02 (dated April 21, 2009). If VHA Handbook 1101.02 is re-issued (dated later than this PACT Handbook) and establishes policy on PCMM configuration for PACT or cites this subparagraph, then the reissued VHA Handbook 1101.02 supersedes this sub-paragraph. If there is a conflict between the content on PCMM configuration for PACT in this PACT Handbook and the re-issued VHA Handbook 1101.02, the most recently issued handbook takes precedence.*

(a) PCMM, when properly configured for PACT, enables software features such as team alerts and allows capture and correct attribution of workload data. ***NOTE:*** *Assignment in PCMM is for monitoring and tracking team and patient panel allocations; assignment in PCMM does not indicate a supervisory relationship* (see VHA Handbook 1101.02).

(b) Each PACT has only one PCP, even when the PCP is a part-time PCP. Several part-time PCPs should not be grouped to form one full-time PACT PCP (i.e., five 0.2 FTE PCPs should not be grouped to form one full-time PACT PCP). The PCP is designated to the "Provider" position in PCMM.

(c) Every PCP must be designated in PCMM for at least one PACT. PCPs may be designated for more than one PACT depending on the PCP's duties, but not to exceed the FTE of the PCP (e.g., a 1.0 FTE PCP may be designated for a 0.5 GERI-PACT and a 0.5 WH-PACT).

(d) Associate providers are designated to the "AP" position in PCMM.

(e) Each PACT has a RNCM designated to the "RN" position in PCMM. ***NOTE:*** *Exceptions may apply, see paragraph 12*.

(f) Each PACT has a Clinical Associate designated to the "LPN/LVN/HT" position in PCMM. ***NOTE:*** *Exceptions may apply, see paragraph 12*.

(g) Each PACT has an Administrative Associate designated to the "Clerk" position in PCMM. ***NOTE:*** *Exceptions may apply, see paragraph 12*.

(h) Every RNCM, Clinical Associate, and Administrative Associate must be designated in PCMM for at least one PACT and may be designated in PCMM for more than one PACT to achieve staff's FTE equivalent assignment (e.g., a 1.0 FTE clerk may be assigned to two 0.5 PACTs; two 0.5 FTE RNCMs may be assigned to one 1.0 PACT); fractional allocation of RNCM, Clinical Associate, and Administrative Associate should match the level of appointment of the PCP.

(i) Discipline-specific team members must be designated to a position in PCMM for at least one PACT, and may be designated in PCMM to more than one PACT.

(j) Team names and team position names cannot include the name of any of the staff. Team names may retain previous designations (e.g., Red Team, Blue Team).

(k) Special population PACT names must contain an appropriate indicator in the Team title. The indicator allows the team purpose to be easily distinguishable to staff and patients. The indicator identifies Special population PACTs in the national database and correctly attributes panel size calculations and generates data for PCMM reports. The indicators may be used in any position in the team name. (See Table 1.)

Diagram 1: Example of PCMM Configuration for PACT.
NOTE*: This example does not contain all of the potential staff positions that may be designated to a PACT.*

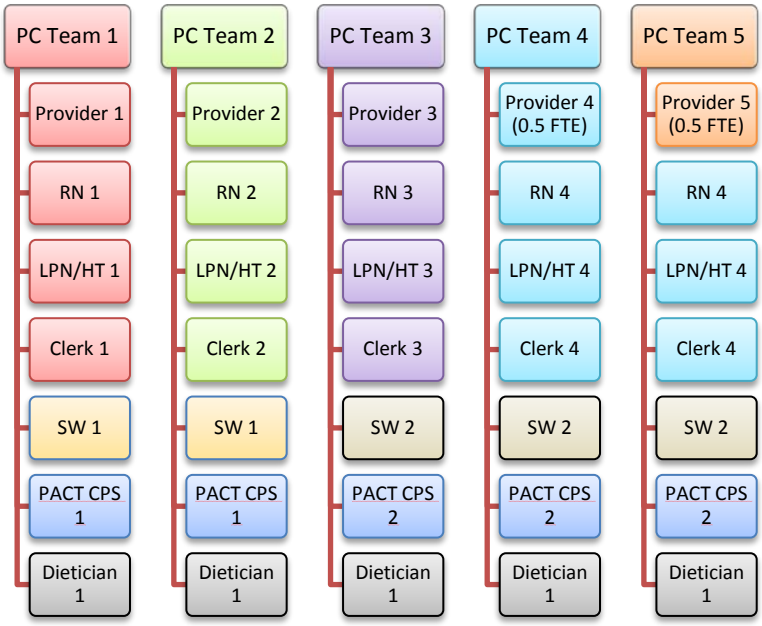

Table 1: Nationally approved indicators for Special population PACTs.

Type of Clinic	Team Title Indicator
Geriatric Primary Care	*GERI*
Home-Based Primary Care	*HBPC*
Homeless Program Primary Care	*H*
Infectious Diseases Clinic	*ID*
Post-Deployment Care	*PD*
Renal Dialysis	*REN*
Serious Mental Illness	*SMI*
Spinal Cord Injuries and Disorders	*SCI/D*
Women's Health	*WH*

(5) **Staff Coverage.** Staff coverage arrangements must ensure patients receive continuity of and access to care. Local service-level officials accountable for PACTs must establish and implement written processes for coverage of PACT staff that ensure:

(a) PACT function, operations, and team-based care continue during absences of individual PACT staff.

(b) Patients with scheduled appointments are contacted as soon as a staff absence that will impact the appointment is known or anticipated, and appropriate alternative care plans are established using a formalized, reliable, and predictable system.

(c) Incoming calls to PACT staff should be assigned to an appropriate covering staff member. In cases of PACT staff absences, every PACT staff member should have a contingency plan for coverage. The contingency plan ensures messages are communicated to the appropriate covering PACT staff. All appropriate PACT staff members should be aware of these communication arrangements.

(d) All PACT staff has coverage arrangements which are made available to other PACT staff. Coverage arrangements need to ensure Computerized Patient Record System (CPRS) view alerts and Secure Messages are managed by the covering provider. ***NOTE:*** *For CPRS coverage, this can be accomplished by setting the covering provider as a "surrogate" in CPRS. For Secure Messaging coverage, the settings must be adjusted to identify a surrogate or triage tree in the Secure Messaging software, which is separate from CPRS. (See the "My HealtheVet: Secure Messaging Health Care Team User Manual" at: http://vaww.vistau.med.va.gov/Documents/SMT/MHV_SM_HCT_User_Manual__FC_0211.pdf. This is an internal VA Website that is not available to the public.*) The RNCM must also arrange surrogates for CPRS and Secure Messaging coverage, as appropriate, and particularly when leave extends beyond 24 hours. PCPs who are not accessible to provide patient care during daily clinic hours (e.g., part-time PCPs, Associate Providers) have formalized coverage arrangements with other PCPs or PACTs that ensure patients receive continuity of and access to care when patients' designated PCP is not available. ***NOTE:*** *Local service lines may find it useful to structure PACTs into formal partnerships or groups to facilitate patients' familiarity and comfort with covering staff.*

(e) PACT staff request and receive approval for planned leave as far in advance as possible and reasonable, and according to national and local policies on time, leave, and attendance.

(6) **Planning for inadequate PACT resources and extended staff absences.** Local service-level officials accountable for PACTs must establish and implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events (e.g., extreme weather conditions, natural disasters). Contingency plans must include systems that:

(a) Identify a cadre of qualified, and if necessary, credentialed and privileged, staff willing to assume coverage responsibilities on short notice (e.g., on-call staff). Strong contingency plans include systems for continuous recruitment and hiring of PACT staff, using temporary staff (e.g., collaborative agreements with academic affiliates, National Primary Care Locum Tenens Program, nursing pool), or employing permanent replacement staff (e.g., "float" PCP). ***NOTE:*** *Large primary care sites have found that 1 "float" PCP for every 10-15 full-time permanent PCP provides adequate coverage for planned or unplanned PCP absences.*

(b) Incorporate processes that estimate future hiring needs, such as monitoring panel sizes, predict supply and demand, assessing unmet staffing needs and gaps in care.

(c) Incorporate flexible options for delivering care (e.g., mobile outreach clinics, telehealth outreach clinics, telework, etc.).

(d) Reassign or redistribute patients to another PACT when the:

1. PCP has discontinued employment with the clinical service or program accountable for the PACT;

2. PCP is not permitted by state or federal law, or VHA or local policy, to provide health care to patients; or

3. PCP's absence is expected to extend longer than six months.

8. PACT OPERATIONS MANAGEMENT PROCESSES:

a. **Panel Management.**

(1) VHA Handbook 1101.02 establishes policy for determining and adjusting panel sizes and provides detailed information on the appropriate use of PCMM software. Actual panel sizes are set for each PACT based upon the characteristics of the patient panel, such as proportion of patients from special populations (e.g., women's health, elderly, end-stage renal disease, Veterans returning from combat) that may require additional time and resource-intensive care management and care coordination to provide high quality care. ***NOTE:*** *Panel sizes for Special population PACTs may be established by other VHA policies. (See paragraph 12.)*

(2) PCMM supports set up and definition of the health care team, assignment of staff to positions within the team, and assignment of patients to the team. PCP and staff assignments and related aggregate data captured in PCMM is stored centrally and reported on the VHA Support Service Center (VSSC) website (http://vssc.med.va.gov). ***Note:*** *This is an internal VA Website that is not available to the public.*

b. **Team Management and Function.**

(1) **Training Requirements for Communication with Patients.** Training in effective communication skills enables PACT staff to partner with patients and develop helping relationships. The following training requirements for communication apply to appropriate staff from all PACTs.

(a) PACT staff performing the responsibilities of the clinical associate and the PCP from each PACT must complete VHA National Center for Health Promotion and Disease Prevention (NCP)-approved communication and coaching skills training (i.e., Patient Education: TEACH for Success (TEACH) or an alternative program approved by NCP).

(b) PACT staff performing the responsibilities of the RNCM must complete NCP-approved communication and coaching skills training (i.e., TEACH or an alternative program approved by NCP) and in motivational interviewing. Training of additional PACT staff in Motivational Interviewing and complementary training in whole health coaching (offered by the Office of Patient Centered Care and Cultural Transformation) is encouraged to further enhance communication and coaching skills.

(c) VA medical facilities and Veterans Integrated Service Networks (VISNs) may, and are encouraged to, require NCP-approved training in patient-centered communication skills for all PACT staff (e.g., discipline-specific team members). ***NOTE:*** *Training in patient-centered communication is available to VA employees through programs delivered by TEACH facilitators and NCP-approved motivational interviewing facilitators. Additional resources to support training in patient-centered communication are available through the Talent Management System.*

(2) **Training on PACT.** All PACT staff must undergo training in accordance with national PACT training standards governed by national PACT guidance issued from the Primary Care Operations Office.

(3) **PACT Communication.** Effective communication between health care professionals and patients is essential to coordinating health care services across the continuum of health care settings, integrating comprehensive health care services, and protecting patient safety. Team members may use VHA-approved innovative technologies to enhance communication as long as patient privacy, confidentiality, and information security are protected (see VHA Handbook 1907.01).

(a) Processes to enhance communication among PACT staff. Informal communication among PACT staff throughout the day enhances prompt information transfer; structured communication processes enhance the team's ability to provide the right information at the right time to the right person. Respectful communication among PACT staff allow each person a voice in making decisions that affect the care of the patient and team function.

1. Huddle.

a. The purpose of the huddle is to enhance timely communication among team members and perform proactive planning about the logistics of running the clinic that day. Examples of huddle activities are reviewing the scheduled patients for that day, assembling the necessary information needed for decision-making, anticipating patient issues or problems, alerting team members to family or caregiver concerns, and considering engagement of discipline-specific assistance, upcoming transitions of care (e.g., admissions, discharges), ancillary programs, or resources. Conversations occurring within the huddle must occur in an area that ensures adequate privacy and confidentiality.

b. Teamlet members need to come together for a huddle at least once a day, usually prior to the clinic session, and may huddle at other times throughout the day as needed to keep each other informed of active patient or clinic issues.

c. Discipline-specific team members are encouraged to be present at huddles.

2. Team Meetings.

a. The purpose of the team meeting is to engage the team in:

(1) Developing care management strategies for patients needing complex care;

(2) Performing continuous improvement team activities (e.g., evaluation of team performance data, team building activities, innovating new processes and approaches);

b. PACT staff meet at least monthly (typically weekly) and as necessary for a team meeting. Specific team meeting schedules are determined locally.

c. Service-level officials accountable for PACTs must allocate at least 2 hours of protected time per month to all PACT staff for team meetings.

d. When requested, other health care professionals or VA representatives (e.g., facility leadership, patient safety officer, quality management representative, general counsel, systems redesign representative, chaplain, PCMM coordinator) attend team meetings.

(b) Communication with VA and community-based health care professionals. PACT staff may use informal and formal communications with VA and community-based health care professionals to coordinate comprehensive care for patients.

(c) Communication with Patients. PACT staff needs to establish ongoing communication with Veterans and their personal support persons and solicit and listen to what really matters to Veterans in their life, their values, and preferences for care and obtain Veterans' input regarding their experiences with the PACT. (See Appendix A. Engaging Veterans in the PACT). This communication should include a discussion of mutual expectations, roles, and responsibilities of all PACT members.

c. **PACT Quality Management and Quality Improvement.**

(1) The same standards for clinical quality, safety, access, timeliness, patient satisfaction, and efficiency are required of all VA medical facilities and contract-VA sites that provide primary care.

(2) Each site and each PACT continually assess and, as needed, improve processes for providing care using: relevant data; new and emerging information and evidence; national and local information and guidance; metrics; and input from patients receiving primary care. (See Appendix B.)

(3) Performance metrics:

(a) Performance metrics are used to enhance quality of care.

