Department of Veterans Affairs

Memorandum

Date: October 3, 2014

From: Executive Director Primary Care Operations (10NC3)

Subject: PACT Synthesis Report Distribution

To: Higher Level Management Official

Beginning in 2010, VHA began implementation of PACT, the most comprehensive and dramatic change in Primary Care delivery in more than 20 years. This transformation involved not only changes to long-established processes, but changes in the very culture of Primary Care. A highly functioning team became the key means by which care was to be delivered, and that care was to be patient-centered, accessible, and coordinated.

Because of the scope of PACT implementation, the challenges envisioned in changing such a large organization, and the uncertainties entailed in transformation, the PACT Demonstration Laboratories were formed to monitor, document, analyze and study the implementation process. As a result, PACT is the largest and arguably the most documented transformation of a health care system to the patient centered medical home model in the US if not the world.

By many measures, PACT has been a success. Processes have changed, staff is engaged, and most importantly patients are receiving superb, coordinated, patient-centered care that stresses prevention and health promotion. Published data documents that the sites that have implemented PACT effectively demonstrate higher patient satisfaction, higher performance on clinical quality metrics, lower ambulatory care sensitive hospital admission rates, fewer emergency department visits, and lower staff burnout. Tellingly, although Primary Care physicians in the 2013 VHA All Employee Survey displayed higher rates on several burnout indicators than other physicians, they felt significantly more fulfilled in their work.

Despite the evidence of PACT's effectiveness, implementation remains variable throughout our large health care system. There are still sites where full staffing is not in place, where processes have not been improved, and where practices do not reflect a team approach to care. In order to explore the reasons behind and possible solutions for this disparity, VHA has taken advantage of the extraordinary resource that we have available in the Demonstration Laboratories. Not only can we refer to published literature which is specific to VHA, but we also have available the analysis and guidance of experienced and knowledgeable health services investigators who have been watching PACT evolve and grow. Their critical expertise is an important and valuable resource as we continue to spread and refine PACT. This Synthesis Report is the distillation of their honest appraisal.

PACT is moving into a new phase as it becomes the standard way VHA provides Primary Care. Because it is our core business, it is leadership's responsibility at every level of the organization to take responsibility for PACT's shortcomings and successes. The need for PACT, the inspiration for

PACT, the energy for PACT, and the strength of PACT emanates from the staff and patients in our clinics. As leaders, we owe it to them to take a sincere look at how far we have come and how far we could and ought to be, and do whatever we can to allow and encourage PACT to flourish. The Synthesis Report is one step in the introspective examination that must take place to enable us to enhance and improve PACT and better serve our Veterans.

The recommendations in this report are aligned with strategies and even specific transformational actions outlined in VHA's recent "Blueprint for Excellence", and provide us with an early opportunity to engage in "alignment of resources to transform VHA health services from being provider-centric to being Veteran-centric."

We hope that you will take a few moments to review this provocative report! Perhaps we can use this Synthesis to stimulate a new vantage point, one that encourages fresh discussion about where and how we need to improve. We encourage you to e-mail back your thoughts and comments.

Thanks!

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October 3, 2014
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OFFICES OF PRIMARY CARE SERVICES AND PRIMARY CARE OPERATIONS
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PACT DEMONSTRATION LABORATORIES SYNTHESIS PROJECT PANEL FINAL REPORT

OFFICES OF PRIMARY CARE SERVICES AND PRIMARY CARE OPERATIONS/
ANALYTICS AND BUSINESS INTELLIGENCE
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

MESSAGE FROM THE DIRECTOR

In 2010 VHA undertook a massive restructuring of its "core