(b) Performance metrics evaluate effectiveness of current processes for providing primary care services that are patient-centered, team-based, accessible and timely, comprehensive, coordinated, and provide continuity of care.

(c) Data from metrics measuring quality of primary care and that require local and national focus (e.g., recognition metric) is published and made available to PACT staff through the PACT Compass.

(d) Performance metrics developed by the VHA Primary Care Services in collaboration with the Office of Primary Care Operations, the Office of Informatics and Analytics and relevant VHA Program Offices can be used to:

1. Assess clinical quality of care;

2. Assess the course and effectiveness of PACT implementation;

3. Assess Veterans' experience of care;

4. Identify, prioritize, and assess the effectiveness of quality improvement and systems redesign activities;

5. Assess access to and timeliness of care;

6. Assess cost and efficiency of primary care services in VHA;

7. Ensure compliance with accreditation and regulatory standards;

8. Provide information required for VA reporting; and

9. As feasible, evaluate incorporation of PACT Principles (see paragraph 6).

(4) Data sources for comprehensive primary care.

(a) PACT-Compass. The PACT-Compass is a VSSC application that extracts data from VHA databanks on patients assigned in PCMM to a PCP or to a PACT. The PACT-Compass compiles relevant data and generates reports on metrics that evaluate key dimensions and PACT principles. The PACT-Compass provides VHA leadership and staff with decision-making information for panel management, population management, and patient care.

(b) PC Almanac. The PC Almanac is a set of population reports intended to support the management of PACT patient panels. The PC Almanac allows a PACT team to look across its entire panel at registries of patients with various chronic diseases and demographic characteristics and to assess risk. It also provides information about teams' practice habits and

how they compare to others at their site, the VISN, and the nation, and about success with performance measures and other clinical parameters, including adherence.

d. **Access Management**.

(1) Excellent access is a cornerstone of patient-centered care. Excellent access means PACT staff is available to provide appropriate clinical advice or care using appropriate modalities of health care delivery at the time patients want and need the advice or care.

(2) Every VHA site that provides primary care implements accepted access management principles and processes to ensure that Veterans receive care in a timely manner. ***Note:*** *For additional information and guidance see "Principles and Strategies of Advance Clinic Access" on the Systems Redesign website: https://srd.vssc.med.va.gov/Topics/Literature/bibliography%20Document%20Library/Access%20and%20Office%20Efficiency%20Principles%20022010.doc. This is an internal VA Website that is not available to the public.*

(3) All PACT staff share responsibility for creating and maintaining access for in-person, face-to-face encounters, group visits, telehealth, secure messaging and telephone encounters for the designated panel of patients. Access to care is measured and reported in the PACT Compass. PACT staff monitor PACT Compass metrics and, as appropriate, establish action plans for achieving access to care.

(4) PACT staff may use a range of processes (e.g., pre-planning calls, recall reminder calls), procedures (e.g., walk-in rapid evaluation procedures), systems (e.g., MyHealth*e*Vet automated medication refill systems), modalities of health care delivery (e.g., in-person, telephone, group medical appointments, telehealth) and tools (e.g., standardized health assessment tools and protocols) to manage access. ***Note:*** *For additional information and guidance see "Systems Redesign Consultation Team Guide, 2008" on the Systems Redesign website: http://srd.vssc.med.va.gov/Topics/Tools/Basic%20Systems%20Redesign%20Concepts/Consultation%20Team%20Guide%20-%20Final%20(2).doc. This is an internal VA Website that is not available to the public.*

(5) When a patient requests health care, the patient's request is evaluated promptly by the PACT staff member who has appropriate competency. PACT staff must offer clinically indicated care to the patient that is respectful of the patient's preferences and appropriate for the safe delivery of care. PACT staff may employ rapid evaluation mechanisms to evaluate patients' requests for care. The setting of health care should be appropriate to the health condition. If a face-to-face in-person visit is required for the delivery of safe and appropriate care, telephone care, CVT or secure messaging is not an appropriate care modality even if it is the patient preference.

(6) All PCPs and RNs must ensure they have same-day access (unless it is too late in the day as determined by the individual facility) for face-to-face encounters, telephone encounters and, when required by VHA guidance or policy, other types of encounters.

(7) PACT staff determines the proportion of clinic time necessary for delivering appropriate care to the patient panel based on access metrics and supply and demand assessments. PACT staff establishes apportionment of staff time across all modalities of care delivery. (See Paragraph 10 and for additional information and guidance see "Principles and Strategies of Advance Clinic Access" on the Systems Redesign website: https://srd.vssc.med.va.gov/Topics/Literature/bibliography%20Document%20Library/Access%20and%20Office%20Efficiency%20Principles%20022010.doc.)

(8) Processes for managing patients' requests for non-emergency care and same-day access must implement the principle of continuity of care by preferentially directing requests for non-emergency care according to the following descending hierarchy of care providers:

(a) The patient's assigned PCP and other assigned PACT staff;

(b) The designated covering PCP and covering PACT staff;

(c) Any PCP and any PACT staff; and

(d) Next day appointment (if acceptable to the patient) with the patient's assigned or designated covering PCP and other PACT staff.

(9) PACT staff use procedures and processes for scheduling outpatient clinic appointments in a fashion that best suits patients' clinical needs and preferences established in VHA outpatient scheduling policy (such as soliciting patients' desired date for the appointment and scheduling as closely as possible to that date; using the Recall/Reminder software for managing appointments scheduled beyond the 3-4 month window; scheduling follow-up or referral for consultation appointments before the patient leaves the PACT's clinic area).

(10) Recall scheduling is used to provide patient-centered care and increase availability for same-day access appointments, unless it is too late in the day as determined by the individual facility. Recall scheduling provides patients the opportunity to request appointments at their own convenience, to specify appointment dates and times, and to specify a preferred modality for health care delivery. Recall scheduling is the preferred scheduling process for routine appointments scheduled more than 3-4 months in advance. Successful recall scheduling requires excellent access for scheduled appointments, as patients must be offered convenient appointments even if requested in close proximity to when patients call.

e. **Care Management.**

(1) Care management integrates and augments health care quality by providing health education (promoting, among other things, self-care), clinically appropriate preventive and therapeutic care and partnerships among patients, personal support persons, and PACT staff. ***NOTE:*** *Most care management is provided by RNCMs.*

(2) Care management processes must be established that are sufficient to ensure that appropriate PACT staff:

(a) Offers and provides appropriate care management services to patients assigned to the PACT.

(b) Assesses factors impacting patients' health status, and works with the patient and personal support persons to manage care in a way that relieves constraints or barriers to desired health status (see VHA Handbook 1120.04).

(c) Provides patients and personal support persons with health education and coaching, and engages them in developing strategies for managing their full range of health conditions according to agreed upon goals of care (see VHA Handbook 1120.04).

(d) Collaborates with appropriate PACT members to develop and implement personal health plans for individual patients and for cohorts of patients.

(e) Assesses patients' communication abilities, including educational and literacy level, language preferences, ethnic or cultural communication preferences, the patient's preferences for participation in health care decision-making, speech or visual impairments, assistive devices (e.g., writing boards, hearing aids, visual and blind aids), and the need for translators or interpreters (see VHA Handbook 1120.04).

(f) Patients, and if appropriate, personal support persons, receive information about transitions of care and who will be responsible for patient information and follow-up regarding the transition.

(g) Assesses patients' preferences for access and modalities for health care delivery.

(h) Engages case managers or proposes reassignment of patients to appropriate special population PACTs when patients' needs exceed the resources available to PACT staff or when patients' needs require specialized case management services (e.g., case management for Operation Enduring Freedom-Operation Iraqi Freedom-Operation New Dawn (OEF-OIF-OND), Serious Mental Illness (SMI), Spinal Cord Injuries and Disorders (SCI/D), Blind and Vision Rehabilitation Continuum of Care). PACT staff providing care management serves as the primary point of contact for case managers and collaborate with case managers for comprehensive care.

f. **Care Coordination.**

(1) Care coordination facilitates integration of health care services and navigation through complex health care systems. It involves working across care settings, accessing health care providers and other services such as community programs, to help patients receive the care they need and want without unnecessary duplication of services or avoidable inconvenience. Care coordination involves open communication among health care providers, legally permissible exchange of health care information, and logistical integration of health care encounters.

(2) Care coordination processes must be sufficient to ensure PACT staff, typically the RNCM or Clinical Associate, coordinates care for patients assigned to the PACT when patients are:

(a) Admitted to hospital, Emergency Department (ED), or Community Living Center (CLC).

(b) Discharged from hospital, ED, or CLC.

(c) Re-assigned to or from another PACT.

(d) Receiving care from provider(s) of specialty care.

(e) Receiving care from several health care providers, including VA providers, VA-contract providers, or providers unaffiliated with VA (e.g., dual care).

(f) Undergoing complex or high risk surgical or interventional procedures.

(3) Care coordination processes must ensure:

(a) There is no lapse in care for the patient.

(b) Relevant information is communicated to involved providers. Communications between providers need to ensure that during the transition the receiving provider is provided with necessary information for health care decision-making.

(c) PACT staff knows about transitions of assigned patients between care settings and are involved when needed to facilitate safe, effective, and patient-centered transitions.

(d) Health record information is made accessible to involved providers in a timely manner.

(e) Clinically recommended care is integrated to avoid duplication, poor timing, or missed care opportunities.

(f) When required, the patient's (or surrogate's) release of information is obtained and documented in the health care record (e.g., VA Form 10-5345 "Release of Information") (see VHA Handbook 1907.01). Patients must provide specific written release of information to permit VA providers to disclose patient information about testing for Human Immunodeficiency Virus (HIV), or treatment for Acquired Immune Deficiency Syndrome (AIDS), Sickle Cell Anemia, or alcohol or substance abuse. (See 38 U.S.C. 7332.)

(g) Service agreements, or formalized documents of agreement (e.g., Care Coordination Agreements, Memorandum of Understanding, Memorandum of Agreement), are established between services or between health care facilities, as necessary, and according to VHA policy.

g. **Population management.**

(1) Population management is a data-driven process for proactively defining a cohort of patients who might benefit from a health care plan or reaching out to individual patients in the cohort to offer the right intervention at the right time, rather than waiting for the patient to self-identify and seek out health care.

(2) Population management processes must be sufficient to ensure:

(a) PACT staff use data sources (e.g., PACT almanac, clinical reminders, disease specific registries, dashboards, Decision Support Systems (DSS) data, VSSC) for population management of:

1. Patients at high-risk for clinical complications;

2. Patients needing complex health care plans;

3. Patients needing health care interventions;

4. Patients needing educational services to self-manage their acute or chronic conditions; or

5. Patients needing preventive health care.

(b) PACT staff develops and implements plans for contacting, offering, and, with patients' consent, providing clinically indicated health care services for which patients are eligible. Plans must include how services will be coordinated to achieve access and follow-up that is both clinically appropriate and amenable to patients' preferences.

9. EXAMINATION ROOM PRIVACY STANDARDS:

a. The health care environment directly and indirectly affects the quality of care provided to Veterans. It affects the Veterans' comfort and sense of security, as well as their perceptions of care received. Measures should be taken to maintain and adjust care environments to support privacy, dignity and safety for all Veterans. ***NOTE:*** *Systems Redesign processes can help in identifying needed equipment or resources to improve clinic efficiency.*

b. Examination rooms must be located in a space where they do not open into a public waiting room or a high-traffic public corridor. Access to hallways by patients or staff who do not work in that area should be restricted.

c. Appropriate locks (either electronic or manual) for examination room doors are required (allowing staff to have key or code access in the case of emergency).

d. Privacy curtains must be present in examination rooms. Examination tables should be shielded from view by the privacy curtain when the door is opened. Examination tables must be placed with the foot facing away from the door.

e. Examinations and procedures that may necessitate a need for quick access to a restroom should be performed within the context of ensuring patient privacy.

10. MODALITIES OF HEALTH CARE DELIVERY: As compared to the standard one-on-one in-person patient-to-provider encounter, PACT staff is able to provide patients with enhanced access to care by employing a range of modalities of health care delivery and using all available VHA-approved advanced communications technologies.

a. **Criteria for usage of health care delivery modalities.**

(1) The modality must be appropriate for delivery of safe, effective, patient-centered, clinically indicated health care;

(2) Patients' preferences for communication and health care delivery must be taken into consideration when choosing a modality; and

(3) The PACT staff and patient have received appropriate orientation and training for use of the modality.

b. **In-person face-to-face care delivery.**

(1) **One-on-one encounter with PCP.** One-on-one encounters provide patients and personal support persons with the opportunity to meet privately with health care professionals. One-on-one encounters are essential for some diagnostic and therapeutic evaluations, but can be augmented by non-face-to-face encounters.

(2) **One-on-one encounter with other PACT staff (including discipline-specific team members).** Frequently patients need care from the other members of the PACT and do not need to meet with the PCP. PACT staff can arrange to meet with patients for the purposes of providing care related to the PACT staff's role and responsibilities.

(3) **Shared medical appointment.** Shared medical appointments provide the opportunity for patients to meet in a group of patients with the PCP (or other discipline-specific team members) and appropriate PACT staff to discuss health care concerns, receive primary care or specialty care along with education and peer support from the team members in attendance. Shared medical appointments can be an effective alternative to one-on-one encounters when:

(a) A cohort of patients with a similar health condition, such as patients with chronic pelvic pain, recurrent pressure ulcers, or chronic arthritic pain syndromes, desire and could benefit from disease-based education, self-management skill development, or treatment;

(b) Subject matter expertise from multiple team members, including subject matter expertise from patients and personal support persons, is needed to provide a rich learning experience for a cohort of patients using a group setting; or

(c) Patients need frequent encounters for care management or care coordination of a complex health plan, such as for management of multiple co-morbid health conditions.

(4) **Drop in Group Medical Appointments.** Drop in Group Medical Appointments (DIGMAs) provide patients with the opportunity to meet in a group setting with the PCP and appropriate PACT staff to receive specific medical care for the unique health condition of the individual patient. DIGMAs provide an alternative to one-on-one encounters and can be an effective care modality for patients requesting same-day access for a health concern needing in-person evaluation, unless it is too late in the day. Unlike patients attending a shared medical appointment, patients attending a DIGMA generally have a range of health conditions.

(5) **Group education appointment.** Group education appointments provide patients with the opportunity to meet in a group setting with appropriate PACT staff to discuss health care concerns and receive education and peer support from attendees. The PCP is not required to attend group education appointments. Group education appointments provide an alternative to one-on-one encounters and can be effective for health behavior management and self-management skill development when patients do not need PCP-level medical evaluation or PCP-level treatment of a health condition. Examples of group education appointments are weight management services (i.e., MOVE!®), new patient appointments, caregiver support clinics, and chronic disease self-management programs.

c. **Virtual face-to-face care delivery.**

(1) **Clinical Video Telehealth.** Videoconferencing technologies and diagnostic equipment are means by which PACT staff can use on-screen viewing to communicate with and visualize patients located remotely thus avoiding unnecessary travel and offering easier access to clinically indicated care. Clinical Video Telehealth (CVT) provides an alternative to in-person encounters while still providing a face-to-face interaction between the patient, personal support persons, PACT staff, and other health care providers. Telehealth Clinical Technicians (TCTs) serve as telepresenters for CVT and assist PACT staff in providing care to patients using telehealth equipment and technologies. Effective usage of CVT requires special training and equipment for all parties in the encounter. (See http://www.telehealth.va.gov or http://vaww.telehealth.va.gov).

d. **Non-face-to-face care delivery.**

(1) **Telephone care.** Telephone care is a general term for contact between a patient and a health care professional using telecommunications for purposes related to the delivery of health care to the patient. Scheduling, documentation, or DSS coding is not required to contact the patient using telecommunications. ***NOTE:*** *If contact with the patient is a telephone encounter, health care professionals should document and code the encounter appropriately.*

(a) Local systems for telephone care must accommodate the following telephone communications with patients:

1. Incoming calls from patients, or personal support persons;

2. Outgoing scheduled telephone encounters; and

3. Outgoing unscheduled telephone care.

(b) Typical reasons for incoming telephone calls to PACTs include:

1. Requests for appointments or questions regarding appointment scheduling;

2. Questions related to recent outpatient encounters, recent discharge from inpatient care, recent acute care encounters;

3. Medication or treatment related questions;

4. Information regarding diagnostic or therapeutic tests; or

5. Clinical advice.

(c) Centralized call center. Use of a centralized call center may provide important efficiencies regarding telephone care, including the opportunity to provide formal and standardized training to call center personnel, monitor quality and access using automatic call distribution systems, and develop telephone trees, which permit efficient routing of calls directly to appropriate services such as scheduling and pharmacy personnel.

(d) Responding to incoming calls from patients and personal support persons:

1. Calls requiring the expertise of the PACT should be transferred to the appropriate PACT staff using the most effective and efficient technology and systems available. Calls where the patient is requesting an immediate response should be handled in the most expeditious way possible, even if that requires routing outside the PACT;

2. Recommended practice for responding to incoming calls received by the PACT is to provide a response to patients within four business hours. However, all calls must receive a response within one business day, depending on the clinical need; and

3. Patient concerns should preferably be addressed during the initial call thus obviating the need for a return call.

(e) Scheduled Outgoing calls. Scheduled outgoing calls are an efficient method for managing non-urgent clinical concerns when the patient does not need or desire a face-to-face evaluation but may benefit from telephone contact. Telephone clinics and telephone encounters are an efficient PACT process for managing and documenting non-face-to-face patient encounters.

1. Telephone Clinic. A telephone clinic is scheduled time for telephone encounters. A telephone clinic is assigned one of the DSS Identifier telephone codes and is designated as a count clinic.

2. Telephone Encounter. A telephone encounter is a professional contact between a patient and a health care professional using telecommunication technology for the purposes of assessing, evaluating, counseling, diagnosing and/or treating the patient's condition or providing patient education. Telephone contact between a patient and a health care provider is only considered an encounter if the telephone contact is documented and that documentation includes elements of a face-to-face encounter, namely, history, clinical decision-making, education, and counseling, as appropriate for that encounter. Telephone encounters must be associated with a clinic that is assigned one of the DSS Identifier telephone codes and are designated as count clinics. A scheduled telephone encounter is very similar to an in-person, face-to-face encounter in that:

a. The encounter is scheduled in advance; scheduling takes into account patients' availability;

b. PACT staff notify patients of the time and date of the telephone encounter;

c. The same performance and access metrics for measuring missed opportunities or canceled appointments that apply to in-person, face-to-face encounters, also apply to scheduled telephone encounters;

d. Telephone Clinic availability and utilization is tracked using the Clinic Utilization Statistical Summary report; and

e. Telephone encounter forms and progress notes must include information on duration of call, complexity, and decision-making.

(f) Unscheduled Outgoing Calls. PACT staff may contact patients without scheduling a telephone encounter. PACT staff can use unscheduled outgoing calls as a "just-in-time" method of responding to a patient care need. When an unscheduled call results in clinical decision-making, the call needs to be documented in the health record and encounter information needs to be entered. When encounter information for an unscheduled call has been appropriately entered, the encounter workload is equal to that of a scheduled telephone encounter.

(2) **Home Telehealth.** Home Telehealth technologies include messaging devices, videophones and video monitoring devices. Messaging devices regularly deliver and receive disease management information, including vital signs and other health status data, directly from patients' homes. Patients are selected for a particular technology using an algorithm that matches the complexity of their disease to the level of sophistication of the home telehealth device. Each patient being supported by Home Telehealth has a Home Telehealth care coordinator who provides ongoing care and case management. Home Telehealth enhances health care delivery for many patients unable to easily travel to the PACT clinic for health care and should be considered in all patients with complex health conditions or multiple co-morbidities. (See http://www.telehealth.va.gov and http://vaww.telehealth.va.gov).

(3) **Secure Messaging.** Secure Messaging is a web-based, encrypted, secure communication tool available through My Health*e*Vet. Secure messaging allows participating patients and PACT staff to communicate non-urgent, health related information through a private and secure

electronic environment. ***NOTE:*** *To participate in secure messaging, users need to have a My HealtheVet account; see www.myhealth.va.gov.*

e. **Other modalities for health care delivery.** As technology progresses, additional modalities for safe, effective, patient-centered health care delivery may be developed. Continuous improvement activities may be used to explore, innovate, and, as permitted by VA, use new modalities of care.

11. PACT SERVICES REQUIRED FOR DELIVERY OF COMPREHENSIVE PRIMARY CARE: Comprehensive primary care ensures that all of the health care that a patient needs or desires to improve health (that is, to promote, preserve, or restore health, including that needed to maintain the current quality of life of the Veteran under 38 CFR 17.38(b)(2)) is either provided by the PACT or arranged to be provided by others. Health care provided by the PACT is not limited to addressing only acute symptoms, but also provides longitudinal care within the context of sustained relationships. After enrollment in VHA, the PACT to which patients are assigned becomes the patients' primary access point to VHA's health care system. PACT staff must provide all of the following primary care services to all assigned patients. Special population PACTs also provide additional specialized services to assigned patients.

a. **Chronic care and care for patients at high risk for complications or morbidity.** For patients with chronic health conditions, PACT staff provides evaluation, diagnosis, treatment to which the patient has consented, care management, care coordination, health education, and self-management support. Teamlets utilize registries and other tools to quickly identify individuals requiring additional services and closer follow-up. In addition, patients at high-risk for complications or morbidity receive a special focus from the PACT to ensure integrated and comprehensive care management and coordination over the lifetime of the patient and across the continuum of care settings. PACT staff provides care coordination and care management to meet the needs of patients.

b. **Acute or urgent care.** PACT staff provides evaluation, diagnosis, and treatment of acute health conditions so long as the clinically indicated acute or urgent care to which the patient has consented can be provided safely at the site of care and is within the clinical privileges, or scope of practice and expertise of PACT staff. PACT staff engages appropriate discipline-specific team members for acute or urgent care requiring discipline-specific skills, expertise, or licensure. PACT staff arranges for safe transition and transfer of patients to other health care settings (e.g., Emergency Department, hospital admission) when needed.

c. **Emergent assessment and Basic Cardiopulmonary Resuscitation (CPR).** Regardless of qualifications that PACT staff may have in other clinical settings, PACT staff may not assume the responsibilities of emergency medicine providers when functioning in a primary care role. When a patient presents to a site of primary care delivery needing emergency medical care (see VHA Handbook 1101.05, Emergency Medicine Handbook) PACT staff must rapidly evaluate the patient and:

(1) Access emergency responders according to local policy and procedures for patients who are in medical distress;

(2) As determined by local policy and the capacity of the PACT clinic staff and setting, administer Basic Life Support, activate 9-1-1, or use an automated external defibrillator when clinically indicated and consistent with patients' goals of care (see VHA Handbook 1101.05); and

(3) Transfer patients to appropriate acute care settings, when necessary.

d. **Preventive Health Care.** PACT staff offers preventive health care tailored to individual patients' needs and preferences, and provides preventive care to which the patient has agreed. PACT staff uses population management tools, such as registries, to identify patients and cohorts who may benefit from preventive health care and develop health care plans for efficient delivery of care to patient cohorts. PACT staff uses nationally and locally developed data collection methods for evaluation and measurement of preventive health care services. PACT staff uses and applies VHA Clinical Preventive Services Guidance Statements to offer recommended screening for conditions or risky health behaviors (e.g. cancers, mental health conditions, tobacco use), immunizations, health education (including counseling regarding health effects associated with certain health behaviors, e.g., tobacco use, physical activity, healthy eating), and preventive medications for selected high risk conditions, as appropriate. When clinically indicated, PACT staff engages providers of specialty care and discipline-specific team members for preventive care services (e.g., colonoscopy, special services for women with spinal cord injury, Health Behavior Coordinator; *MOVE*!® Coordinator), (see VHA Handbook 1120.01). ***NOTE:*** *VHA Clinical Preventive Services Guidance Statements are available at http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp*. This is an internal VA Website that is not available to the public. (See VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services.)

e. **Mental Health Care.**

(1) PACT staff provides routine mental health care, consistent with team members' clinical privileges, skills, scope of practice or functional statements. PACT staff performs nationally required preventive mental health screenings. In addition to screening, clinical evaluation of patients during routine primary care may also lead to recognition of symptoms of mental disorder.

(2) PACT staff typically provides brief alcohol counseling and treatment for uncomplicated disorders such as anxiety, depressive, and adjustment disorders. When caring for patients with mental health disorders, PACT staff engages Primary Care-Mental Health Integration (PC-MHI) providers, behavioral health providers, disease prevention specialists, or other discipline-specific members of the PACT when appropriate.

(3) PC-MHI providers are discipline-specific members of the PACT and perform the following functions when established by local policy or service agreements (see VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics):

(a) Co-located Collaborative Care PC-MHI providers enhance access and availability to mental health care providers at the PACT clinic. Co-located Collaborative Care PC-MHI providers generally provide assessment and time-limited treatment of uncomplicated mental disorders working in close collaboration with PACT staff. They may also provide consultative advice to PACT staff, suggest referral, or assist in referral of patients with complex mental health conditions to mental health programs. Co-located Collaborative Care providers are discipline-specific members of the PACT.

(b) Care management of patients assigned to the PACT who need telephone assessment, treatment and follow-up for acute exacerbations of mental disorders, such as depression, using disease specific care management protocols.

(c) PC-MHI co-located collaborative care and care management options must be available at VAMCs and CBOCs, as specified in VHA Handbook 1160.01. For smaller CBOCs where actual presence of PC-MHI staff is not feasible, virtual arrangements using CVT and telephone care are recommended options.

(4) PACT staff with, optimally, input from the discipline-specific PC-MHI provider refers patients with complex mental illnesses to providers of specialty mental health care.

(5) PACT staff collaborates with Mental Health Treatment Coordinator and designated mental health providers when caring for Veterans with serious mental illness or other specialty mental health services.

(6) VA medical facilities, clinics, or mental health services may establish a Serious Mental Illness-PACT (SMI-PACT) to manage patients with serious mental illness. SMI-PACTs assume full responsibility for providing comprehensive primary care to assigned patients (see paragraph 12).

f. **Health education, coaching, and developing health care partnerships.** PACT staff provides patients with information, education, and skill building to support self-management, as well as access to materials, resources, and programs appropriate to the patient's needs. PACT staff promotes therapeutic alliances between the patient, the patient's personal support persons, and the patient's health care team by using health education interventions, health coaching, motivational interviewing, self-care strategies, and connecting patients to community resources to encourage, guide and support health behavior changes that promote wellness or reduce the risk of illness and adverse health events.

g. **Military Health History and unique concerns and health risks associated with deployment.** PACT staff is knowledgeable on issues related to deployment health risks with basic competencies for the common concerns of post-deployed Veterans including but not limited to: unique health risks, exposures, sleep issues, pain, chronic multisystem illness, traumatic brain injuries and mental health issues, including PTSD. PACT staff must be provided the necessary education and training required to attain this knowledge and competency. PACT staff should include a military health history in the initial assessment to assist in understanding

the Veteran's problems and concerns, and to build therapeutic partnerships with the Veteran. PACT staff screens patients for post-deployment related health issues and coordinates referral to the appropriate specialist when further evaluation is indicated. (See Military Health History Pocket Card for Clinicians at http://www.va.gov/oaa/pocketcard/ and Primary Care Resources – Post Deployment SharePoint at http://vaww.infoshare.va.gov/sites/primarycare/resources/pcedresourcesforPACT/postdeploymentcare/default.aspx).

h. **Patient comfort and pain management.** PACT staff manages common acute and chronic pain conditions and consults with providers in pain medicine and other related specialty care when appropriate and according to VHA policy on pain management.

i. **Advance care planning.** PACT staff notifies and screens patients for Advance Directives. PACT staff offers assistance or engages appropriate health professionals to assist patients in stating their advance care preferences according to the processes and procedures established by VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives.

12. PACT FOR SPECIAL POPULATIONS: The presence of special population PACTs at a facility depends upon an evaluation of the population need and availability of appropriate resources to provide efficient care for these Veteran cohorts (with the exception of Women's Health where the expectation is that all women Veterans will eventually be assigned to Women's Health PACTs with a designated Women's Health PCP). If a decision is made not to establish a local special population PACT, PACTs must engage appropriate specialty care providers and case managers to ensure patients are offered and can receive comprehensive care.

a. **General requirements for Special population PACTs.** ***NOTE:*** *Paragraphs on specific special population PACTs may contain justifiable specifications or exceptions to the general requirements.*

(1) Special population PACTs are responsible for providing all PACT services required for delivery of comprehensive primary care (see paragraph 11), specialized services directed by VHA national program directives or guidance, and coordinating all specialty care.

(2) **Patient assignment to Special population PACTs.** Service-level officials accountable for PACTs must use VHA approved and published qualifying criteria, when they exist. When national qualifying criteria have not been approved or published, service-level officials must use locally approved and published qualifying criteria for assigning patients to special population PACTs.

(a) If a patient qualifies for assignment to more than one special population PACT, service-level accountable officials must collaborate to determine which PACT can best serve the patient's needs and determine how comprehensive care will be provided. The patient's preferences regarding PACT assignment must be taken into consideration.

(b) If service level accountable officials cannot reach agreement, they must provide recommendations to the Chief of Staff. The Chief of Staff is responsible for arbitrating and resolving conflicts regarding assignment of Veterans to PACTs.

(3) Special population PACTs provide care commensurate with PACT Principles established in paragraph 6.

(4) Special population PACTs implement PACT member and staffing, staff coverage, and contingency planning as established in paragraph 7.

(5) Special population PACTs adhere to PACT operations management processes as established in paragraph 8.

(6) Special population PACTs use modalities of health care delivery as established in paragraph 10.

(7) Special population PACTs must be configured in PCMM using nationally approved team title indicators (see paragraph 7). Team members may include an RN/LVN/HT and Clerk or may also be configured with different team members with different designated roles. The composition of team members for a special population PACT will be determined according to the needs of the special population being served.

(8) Service level officials accountable for PACTs collaborate to develop and implement quality and performance metrics appropriate to the delivery of comprehensive primary care that meet the needs of the special population.

b. **Geriatrics PACT (GERI-PACT).**

(1) **Qualifying criteria.** The same qualifying criteria for determining the target population of Veterans that may be assigned to a GERI-PCP apply to assigning patients to a GERI-PACT and are established in VHA Handbook 1140.07, Geriatric Primary Care.

(2) **Service level accountable official.** The service level accountable official for GERI-PACTs is the local Medical Director of Geriatric Primary Care (see VHA Handbook 1140.07).

(3) GERI-PACTs may be established for any geriatric team that assumes responsibility for comprehensive, coordinated primary care and specialized geriatric care of an assigned panel of patients. Geriatric services for Veterans are not limited to only those services provided by GERI-PACTs; additional geriatric services include GEM (see VHA Handbook 1140.04, Geriatric Evaluation and Management (GEM) Procedures) and Geriatric consultation (see VHA Handbook 1140.09, Geriatric Consultation).

(4) **PCMM configuration for GERI-PACTs.**

(a) PCMM Team Title Indicator is *GERI*.

(b) Teamlet positions:

1. PCP position: GPC Provider;

2. Care Manager position: RNCM;

3. LPN/LVN/HT position: Clinical Associate;

4. Clerk position: Administrative Associate;

5. SW Position: Social worker; and

6. Pharmacy Position: Clinical Pharmacy Specialist

(c) Discipline-specific team members for GERI-PACTs are assigned in PCMM as follows:

1. Dietitian: Registered Dietitian;

2. Other position: Geriatric psychiatrist;

3. Other position: Geriatric psychologist;

4. Other position: Hospice and Palliative Care Provider; and

5. Other position: Physical Medicine and Rehabilitation Services (e.g., Physical Therapist, Occupational Therapist, Kinesiotherapist, Recreational Therapist, etc.)

(5) **Additional staffing requirements.**

(a) Staff for GERI-PACTs have advanced training and experience in: (1) addressing the discipline-specific, health related challenges encountered in frail, chronically-ill Veterans of advanced age; (2) communicating and collaborating effectively with health professionals from other health disciplines; and (3) communicating effectively with the population served, including elderly Veterans and their caregivers.

(b) Other staff proficiencies or specific staffing qualifications are established in VHA Handbook 1140.07.

(6) **Panel management**. Panel size requirements for GPC providers set forth in VHA Handbook 1140.07 apply to panel size determinations for GERI-PACTs.

(7) **Access management.** GERI-PACT scheduling processes may need to include provisions for scheduling follow-up appointments far in advance to ensure longitudinal care for certain patients and accommodate the needs of patients with cognitive impairment or at elevated risk for decline. (See VHA Handbook 1140.07.)

(8) **Preventive health care.** In addition to preventive health care requirements set forth in Paragraph 11 of this Handbook, VHA Handbook 1140.07 sets forth specific quality assurance indicators for patients age 75 and older.

c. **Home Based Primary Care PACT (HBPC-PACT).**

(1) **Qualifying criteria.** The same qualifying criteria for determining the target population of Veterans that may be assigned to a HBPC team apply to assigning Veterans to a HBPC-PACT and are established in VHA Directive 1411, Home-based Primary Care Special Population Patient Aligned Care Team Program.

(2) **Service level accountable official.** The service level accountable official for HBPC-PACTs is the HBPC Medical Director and HBPC Program Director.

(3) HBPC-PACTs may only be established for programs where primary care visits by a physician or licensed independent provider are conducted at the Veteran's home (not in an outpatient clinic based setting), and where the provider assumes responsibility for comprehensive, coordinated primary care and, as needed, specialized geriatric care of an assigned panel of patients.

(4) **PCMM configuration for HBPC-PACTs.**

(a) PCMM Team Title Indicator is *HBPC*.

(b) Teamlet positions:

1. Medical Director position: HBPC Physician Medical Director;

2. PCP Position: HBPC NP, PA, or Physician;

3. Care Manager position(s): HBPC RN (optional);

4. LPN/LVN/HT position: HBPC Clinical Associate (optional);

5. Clerk position: HBPC Program Support Assistant or Medical Support Assistant;

6. SW position: HBPC Social Worker;

7. Pharmacy position: HBPC Clinical Pharmacy Specialist;

8. Dietitian position: HBPC Registered Dietitian;

9. Rehab Therapist position: HBPC Physical Medicine and Rehabilitation Services (e.g., Physical Therapist, Occupational Therapist, Kinesiotherapist, etc.);

10. Mental Health Provider position: HBPC Psychologist or Psychiatrist; and

11. Other: HBPC Recreation Therapy, Chaplain, Respiratory Therapy, etc. (optional).

(5) **Additional staffing requirements.**

(a) Staff for HBPC-PACTs must have advanced training and experience in: (1) addressing the discipline-specific, complex medical, social, rehabilitative, and behavioral care needs of their patients; (2) communicating and collaborating effectively with health professionals from other health disciplines; and (3) communicating effectively with the population served and their caregivers.

(b) Other staff proficiencies or specific staffing qualifications are established in VHA Directive 1411.

(6) **Panel management**. HBPC Special Population PACT panel requirements are established in VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program.

(7) **Access management.** HBPC-PACT access is based on the case management model of care. An assigned caseload is based on multiple determinants and allows for timely access to follow-up care while achieving positive outcomes, such as reduced hospitalization and high satisfaction. (See VHA Directive 1411.)

(8) **Modalities of Health Care Delivery.** Modalities of health care delivery may include: home visits, home telehealth, CVT, telephone care and secure messaging. HBPC PACT staff members are not required to provide health care delivery that would require the patient to travel outside the home for health care.

(9) **HBPC-PACT Programs Operating in Highly Rural Areas.** HBPC-PACT programs operating in highly rural areas may warrant adjustment of HBPC-PACT staffing standards. It may be necessary to facilitate care delivery and to facilitate staff recruitment and retention because of the difficulties with hiring and retaining staff in highly rural areas. Expected staffing targets for HBPC-PACT programs in highly rural areas may be adjusted for program recognition purposes. ***NOTE:*** *Highly rural areas are non-urban areas located in counties with less than 7 persons per square mile.*

d. **Homeless PACT (H-PACT)**

(1) The goal of the Homeless PACT (H-PACT) is to create a collaborative Primary Care-Homeless Program treatment model for eligible homeless Veterans who have difficulty accessing care and engaging in VA services by eliminating access barriers and providing integrated, coordinated homeless-specific care and case management. This goal will be accomplished by:

(a) Placing and organizing care models in settings that enhance access and engage homeless Veterans in clinical care earlier in their homelessness before complications arise;

(b) Providing comprehensive medical, mental health, case management and social services, preferably in one setting; and

(c) Tailoring care to the specific medical, mental health and homeless service needs of homeless Veterans.

(2) An effective care model for homeless Veterans requires the capability to:

(a) Implement strategies and systems modeling to engage homeless Veterans in the care and case management necessary to leave homelessness;

(b) Establish longitudinal relationships that encourage behavior change, engagement in treatment, and address the disproportionate chronic care needs of the homeless population; and

(c) Provide the necessary care management or care coordination services necessary to proactively and preemptively intervene with Veterans at imminent risk of becoming homeless or returning to homelessness.

(3) Each VA medical facility with an H-PACT may choose from one of the two recommended homeless-oriented primary care PACT models. Consistent across both models are same-day access capability; use of clinical protocols and templates to address common issues and needs of homeless Veterans and effective engagement of community partners and homeless service agencies, as appropriate; and providers who are trained to provide health care to homeless Veterans. Facilities typically select a model depending upon their local resources and capacity, the volume of homeless Veterans seen and the specific needs being targeted (i.e. reducing emergency department use within a Medical Center, treatment engagement at a Community Resource and Referral Center, care management during high risk shelter transitions). The H-PACT models are:

(a) Model 1: Comprehensive H-PACT model. Primary Care is delivered by H-PACTs co-located and integrated with VHA Homeless Program services. VHA Homeless programs provide an array of services for eligible Veterans who are homeless or at imminent risk of becoming homeless, including outreach, prevention, therapeutic transitional housing case management, therapeutic employment and health care services that are a part of a continuum of care and services aimed at ending and preventing homelessness among Veterans. VHA services relevant to H-PACTs include: outreach; VA's Homeless Providers Grant and Per-Diem housing; the Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) case management; Veterans Justice Outreach (VJO); Health Care for Homeless Veterans programs; Supportive Services for Veteran Families; etc. The key features of this model are "one-stop care capacity" where:

1. Primary care is available to address immediate care needs, treatment engagement or behavior change and housing placement-stabilization treatment goals, in addition to traditional chronic and acute disease management.

2. Assistance is provided to the Veterans, either through direct provision of services within the scope of admissible services defined by VHA policy or through linkages with non-VA providers to facilitate access (i.e. transportation), address needs that may preclude them from receiving care or services that are necessary to optimize their clinical care (i.e. clothes, foot wear, hygiene, food assistance).

3. Eligible homeless Veterans have access to VA outreach and housing coordinators, HUD-VASH case managers, and Veterans Benefit Administration case workers.

(b) Model 2: Community Resource and Referral Centers (CRRC)-based H-PACT. In this model, care is provided in a non-traditional setting likely to attract homeless Veterans not otherwise in receipt of VA care. The health care available in these setting is typically more limited, focused, episodic, event-based care because of location and lack of primary care infrastructure. Health care goals in this setting include engaging the Veteran in initial treatment and, if acceptable to the patient, referring to a more structured and better resourced PACT care model.

(4) **Qualifying criteria.** Qualifying criteria for assigning a treatment eligible Veteran to an H-PACT:

(a) The Veteran is currently homeless (i.e. spending their nights in an unsheltered setting, emergency shelter, or staying in a VA grant and per-diem program transitional housing program). Also considered eligible are those Veterans recently housed in a HUD-VASH unit or who are doubled-up with a family member or friend and at imminent risk of becoming homeless consistent with the definition of "homeless" in 38 U.S.C. 2002(1) and section 103(a) of the McKinney-Vento Homeless Assistance Act, 42 U.S.C. 11302(a)).

(b) If the Veteran is receiving primary care from another PACT at the time of becoming homeless, the Veteran may continue to receive care in their current PACT if their complex health care needs are being met with care at the CRRC H-PACT service as a bridge to that team's care. If the PACT is unable to meet the needs of the homeless Veteran, or if the Veteran prefers assignment to the H-PACT, a transfer should be facilitated. Signs that the homeless Veteran's health care needs are not being met include high no-show rates, poor chronic disease management outcomes, and/or high use of emergency department and inpatient care for non-acute and preventable conditions.

(5) **Service level accountable official.** The service level accountable official for H-PACTs is the Primary Care Service Chief or equivalent facility official designee.

(6) **PCMM configuration for H-PACTs.**

(a) PCMM Team Title Indicator is *H*.

(b) Teamlet positions: Each of the care models may have a different team composition based on targeted population, clinical focus and emphasis, on-site resources and caseload. It is expected that staffing intensity will be adjusted to reflect the volume of homeless Veterans

served and the expected case intensity of this population. The following teamlet is a basic guide for the H-PACT composition:

1. PCP position: Assigned Primary Care Provider;

2. Care Manager position: RNCM;

3. Case Manager position: RN or SW;

4. LPN/LVN/HT position: Clinical Associate; and

5. Clerk position: Administrative Associate.

(c) Discipline-specific team members for H-PACTs are assigned in PCMM as follows:

1. Other position: Social Work position;

2. Other position: Homeless Program Staff (may include Outreach, HUD-VASH, VJO, peer mentors and other staff responsible for homeless services delivery);

3. Other position: Mental health professional staff (psychologist, psychiatrist, therapist) depending on site capacity and preferences; and

4. Other position: Clinical Pharmacy Specialist.

(7) **Additional staffing requirements.** Staff for H-PACTs must participate in the H-PACT Cyber Seminar series focused on clinic set-up, structure, patient flow, care protocols and sub-population care needs.

(8) **Specialized care.** Homeless Veterans often have additional special care needs given their greater complexity and disease burden. Similar to Primary Care PACTs, the Homeless PACT initiates these referrals and assists in post-consult care, management and monitoring. For the homeless population, high priorities for the H-PACT include: 1) coordinating and negotiating access to appropriate specialty clinics, 2) addressing transportation and scheduling barriers, 3) encouraging visit-preparedness, and 4) enhancing communication between the Veteran, the Specialty providers, and the H-PACT team.

(9) **Panel management.** Panel size requirements for H-PACTs will be less than that of the primary care PACT. Panels must be adjusted to accommodate increased frequency of appointments, longer appointment times, open access scheduling, case management activities, provision of consultative care and care coordination between mental health, substance abuse and other specialty care. Panels also need to reflect the higher level of intensity and complexity associated with this population as well as reflect the needs of different homeless subgroups in the H-PACT that may have differing needs and care patterns (chronically homeless, high medical or mental health complexity homeless, recently housed formerly homeless, etc.). Currently,

projected panel capacity is determined locally, incorporating these criteria, but is expected to be two-thirds to three-quarters of a general population PACT panel.

(10) **Preventive Care.** Preventive care for homeless Veterans is similar to that of the general population of primary care patients and H-PACT teams will follow the same preventive health guidelines as previously outlined. Added emphasis is given to those conditions more prevalent among homeless persons or that are associated with homelessness and risks for homelessness (i.e. tuberculosis screening, Lyme disease for unsheltered homeless in endemic areas, hepatitis C and HIV screening, hepatitis A and B vaccinations, etc.).

e. **Infectious Diseases PACT (ID-PACT).**

(1) Patients with infectious diseases requiring chronic management, particularly those living with human immunodeficiency virus (HIV) infection, benefit from integration of infectious disease and primary care in an appropriately staffed and organized setting such as can be achieved in an ID-PACT.

(2) **Qualifying criteria.** Qualifying criteria for assigning a Veteran to an ID-PACT:

(a) The Veteran has documented evidence of an infectious disease that requires intensive and chronic management by a specialty provider in Infectious Diseases (ID).

(b) As required by local policy.

(3) ID-PACTs provide comprehensive primary care to assigned Veterans consistent with the General Requirements of this paragraph and specialized care consistent with guidance provided by the Clinical Public Health Strategic Healthcare Group within the VHA Office of Public Health (see http://vaww.publichealth.va.gov/about/pubhealth/index.asp). ***Note:*** *This is an internal VA Website that is not available to the public.*

(4) **Service level accountable official.** The service level accountable officials for ID-PACTs are the Infectious Diseases Service Chief and ID specific coordinator(s) (for example, the HIV Lead Clinician Coordinator for ID-PACTs managing patients with HIV (refer to VHA Directive 2008-082, National HIV Program).

(5) ID services are not limited to only those services provided by ID-PACTs. ID services may also be obtained through specialty services (see paragraph 13). ID coordinators may be designated as discipline-specific team members.

(6) **PCMM configuration for ID-PACTs.**

(a) PCMM Team Title Indicator is *ID*.

(b) Teamlet positions:

1. PCP position: Provider of specialty ID care with licensure at the level of MD, NP, or PA;

2. RN position: RNCM or NP Care Manager (if the PA Care Manager position is filled, this position is optional);

3. LPN/LVN/HT position: Clinical Associate;

4. Clerk position: Administrative Associate; and

5. Other position: PA Care Manager (optional, if RN position is assigned to an RN or NP Care manager).

(c) Discipline-specific team members for ID-PACTs are assigned in PCMM as follows:

1. SW position: Social Worker;

2. Pharmacy: Clinical Pharmacy Specialist;

3. Dietitian: Registered Dietitian;

4. Other position: HIV Clinical Case Registry Coordinator (required under VHA Directive 2008-082, National HIV Program);

5. Other position: HIV mental health provider; and

6. Other position: Homeless outreach worker.

(7) **Additional staffing requirements.**

(a) Staff for ID-PACTs should have clear understanding of ID-related care concerns.

(b) Clinical Pharmacy Specialists must have special training in adherence counseling and medication management for patients receiving care for an infectious disease.

(8) **Panel management.** Panel size requirements for ID-PACTs are determined locally, consistent with the management complexity of conditions, such as HIV infection, medical, and psychiatric comorbidities.

f. **Post-deployment Care PACT (PD-PACT).**

(1) **Qualifying criteria.** Qualifying criteria for assigning a Veteran to a PD-PACT:

(a) Referral from the facility OEF/OIF/OND program manager (see VHA Handbook 1010.01, Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veteran);

(b) The Veteran was discharged from active duty within the past 5 years;

(c) The Veteran is a Veteran from Gulf War I (i.e., Persian Gulf War); or

(d) The Veteran has a deployment-related health issue that warrants specialized care from the PD-PACT, as determined by the designated PD Clinical Champion.

(2) Post-deployment care is usually provided to Veterans during the transition from active duty to civilian life. As the OEF/OIF/OND deployments wind down, fewer VA medical facilities or CBOCs will have designated deployment health clinics or PD-PACTs that would provide services exclusively for returning combat Veterans. It should also be noted that in many facilities, returning combat Veterans are mainstreamed into all PACTs, with the expectation that all providers are trained to recognize and respond effectively to the full spectrum of post-deployment health issues of any Veteran joining their PACT. In these situations, there would be no PD-PACTs per se, and maintaining optimal standards of post-deployment care rests upon the education of all members, the effective collaboration among all relevant post-deployment services (e.g., mental health, polytrauma, addictions, OEF/OIF/OND case management, etc.) and timely consultative support from the PD Clinical Champions within the facility (e.g., primary care, mental health, social work, etc.)

(3) PD-PACTs provide comprehensive primary care to assigned post-deployment Veterans consistent with the General Requirements of this paragraph.

(4) **Service level accountable official.** The service level accountable official for PD-PACTs is the Primary Care Service Chief. (See paragraph 4.)

(5) **PCMM configuration for PD-PACTs.**

(a) PCMM Team Title Indicator is *PD*.

(b) Teamlet positions:

1. PCP position: Designated PD PCP. The PD-PACT PCP is responsible for ensuring that specific post-deployment related concerns are assessed and managed in a collaborative manner. Such post-deployment concerns may be related to polytrauma/Traumatic Brain Injury (TBI), mental health, pain, environmental exposures, and psychosocial issues impacting relationships and family. The PD-PACT PCP ensures that the PD-PACT collaborates closely with the OEF/OIF/OND program, polytrauma, mental health and pain management staff to ensure that interdisciplinary care is integrated and coordinated;

2. RN position: RNCM. The PD-PACT RNCM is responsible for providing integrated, coordinated and patient-centered care to all Veterans in the PD-PACT, working in conjunction with the PD-PACT staff and in collaboration with the OEF/OIF/OND program staff. This will include Veterans with recent combat experience and those who have exacerbations of post-deployment symptoms from more remote conflicts;

3. LPN/LVN/HT position: Clinical Associate; and

4. Clerk position: Administrative Associate.

(c) Discipline-specific team members for PD-PACTs are assigned in PCMM as follows:

1. SW position: Social Worker;

2. Pharmacy: Clinical Pharmacy Specialist;

3. Dietitian: Registered Dietitian;

4. Other position: OEF/OIF/OND Program manager. Provides oversight, assures completion of mandatory case management screen and assigns a lead case manager, if needed, to "ensure OEF/OIF Service members and Veterans receive patient-centered, integrated care" (Handbook 1010.01);

5. Other position: OEF/OIF/OND Case manager; Provides case management for patients in need of such services; and

6. Other: PC-MHI provider or PD-trained Mental Health provider.

(6) **Additional staffing requirements.** To be designated a PD-PACT PCP, the provider's panel must have at least 10 percent recently separated (within two years) Veterans with deployment health issues or the provider must spend at least one half day each week in a PD-PACT. If a PD-PACT has less than 10 percent recently returned service members, an alternative plan to ensure ongoing proficiency must be completed at a local level. It is expected that the PD-PACT PCP and teamlet members receive additional training in military culture, post-deployment health concerns (e.g., polytrauma/TBI, mental health, pain, psychosocial issues, etc.), deployment related environmental exposures and compensation and pension (C&P) benefits for combat Veterans. It is also expected that all PD-PACT staff be involved with Post Deployment Integrated Care Initiative (PDICI) community of practice for ongoing trainings and updates.

(7) **Panel management.** Recommendations for panel size for PD-PACTs are based upon recommendations established in VHA Handbook 1101.02. These may be adjusted by facility leadership to meet individual characteristics and requirements of a specific panel of patients.

(8) **Specialized care.** At the initial visit, all Veterans assigned to a PD-PACT must have a full physical, psychological and psychosocial risk assessment.

(9) **Preventive health care.** In addition to preventive health care requirements set forth in paragraph 11 of this Handbook, Veterans assigned to a PD-PACT must be screened using mandatory national clinical reminders for post-deployment specific screening (e.g., OEF/OIF/OND clinical reminders)

g. **Renal/Dialysis PACT (REN-PACT).**

(1) **Qualifying criteria.** Qualifying criteria for assigning a Veteran to a REN-PACT:

(a) The Veteran has severe chronic renal insufficiency and requires close monitoring by a nephrologist for impending dialysis;

(b) The Veteran is undergoing interventions in preparation for dialysis;

(c) The Veteran requires Hemodialysis or Peritoneal dialysis; or

(d) The Veteran's dialysis is ordered by a VA nephrologist.

(2) REN-PACTs provide care to assigned Veterans that is consistent with the General Requirements of this paragraph and specialized care necessary for management of end-stage renal disease and dialysis.

(3) **Service level accountable official.** The service level accountable official for REN-PACTs is the facility Chief of Nephrology Services or equivalent facility official.

(4) Nephrology services for Veterans requiring dialysis are not limited to only those services provided by REN-PACTs. Nephrology services may be also be obtained through specialty services. (See Paragraph 13)

(5) **PCMM configuration for REN-PACTs.**

(a) PCMM Team Title Indicator is *REN*.

(b) Teamlet positions:

1. PCP position: VA Nephrologist;

2. RN position: Dialysis RNCM;

3. LPN/LVN/HT position: Clinical Associate; and

4. Clerk position: Administrative Associate

(c) Discipline-specific team members for REN-PACTs are assigned in PCMM as follows:

1. SW position: Social Worker;

2. Pharmacy position: Clinical Pharmacy Specialist;

3. Dietitian position: Registered Dietitian;

4. Other position: Home Occupational Therapist;

5. Other position: Vascular surgery service representative; and

6. Other position: ID representative.

(6) **Additional staffing requirements.** REN-PACT staff has advance training and experience in management and treatment of patients with end-stage renal disease who require dialysis.

(7) **Preventive health care.** Preventive health care requirements are adjusted to patients' prognosis and patients' preferences for preventive health care screening and intervention.

h. **Serious Mental Illness PACT (SMI-PACT).**

(1) It is the intent of recovery oriented mental health services to enable all patients with mental illness to live a self-directed life in the community of their choice to reach their full potential. Providing primary care services for patients with serious mental illness within a PACT that provides care to a range of patients is a key objective of recovery. Effective treatment for patients with SMI requires collaboration between mental health providers, mental health case managers, PC-MHI providers, and PACT staff. Some facilities may choose to establish a special population PACT for some patients with serious mental illness (SMI-PACT). Nonetheless, the underlying goal is to eventually transition those patients to a primary care-based PACT.

(2) In an SMI-PACT the Veteran's mental health care is planned and delivered by a team of mental health professionals, including psychiatrists/mental health advance practice nurses, psychologists, RNs, LPNs/Health Techs, therapists and others. In most instances, the mental health team will not be providing the primary care services to the Veterans in SMI-PACTs but incorporating providers with privileges and scopes of practice that include providing these services.

(3) **Qualifying criteria.** Qualifying criteria for assigning patients to a SMI-PACT:

(a) The patient has a Serious Mental Illness defined as an Axis I or Axis II disorder resulting in significant functional impairment and/or disruption in major activities of daily living. This historically has included schizophrenia and other psychotic disorders, bipolar disorder, severe major depression, and severe Post-Traumatic Stress Disorder, and other disorders with significant functional impairment.

(b) The Veteran declines to receive care or is unable to receive care from a Primary Care based PACT.

(c) The facility has established an SMI PACT.

(4) SMI-PACTs provide comprehensive primary care to assigned Veterans that is consistent with the General Requirements of this Paragraph and VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics. Refer to VHA Handbook 1160.01 for

mental health specifications for primary care and mental health specific services for patients with SMI.

(5) **Service level accountable official.** The service level accountable official for SMI-PACTs is the Mental Health Service Line leader.

(6) **PCMM configuration for SMI-PACTs.**

(a) PCMM Team Title Indicator is *SMI*.

(b) Teamlet positions:

1. PCP position: Assigned Primary Care Provider;

2. Primary PACT Mental Health Professional: SMI-PACT member who assumes primary oversight responsibility for coordinating mental health aspects of the patient's care in PACT, working in conjunction with all SMI-PACT members towards a focus of recovery and rehabilitation. This person also will serve as the Veteran's overall Mental Health Treatment Coordinator (MHTC) or will work closely with the MHTC to coordinate PACT and specialty mental health care plans and services;

3. Other Mental Health Providers: (e.g., psychologist, psychiatrist, mental health therapist). Depending upon mental health requirements of a SMI-PACT panel of patients, one or more of these mental health professionals may assist in caring for more than one provider panel and thereby function as discipline-specific providers;

4. RN position: RNCM;

5. LVN/HT position: Clinical Associate; and

6. Clerk position: Administrative Associate.

(c) Discipline-specific team members for SMI-PACTs are assigned in PCMM as follows:

1. SW position: Social Worker Case Manager;

2. Pharmacy position: Clinical Pharmacy Specialist; and

3. Dietitian: Dietitian.

(d) **Additional staffing requirements.** The PCP assigned to SMI PACTs must meet proficiency requirements as set forth in VHA Handbook 1160.01.

(e) **Panel management.** Recommendations for panel size adjustments for SMI patient panels established by VHA Handbook 1160.01 apply to panel size determinations for SMI-PACTs.

(f) **Preventive health care.** In addition to preventive health care requirements set forth in paragraph 11 of this handbook, VHA Handbook 1160.01 sets forth specific preventive care requirements for SMI Veterans.

i. **Spinal Cord Injuries and Disorders PACT (SCI/D-PACT).**

(1) Established patient parameters for inclusion in SCI/D System of Care are described in VHA Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care.

(2) SCI/D-PACTs provide comprehensive primary care to Veterans with SCI/D that is consistent with the General Requirements of this paragraph and VHA Handbook 1176.01. Refer to VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, and VHA Handbook 1176.01 for SCI/D specifications for primary care to Veterans with SCI/D. ***NOTE:*** *Per VHA Directive 1176, the medical center Chief of Staff appoints an SCI/D Support Clinic or SCI/D PACT at each VA medical center without an SCI/D Center.*

(3) **Accountable official.** The accountable official for SCI/D-PACTs in VA medical facilities without a SCI/D Center is the Chief of Staff. The accountable official for SCI/D-PACTs in VA medical facilities with a SCI/D Center is the SCI/D Center Chief.

(4) **PCMM configuration for SCI/D-PACTs.**

(a) PCMM Team Title Indicator is *SCI/D*.

(b) Teamlet positions: ***NOTE:*** *The core team members of the SCI/D-PACT must include at a minimum the physician, registered nurse, and social worker (SCI/D Coordinator), per VHA Handbook 1176.01.*

1. PCP position: SCI/D Physician;

NOTE: *If the SCI/D assigned physician's specialty role does not allow for the provision of primary care services, another SCI/D trained provider (e.g., physician assistant, nurse practitioner, or primary care physician) works with the SCI/D physician to provide primary care, per VHA Handbook 1176.01.*

2. RN position: SCI/D RNCM;

3. LVN/HT position: SCI/D Clinical Associate;

4. Clerk position: SCI/D Administrative Associate; and

5. SW position: SCI/D Coordinator.

(c) Discipline-specific team members for SCI/D-PACTs can be assigned in PCMM as follows:

1. Pharmacist position: Clinical Pharmacy Specialist;

2. Dietitian position: Registered Dietitian;

3. Other position: Wound Care Nurse;

4. Other position: Physical Medicine and Rehabilitation Services (e.g., Physical Therapist, Occupational Therapist, Kinesiotherapist, Respiratory Therapist, etc.);

5. Other position: Recreational Therapist; and

6. Other position: Orthotist.

(5) **Additional staffing requirements for SCI/D-PACTs***:*

(a) Only PCPs who have completed the Veterans Health Initiative SCI/D Medical Education Package or have equivalent training and experience may be designated to SCI/D-PACTs. SCI/D-PACTs are to have clinical educational contact with personnel from the SCI/D Center on a regular basis.

(b) Clinical practice guidelines, as developed by the Consortium for Spinal Cord Medicine and other appropriate bodies, need to be used in the care of patients to the extent supported by current medical evidence and state-of-the-art practice. See VHA Handbook 1176.01 for policy related to incorporation of clinical practice guidelines in the care of Veterans with SCI/D.

(c) Referral guidelines from VHA Handbook 1176.01 need to be used to determine appropriate locations of care for specific conditions.

(d) Veterans with spinal cord injuries and disorders who are receiving high-complex dual care (such as in a "hub and spoke" system of care) may be assigned SCI/D-PCPs at more than one site of SCI/D care (see VHA Handbook 1176.01 and 1101.02).

(6) **Panel management.** Compared to panel sizes recommended for Veterans not belonging to special populations, panel size for SCI/D-PACTs must be adjusted to accommodate increased frequency of appointments, longer appointment times (typically one to 2 hours or more for outpatient visits), case management activities, provision of inpatient consultative care, care coordination between hub and spoke sites of care, and participation in SCI/D Telehealth.

(7) **Performance metrics.** Performance metrics and evaluation of quality for SCI/D-PACTs must be specific to this population and developed and implemented in collaboration with the national SCI/D Services Program Office.

(8) **Preventive health care.** In addition to preventive health care requirements set forth in paragraph 11 of this handbook, VHA Handbook 1176.01 sets forth specific preventive care requirements for Veterans with SCI/D.

j. **Women's Health PACT (WH-PACT).**

(1) **Qualifying criteria.** Qualifying criteria for assigning a Veteran to a WH-PACT: The Veteran is a woman. ***NOTE:*** *VHA Handbook 1330.01, Health Care Services for Women Veterans, establishes policy regarding assignment of women Veterans to a Designated Women's Health Primary Care Provider (WH-PCP).*

(2) Refer to VHA Directive 2012-003, Providing Health Care for Transgender and Intersex Veterans, to determine appropriate PACT assignment of Veterans who self-identify as women.

(3) WH-PACTs provide comprehensive primary care to assigned women Veterans that is consistent with the qualifying criteria in paragraph 5.j of this Handbook and VHA Handbook 1330.01. Refer to VHA Handbook 1330.01 for women's health specifications for primary care and gender specific services for women patients.

(4) VA medical facilities may choose one or more of the following models of comprehensive primary care to best meet the needs of women Veterans. WH- PACTs may function in any of the three models of care.

(a) Model 1: Integrated Model. Comprehensive primary care is delivered by a designated WH-PACT located in a gender neutral primary care clinic.

(b) Model 2: Separate but Shared Space. Comprehensive primary care is delivered by a WH-PACT in a separate but shared space that may be located within or adjacent to a gender neutral primary care clinic. Gynecological care and mental health care are recommended, but not required, to be co-located in this space and readily available.

(c) Model 3: Comprehensive Women's Health Center. WH-PACTs may be located in Women's Health Centers that have separate entrances and waiting areas. In general, gynecological care, mental health care, and social work services are co-located in the same space.

(5) **Service level accountable official.** The service level accountable official for WH-PACTs is either the Women's Health Medical Director or the Women's Health Champion.

(6) **PCMM configuration for WH-PACTs.**

(a) PCMM Team Title Indicator is *WH*. ***NOTE:*** *PACTs with a designated WH-PCP should be designated as a WH-PACT, even if the assigned panel of patients is mixed in gender.*

(b) Teamlet positions:

1. PCP position: Designated WH-PCP;

2. RN position: RNCM;

3. LPN/LVN/HT position: Clinical Associate;

4. Other Position: Chaperone; and

5. Clerk position: Administrative Associate.

(c) Discipline-specific team members for WH-PACTs are assigned in PCMM as follows:

1. SW position: Social Worker;

2. Pharmacy: Clinical Pharmacy Specialist;

3. Dietitian: Registered Dietitian;

4. Other position: Gynecologist;

5. Other position: Military Sexual Trauma Coordinator; and

6. Other position: Mental Health Provider.

7. Other position: RN mammogram/pap/maternity/care coordinator

(7) **Additional staffing requirements.**

(a) WH-PCP must meet proficiency requirements as set forth in VHA Handbook 1330.01. To be a Designated Women's Health Provider, the provider's panel must be at least 10 percent female patients (for an integrated panel) or spend at least one half day each week practicing or precepting in a women's health practice. If insufficient numbers of female patients are available to maintain a panel inclusive of 10 percent women, an alternative plan to ensure ongoing proficiency must be implemented at a local level. Women Veterans who are already assigned to a PCP who is not a designated WH-PCP must be offered the opportunity for reassignment to a designated WH-PCP.

(b) A female chaperone must be in the examination room during gender-specific examinations, procedures, or treatments involving the breast, genitalia, and rectum, regardless of the gender of the provider. The following staff may function as female chaperones for all gender-specific examinations: health technicians, nurse's aides, or Licensed Practical Nurses. (See VHA Handbook 1330.01.)

(c) RN staff may be needed for mammogram and Pap coordination, Maternity Care Coordination, and other outsourced gender-specific care coordination.

(8) **Panel management.** Recommendations for panel size adjustments for WH patient panels established by VHA Handbook 1330.01 apply to panel size determinations for WH-PACTs. Recommended WH-PACT patient panel size is calculated according to the following equation:

(a) $X = Y - 0.2(Z)$; and

(b) X = modeled panel size adjusted for number of women Veterans; Y= panel size unadjusted for women Veterans; Z= number of women Veterans assigned to the WH-PACT.

(9) **Preventive health care.** In addition to preventive health care requirements set forth in paragraph 11 of this Handbook, VHA Handbook 1330.01 sets forth specific preventive care requirements for women Veterans.

13. SPECIALTY CARE SERVICES AND PACT:

a. To provide patients with comprehensive care, PACTs routinely partner with providers of specialty care to ensure patients receive care that is informed by the knowledge and expertise needed to manage and treat uncommon or complex health conditions. Comprehensive care plans for patients receiving specialty care can be complex and frequently require flexibility in the roles, responsibilities, and boundaries between the PACT and provider(s) of specialty care. The development of dynamic relationships between PACT staff and providers of specialty care is essential for providing patients with comprehensive, coordinated, quality health care.

b. Providers of specialty care apply the principles of patient-centered care, access and timeliness, comprehensiveness, and care coordination to the scope of specialty care and measure the implementation of these principles through metrics, guidance or policy established by the Office of Patient Care Services and Office of Administrative Operations.

c. Service Agreements (care coordination agreements) when appropriate or necessary and according to VHA policy, are established between Specialty Services and Primary Care Services, discipline-specific services and programs managing special population PACTs.

d. Providers of specialty care and PACT staff use bidirectional communications through formal and informal mechanisms, as appropriate for safe and effective patient care, and consistent with locally developed service agreements (care coordination agreements).

(1) Formal communications between providers of specialty care and PACT staff occur through the electronic health record consult package. Responses documented by the consultant provider (or others) in the consult package finalize the formal communication.

(2) Informal communications between providers of specialty care and PACT staff occur through unplanned interactions (e.g., unplanned telephone calls, casual “just-in-time” interactions), whenever necessary for expedient and appropriate patient care. Information resulting from informal communications that directs patient care must be documented in the patient’s electronic health record. ***NOTE:*** *Service Agreements often establish local requirements for documentation of informal communications.*

e. PACT staff consult with providers of specialty care when:

(1) The patient requests clinically appropriate consultation;

(2) PACT staff is not clinically privileged or resourced to provide the clinically indicated and desired care;

(3) Appropriate PACT staff seek the opinion, advice, or expertise of the specialty care provider to evaluate or manage a patient's health condition(s); or

(4) VHA clinical guidelines or professionally accepted practice standards recommend consultation with a provider of specialty care.

f. PACT staff provide input for specialty care to:

(1) Provide support and collaboration with specialists for risk stratification and optimization of chronic diseases prior to invasive or surgical procedures; or

(2) Specify specific focus for specialty care investigation and collaboration (as specified by service agreements).

g. PACT staff, patients, personal support persons, and providers of specialty care collaborate to determine the level of involvement required to meet care delivery needs. Specialty care levels of involvement include:

(1) **Non-visit specialty care.** A patient may express preference for a non-visit consult. A requesting provider may formally or informally request a non-visit consult. The provider of specialty care may provide clinical recommendations without a patient encounter (i.e., non-visit) based on adequate health care information to ensure recommendations are safe, clinically appropriate to the patient's needs, consistent with the requesting providers care delivery needs, and within professional practice standards or VHA published guidelines. The patient, requesting provider, or receiving provider may determine that a visit is needed and change the non-visit consult to another level of specialty care. ***NOTE:*** *VHA approved modalities for providing non-visit specialty care includes e-consult, Specialty Care Access Network (SCAN), and informal communications between providers.*

(2) **Episodic specialty care.** Episodic specialty care is used for diagnostic and therapeutic evaluation, development of a treatment plan, follow-up, and when appropriate, discharge from specialty care. Episodic care can be provided using all appropriate modalities of health care delivery (see paragraph 10). The provider of specialty care collaborates with the patient and PACT staff to determine roles, responsibilities, and boundaries for care responsibilities. Generally, patients continue to receive comprehensive primary care from the PACT during episodic specialty care.

(3) **Ongoing specialty care.** Ongoing specialty care can be limited to management of a specific health condition (e.g., management of implantable defibrillators or pacemakers) or can

be extended to the overall management of the patient's care (e.g., patients requiring specialized care for management of end-stage organ failure). Ongoing specialty care can be provided using all appropriate modalities of health care delivery (see paragraph 10). During ongoing specialty care, the roles of the PACT and the provider of specialty care vary depending on the needs and preferences of the patient and require ongoing clarification over time.

(4) Providers of specialty care do not assume total care of the patient without collaboration and agreement with the PACT (including the patient and, as appropriate, personal support persons).

h. PACT staff, typically the RNCM, collaborate with staff supporting specialty care services to establish comprehensive care management plans for patients receiving specialty care (e.g., follow-up calls, clarification of treatment plan, education regarding specialty care recommendations).

i. PACT staff, typically the administrative associate, collaborate with staff supporting specialty care services according to existing service agreements or local guidance to coordinate care using, whenever possible, direct scheduling, coordination of appointments for diagnostic testing or monitoring, and scheduling of follow-up appointments.

14. VHA'S ORGANIZATIONAL STRUCTURE FOR PRIMARY CARE IMPLEMENTATION OF PACT:

a. **Primary Care Services.**

(1) Primary Care Services is organizationally aligned under the Office of Patient Care Services.

(2) The Chief Consultant for Primary Care Services is appointed by the Under Secretary for Health and reports to the Chief Patient Care Services Officer.

(3) The Chief Consultant for Primary Care Services serves as advisor to the Under Secretary for Health, Assistant Deputy Under Secretary for Health for Patient Care Services, program offices, other governmental agencies, and the field on issues related to primary care.

(4) The Chief Consultant for Primary Care Services provides national leadership related to the mission, vision, policies, and strategic goals of Primary Care.

(5) The Chief Consultant for Primary Care Services establishes the charter for the Primary Care Field Advisory Committee (PC-FAC).

(6) The Chief Consultant for Primary Care Services receives advice from the PC-FAC, Veterans Integrated Service Network (VISN) leadership, and facility leadership.

b. **Primary Care Operations Office.**

(1) The Primary Care Operations Office is organizationally aligned under the Associate Deputy Under Secretary for Clinical Operations.

(2) The Director of Primary Care Operations is responsible for implementation, oversight, and support for the day-to-day operations of Primary Care in VHA.

c. **Primary Care Field Advisory Committee (PC-FAC).**

(1) The PC-FAC charter establishes the structure and function of the PC-FAC. The PC-FAC is composed of VISN Primary Care Lead Providers, facility PCPs, and others.

(2) The PC-FAC is supported by standing and ad hoc subcommittees, as necessary, to maintain communications and operations links between Primary Care programs and VHA Primary Care Services.

d. **VISN and Facility Primary Care Structure.**

(1) VISN and facility Primary Care structures vary according to local governance structures. VISN and facility governance and organizational structures must be sufficient to ensure that:

(a) PACT staff communicates through formal and informal communication modalities and in all care settings to provide integrated, comprehensive, coordinated care to Veterans.

(b) The course and effectiveness of PACT implementation is evaluated.

(c) The quality and safety of care delivered through PACTs are evaluated.

(d) PACT function is optimized and resourced through continuous quality improvement (e.g., system redesign), adequate staffing, sharing of strong practices, appropriate professional development, and team building activities.

(e) Succession planning and leadership development, mentoring, and coaching is provided to current and emerging Primary Care leaders.

(2) **Primary Care Communication Infrastructure.** The Primary Care communication infrastructure aligns VISN leadership, the VISN Primary Care Lead Clinician, Facility and CBOC Primary Care leaders, and VHA Primary Care Services, Office of Patient Care Services, and the VHA Office of Primary Care Operations promoting and rapid transmission of critical initiatives, performance issues, and motivation for constructive change. Special population PACTs are included in this infrastructure to the extent that they provide primary care within the Network.

(a) Primary Care Lead Clinician.

1. Each VISN Chief Medical Officer (CMO) selects a Primary Care Lead Clinician to represent the VISN on the PC-FAC. This individual may also be well-suited to serve as the Operations point of contact for the Network.

2. Primary Care Lead Clinician attendance at periodic VISN leadership meetings is highly recommended.

3. The Primary Care Lead Clinician must charter and lead the Primary Care council.

(b) Primary Care Council.

1. The Primary Care Lead Clinician is the leader of the Primary Care Council and reports the activities of the Primary Care Council directly to the VISN CMO or VISN CMO-led committee.

2. The Primary Care Council typically consists of Primary Care leaders from each facility and larger CBOCs. In addition to PCPs, Council members may include non-provider Primary Care leaders and representatives from other disciplines. Representatives from special population PACTs should be included in council membership.

3. The Primary Care Council convenes periodically via telephone conferences, and/or face-to-face conferences. Periodic face-to-face meetings are highly valued to encourage networking and enhance relationships.

4. Agenda for these meetings are preferably prepared jointly by the Primary Care Lead Clinician and VISN CMO. ***NOTE:*** *Typical agenda items to consider are quality, access, safety and performance issues; VHA policy including newly released Memoranda, Directives and Handbooks, clinical practice guidelines; implementation of VHA initiatives such as PACT, post-deployment care, and Primary Care-Mental Health Integration; or partnering with collaborative services such as Mental Health, Geriatrics, Specialty Care, Physical Medicine and Rehabilitation, or Spinal Cord Injury.*

(c) Administrative support. Administrative support necessary to initiate and maintain the Primary Care communication infrastructure is provided by the VISN or a facility. Administrative support assists in scheduling and coordinating meetings, preparing and managing council documents or materials, and documenting meeting actions and decisions (e.g., minute taking).

15. RESPONSIBILITIES OF THE CHIEF CONSULTANT FOR PRIMARY CARE SERVICES: The Chief Consultant for Primary Care Services is responsible for:

a. Providing national leadership related to the mission, vision, policies, and goals of Primary Care.

b. Identifying strong clinical practices worthy of further evaluation or development, and communicating this information to VISN and facility leaders.

c. Partnering with other Program Offices to develop and evaluate innovative programs that integrate VHA resources into the PACT model.

d. Promoting the use of applied research, such as that performed by the Demonstration Labs, Quality Enhancement Research Initiative, or VA Health Services Research and Development to inform the effectiveness of the PACT model.

e. Facilitating pilot and other programmatic efforts to incorporate research results into the health care delivery system.

f. Providing input into the development, selection and evaluation of PACT metrics through collaborative efforts with the Office of Primary Care Operations, the Office of Informatics and Analytics and relevant VHA Program Offices.

g. Ensuring that metrics on the PACT Compass that require local and national focus (e.g., recognition metric) are published and regularly updated.

h. Participating in the development and implementation of internal or external recognition or certification processes that identify and recognize high performing PACTs.

i. Advising the Under Secretary for Health, Deputy Under Secretary for Health for Policy and Services, Assistant Deputy Under Secretary for Health for Patient Care Services, VHA Program Offices, other governmental agencies, and field on issues related to Primary Care.

j. Developing and establishing PACT policy and other VA regulation or VHA policy related to the delivery of primary care.

16. RESPONSIBILITIES OF VHA EXECUTIVE DIRECTOR OF PRIMARY CARE OPERATIONS: The Executive Director of Primary Care Operations is responsible for:

a. Ensuring standard implementation of this PACT handbook, and other VA regulation or VHA policy across VHA's Primary Care operations, including trainings, implementation initiatives, and technical assistance.

b. Overseeing and supporting the day-to-day operations of Primary Care in VHA.

c. Providing input into the development of PACT metrics through collaborative efforts with VHA Primary Care Services, the Office of Informatics and Analytics and relevant VHA program offices.

d. Participating with other responsible offices to establish and report on performance and quality metrics for primary care and for PACT function in VHA.

e. Monitoring and overseeing performance and quality metrics to ensure the integrity, effectiveness, quality and value of VHA Primary Care and PACT.

f. Reporting data from metrics measuring quality of primary care to the Deputy Under Secretary for Health and Operations and Management.

g. Providing input on VHA policies related to Primary Care Clinic operations.

h. Integration and coordination of Primary Care clinical services with other components of the health care organization.

17. RESPONSIBILITIES OF VISN DIRECTOR: The VISN Director is responsible for:

a. Ensuring implementation of this Handbook at all sites of care in the VISN where Veterans receive primary care.

b. Providing leadership that endorses, supports, and promotes PACT function for delivery of comprehensive, coordinated, patient-centered care to Veterans.

c. Ensuring all facilities in the VISN are adequately staffed and resourced to develop and maintain effective PACTs for Veterans' primary care (e.g., budget, space, ongoing training).

d. Ensuring that facilities in the VISN achieve national and local PACT performance and quality improvement goals.

18. RESPONSIBILITIES OF VISN CHIEF MEDICAL OFFICER: The VISN Chief Medical Officer is responsible for:

a. Ensuring operations of PACT throughout the VISN are:

(1) Coordinated with operations of other services;

(2) Aligned with VISN and national VHA initiatives and priorities; and

(3) Continuously improving.

b. Ensuring involvement and input of Primary Care leadership in VISN deliberations and decisions, where appropriate.

c. Designating and providing oversight to a VISN Primary Care Lead Provider, and establishing responsibilities consistent with Paragraph 11, include representing the VISN on the PC-FAC, and other responsibilities as appropriate.

d. Ensuring the VISN Primary Care Council is established and chartered consistent with this Handbook (see Paragraph 14), and charged with, at minimum, advising VISN Primary Care leadership regarding topics related to Primary Care that are of import to the field.

19. RESPONSIBILITES OF THE VHA PRIMARY CARE FIELD ADVISORY COMMITTEE (PC-FAC): The VHA PC-FAC is responsible for:

a. Advising the VHA Chief Consultant for Primary Care on issues related to communications, operations, and policy regarding primary care services in the field;

b. Chartering standing and ad hoc subcommittees, as needed; and

c. Functioning and performing according to the charter.

20. RESPONSIBILITIES OF MEDICAL FACILITY DIRECTOR: The medical facility Director is responsible for:

a. Ensuring implementation of this Handbook at all sites of care administered by the VA medical facility where Veterans receive primary care.

b. Ensuring PACTs are staffed according to the requirements of this Handbook.

c. Ensuring protected time is provided for PACT huddles, team meetings, and approved team development activities.

d. Providing leadership that endorses, supports, and promotes PACT function for delivery of comprehensive, coordinated, patient-centered care to Veterans.

e. Developing and sustaining processes that will educate and train primary care teams in PACT principles and processes and ensuring PACT staff receive the necessary time and resources needed to participate in periodic and ongoing training in post deployment competencies, as appropriate.

f. Developing and implementing plans that implement, spread and sustain PACT throughout the medical center and allied CBOCs. This plan should build on available national training and educational programs.

g. Providing adequate resources to train appropriate staff in patient-centered care communications (see paragraph 8).

h. Providing adequate resources to ensure timely recruitment and hiring of PACT staff, equipping PACT clinic space to enhance clinical efficiencies, and supporting continuous improvement activities to optimize PACT function.

i. Collaborating with the facility service chiefs, facility leadership, and the Quality Management Officer to develop and implement systematic methods for soliciting and analyzing patient input regarding primary care and PACT function.

j. Ensuring overall quality of care and performance improvement.

21. RESPONSIBILITIES OF FACILITY CLINICAL EXECUTIVES:

a. The facility clinical executives include the Chief of Staff, Clinical Nurse Executive, and others as established by the facility organizational structure.

b. The facility clinical executives are responsible for:

(1) Ensuring implementation of this Handbook at all sites of care administered by the facility where Veterans receive primary care.

(2) Providing leadership that endorses, supports, and promotes PACT function for delivery of comprehensive, coordinated, patient-centered care to Veterans.

(3) Ensuring that all PACT staff fully participate in PACT training and education.

(4) Promoting the expectation that PACT staff conduct frequent team meetings for the purpose of a) interdisciplinary discussion of complex patients, b) enhancing team communication skills and function, and c) promoting rapid cycle performance improvement activities.

(5) Empowering Primary Care leaders to implement systems that ensure continuity of care and access to care.

(6) Ensuring that PACT staff provide timely access for face-to-face visits, telephone care, and secure messaging. Ensuring that PCPs and RNCMs, or their designated covering providers, provide same-day access (unless it is too late in the day) for in-person face-to-face encounters and telephone encounters to patients assigned to the PACTs panel.

(7) Identify appropriate expertise within the facility (i.e. Quality Management Officer or Systems Redesign Coordinator) to:

(a) Collaborate with facility leadership at the service level to develop and implement systematic quality improvement processes for team development that incorporate soliciting and analyzing patient input regarding patient's experiences with PACTs.

(b) Collaborate with facility Primary Care Service Chiefs and other facility leadership to measure the quality and safety of care, develop and implement effective quality improvement cycles to improve PACT delivery of comprehensive primary care.

(c) Monitor and reporting on clinical quality metrics.

(8) Ensuring all clinical services are communicating by informal and formal means and, as necessary, have established clinically appropriate Service Agreements that enhance care delivery systems for continuous, comprehensive, accessible health care to patients receiving primary care.

(9) Supporting development and implementation of systematized, standardized protocols for PACT operation management processes (e.g., pre-visit reminder calls, post-hospitalization

follow-up calls, recall scheduling procedures, rapid evaluation processes, new patient orientation) and customized clinical care delivery processes (e.g., RNCM protocols for chronic disease management).

(10) Arbitrating and resolving conflicts between service level officials regarding appropriate assignment of Veterans to PACTs.

22. RESPONSIBILITIES OF SERVICE LEVEL OFFICIALS ACCOUNTABLE FOR PACT:

a. The Facility Primary Care Service Chief (see paragraph 4.h.) is responsible for PACTs practicing under the auspices of Primary Care Services. The Facility Primary Care Service Chief typically is accountable, either directly or indirectly to the Facility Clinical Executive.

b. Facility discipline-specific Service Chiefs are responsible for discipline-specific staff designated to PACTs, unless otherwise specified by facility policy.

c. Facility officials accountable for Special population PACTs are responsible for PACTs practicing according to VHA programs for special populations, and may also be directed by other VHA policies (see Paragraph 12).

d. Facility service level nursing officials are responsible for nursing staff designated to PACTs.

e. Facility service level officials accountable for PACT are responsible for:

(1) Ensuring service level implementation of this Handbook at all sites of care administered by the VA medical facility where Veterans receive primary care;

(2) Providing leadership that endorses, supports, and promotes PACTs for delivery of comprehensive primary care to Veterans;

(3) Ensuring all PACTs are configured in PCMM (see Paragraph 7, Paragraph 12, and VHA Handbook 1101.02) and all Veterans receiving primary care are assigned to PACTs.

(4) Determining whether PACT staffing is sufficient to provide comprehensive primary care to all patients assigned to PACTs and submit staffing needs to the clinical executive(s) responsible for staffing decisions.

(5) Overseeing and approving assignment and reassignment of teamlet members.

(6) Collaborating among services to establish coordinated service delivery processes for patients assigned to PACTs. Establishing Service Agreements with appropriate services when necessary and according to VHA Directive 2008-056, VHA Consult Policy.

(7) Collaborating among services to develop and implement plans that ensure all eligible patients assigned to PACTs are offered clinically appropriate, coordinated health care services that achieve VHA established health care performance and quality metrics related to clinical quality.

(8) Ensuring that PACTs provide timely access for face-to-face visits, telephone care, and secure messaging. Ensuring that PCPs and RNCMs, or their designated covering staff, provide same-day access (unless it is too late in the day) for in-person face-to-face encounters and telephone encounters.

(9) Collaborating with Quality Management Officers to develop and implement systematic quality improvement processes for team development that incorporate soliciting and analyzing patient input regarding patients' experiences with PACTs.

(10) Establishing a facility plan for population management activities, ensuring appropriate data is made available to PACT staff and PACT staff is appropriately trained to use available data. Collaborating among services to ensure population management plans provide comprehensive, coordinated care to Veterans. Population management activities include discipline-specific health conditions.

(11) Ensuring PACT staff is appropriately trained.

(12) Supporting development and implementation of systematized (e.g., electronic), standardized, protocols for PACT operation management processes (e.g., pre-visit reminder calls, post-hospitalization follow-up calls, recall scheduling procedures, same-day access rapid evaluation processes, new patient orientation) and customized clinical care delivery processes (e.g., RNCM protocols for chronic disease management).

(13) Ensuring PACT staff use formal and informal communications that are respectful, effective, timely, and bidirectional with all team members (including the patient and personal support persons) and specialty care providers to convey significant, clinically relevant information for the care of the patient.

23. RESPONSIBILITIES OF PACT STAFF: Each PACT staff member is responsible for:

a. Ongoing, continuous care of one or more assigned panel(s) of Veterans.

b. Utilizing all available tools, such as registries, to enable effective and efficient identification and intervention of individual patients and cohorts.

c. Ensuring appropriate evaluation and access is provided to patients assigned to the patient panel.

d. Functioning at the full extent of the team member's relevant clinical privileges, credentials, scopes of practice, elements of practice, certification, functional statement, position description, or other VHA or local facility approved documentation of competency.

e. Participating in team performance improvement and sustainment activities to optimize team efficiency and care delivery to patients.

f. Implementing primary care operations management processes, as appropriate.

g. Managing communications and facilitating safe transitions of patients between the PACT's site of care and other health care settings, using informal and formal communication methods, as appropriate.

h. Providing health education and health coaching on wellness, disease prevention, chronic care management, and self-management skills to patients and personal support persons, commensurate with the documented expertise or professional training of the PACT member.

i. Engaging patients in using health care, encouraging patients to engage personal support persons, receiving input from patients and personal support persons regarding VA care.

j. Using formal and informal communications that are respectful, effective, timely, and bidirectional with all team members (including the patient and personal support persons) to convey significant, clinically relevant information for the care of the patient.

k. Collaborating with informatics technology staff to develop and implement systematized, electronically supported, standardized, tools to support PACT care delivery processes (e.g., pre-visit reminder calls, post-hospitalization follow-up calls, recall scheduling procedures, new patient orientation, disease registries and primary care protocols for chronic disease management).

24. RESPONSIBILITIES OF PCP: The PCP is responsible for:

a. All responsibilities listed in Paragraph 23 of this Handbook.

b. Providing health care commensurate to the PCP's licensure and clinical privileges or scope of practice.

c. Ensuring the patient's care plan contains medical recommendations for clinically indicated care.

d. Offering clinically indicated health care services to patients assigned to the PACT, and providing or arranging for care to which patients consent.

e. Providing leadership to the team including shared delegation of appropriate care and care processes to appropriate team members.

f. Reviewing available clinical and performance data with the team, focusing on continuous improvement of critical team processes.

g. Ensuring the patient has same-day access for face-to-face and telephone care visits during regular clinic hours.

h. Collaborating with PACT staff to develop personal health plans that incorporate care management and care coordination appropriate to the patient's needs.

i. Communicating with facility leadership regarding the resources needed by the PACT for optimal function.

25. RESPONSIBILITIES OF PACT RNCMs OR PACT STAFF ASSIGNED TO THE RN POSITION IN PCMM: The RNCM and PACT staff assigned to the RN position in PCMM is responsible for:

a. All responsibilities listed in Paragraph 23 of this Handbook.

b. Providing all aspects of professional nursing services consistent with licensure, certification, nursing professional standards of practice, and the clinician's Functional Statement with elements of practice.

c. Enhancing patient safety and quality of care by collaborating with PACT staff to develop, oversee, and manage care management plans and care coordination for patients assigned to PACTs.

d. Participating in modes of communication and care delivery including, but not limited to, secure messaging, telephone care, view alerts management, shared medical appointments, clinical video telehealth visits, face to face visits, etc.

e. As part of care management, identifying patient needs for involvement of discipline-specific team members and discussing nursing recommendations with the PCP.

f. Engaging relevant PACT staff to support nursing care, according to locally established informal and formal communication processes, including entering consultation requests to discipline-specific PACT members, if required for formal communications.

g. Assuming full accountability for the appropriateness of assignments made by the RNCM to clinical associates or administrative associates related to care management, care coordination, nursing services, and outcomes of care.

h. Entering orders in CPRS for tests per approved standardized RN care management protocols or PCP orders.

i. Ensuring the RNCM has same-day access for face-to-face and telephone care visits unless it is too late in the day.

j. Using nursing expertise, evidence-based guidelines, standardized nursing protocols, and professionally accepted practice standards to promote patient engagement, self-care and

wellness, provide care to patients and determine care management requirements for individual patients or cohorts of patients.

26. RESPONSIBILITIES OF CLINICAL ASSOCIATE OR PACT STAFF ASSIGNED TO THE LPN/LVN/HT POSITION IN PCMM: The Clinical Associate or PACT staff member assigned to the LPN/LVN/HT position in PCMM is responsible for:

a. All responsibilities listed in paragraph 23 of this Handbook.

b. Providing evaluation and care consistent with licensure, certification, and functional statement with elements of practice, to patients assigned PACTs.

c. Collaborating with PACT staff to develop comprehensive health care plans and care management plans for patients assigned to patient panels.

d. Managing clinic workflow. Ensuring patients are placed in examination rooms in a timely manner, and providing direction to patients as they move through the clinic environment.

27. RESPONSIBILITIES OF ADMINISTRATIVE ASSOCIATE OR PACT STAFF ASSIGNED TO THE CLERK POSITION IN PCMM: The Administrative Associate or PACT staff assigned to the clerk position in PCMM is responsible for:

a. All responsibilities listed in paragraph 23 of this Handbook.

b. Providing clerical support and administrative functions to PACT staff.

c. Collaborating with PACT staff to incorporate the logistical elements of care coordination into comprehensive care management plans.

d. Providing guidance and direction to patients and personal support persons for navigating the VA health care system and administrative functions in VA.

e. Coordinating care for patients assigned to the PACT.

28. RESPONSIBILITIES OF DISCIPLINE-SPECIFIC TEAM MEMBERS: Each discipline-specific team member is responsible for:

a. All responsibilities listed in Paragraph 23 of this Handbook.

b. Collaborating with PACT staff to ensure all eligible patients assigned to a PACT are offered clinically appropriate, coordinated health care services related to the specific discipline.

c. Communicating with and directing patients to appropriate PACT staff if care needs are identified during an encounter with the discipline-specific provider that are unrelated to the discipline-specific provider's scope of practice.

d. Providing discipline-specific care to patients when:

(1) Discipline-specific services are clinically indicated;

(2) Discipline-specific services are requested by the patient, PACT staff, or through consultation from other services; and

(3) The patient has consented to the care.

e. Using proactive population management to identify eligible patients assigned to a PACT who have clinical indications for health care related to the discipline-specific team member's health care practice or discipline.

f. Coordinating population management of discipline-specific health conditions with PACT staff.

g. Participating in PACT operations management processes (i.e., huddles, team meetings, care coordination activities, quality of care activities) when:

(1) Discipline-specific services are part of the workload under discussion;

(2) Discipline-specific representation is needed for PACT staff education;

(3) Discipline-specific representation is needed for panel management;

(4) Discipline-specific representation is needed for population management and proactive patient care planning;

(5) Discipline-specific representation is needed for team development, continuous quality improvement or systems redesign.

(6) Discipline-specific services are part of the coordination of patients during transitions between care settings.

(7) Discipline-specific representation is needed to communicate information to appropriate health care professionals, patients and personal support persons during transitions of the patient between care settings.

h. Providing adequate staffing and coverage for discipline-specific service needs.

i. Ensuring accurate contact information is available to patients, personal support persons, and all team members.

29. REFERENCES:

a. Title 38 U.S.C. 7332.

b. Title 38 CFR 17.38.

c. VA Handbook 6310.2, Collections of Information Procedures.

d. VHA Directive 1120, Responsibilities of the National Center for Health Promotion and Disease Prevention (NCP).

e. VHA Directive 1176, Spinal Cord Injury and Disorders System of Care.

f. VHA Directive 2006-041, Veterans Health Care Service Standards.

g. VHA Directive 2007-033, Telephone Service for Clinical Care.

h. VHA Directive 2008-056, VHA Consult Policy.

i. VHA Directive 2008-082, National HIV Program.

j. VHA Directive 2008-084, National Clinical Reminder Program.

k. VHA Directive 2009-038; VHA National Dual Care Policy.

l. VHA Directive 2009-053, Pain Management.

m. VHA Directive 2010-012, Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans.

n. VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures.

o. VHA Directive 2010-033, Military Sexual Trauma (MST) Programming.

p. VHA Directive 2012-011, Primary Care Standards.

q. VHA Directive 2013-003, Providing Health Care for Transgender and Intersex Veterans.

r. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

s. VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives.

t. VHA Handbook 1010.01, Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans

u. VHA Handbook 1101.02, Primary Care Management Module (PCMM).

v. VHA Handbook 1101.05, Emergency Medicine Handbook.

w. VHA Handbook 1120.01, MOVE! Weight Management Program for Veterans (MOVE!).

x. VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements.

y. VHA Handbook 1120.04, Veterans Health Education and Information Core Program Requirements.

z. VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services.

aa. VHA Handbook 1140.04, Geriatric Evaluation and Management (GEM) Procedures.

bb. VHA Handbook 1140.07, Geriatric Primary Care.

cc. VHA Handbook 1140.09, Geriatric Consultation.

dd. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.

ee. VHA Handbook 1172.01, Polytrauma System of Care.

ff. VHA Handbook 1176.01, Spinal Cord Injury and Disorder (SCI/D) System of Care Procedures.

gg. VHA Handbook 1330.01, Health Care Services for Women Veterans.

hh. VHA Handbook 1400.01, Resident Supervision.

ii. VHA Handbook 1400.04, Supervision of Associated Health Trainees.

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ENGAGING VETERANS IN THE PACT

To be patient-centered, PACT staff members need to seek and consider Veteran preferences into the design, implementation and continual improvement processes of the PACT over time. There are many methods that Veterans Integrated Service Networks (VISNs) and facilities may use to obtain Veteran input, and local circumstances and issues will help to guide strong practices.

An important consideration when seeking Veteran input is the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2. Any group, with limited exceptions, that is established or utilized by VA to obtain group (consensus) advice and that has at least one member who is not a Federal employee, must comply with FACA and must be authorized by the Secretary of VA or an act of Congress. The following are examples of Veteran participation in PACT development that may not be subject to FACA:

a. **PACT Implementation/Steering Committees.** A PACT committee may invite feedback from a Veteran representative. The Veteran may provide individual advice or factual information, but cannot participate in developing consensus views, advice or recommendations.

b. **Focus Groups.** Networks or facilities may choose to conduct Veteran focus groups to learn about customer perceptions, preferences and opinions regarding VHA services (see VA Handbook 6310.2 Collections of Information Procedures).

NOTE: *Legal questions regarding FACA should be directed to the Office of General Counsel (023). Administrative questions regarding FACA should be directed to VA's Committee Management Office (OOAC).*

Though Networks and facilities will each have their own unique needs, the following guidelines are strongly recommended:

a. Personal invitations are more likely to result in better participation than open announcements or requests for input. Invitations may be targeted to specific populations (i.e. Women Veterans, Veterans with specific health issues) so long as objective criteria are used to identify and select participants.

b. Meetings should be held at times that are convenient for the participating Veterans. When scheduling the time and location of meetings consider preferences of the targeted Veteran population (e.g. working mothers, elderly).

c. Veteran participation should include Veterans who receive care at CBOCs and live in distant parts of the catchment area as well as those Veterans who receive care at VA medical facilities.

d. To encourage participation, consider using tele- or video-conferencing for Veterans who cannot easily travel to the meeting site.

e. To obtain input from Veterans who are not enrolled or do not receive care from VA, personal invitations are recommended.

f. Inform Veterans as to the specific purpose of the group, how their input will be used, and how they will receive feedback about their suggestions.

g. To encourage full participation of Veterans in focus groups, it will be helpful to provide orientation and education in the principles of PACT and performance improvement to help Veterans fully understand and appreciate the importance of their input.

h. Meetings should be led by trained facilitators and minutes recorded.

i. To broaden the audience of Veteran participants, linking PACT input meetings to other Veteran outreach meetings is helpful.

j. Social media provide valuable information, which should be considered, though it is not a substitute for an advisory group or solicited input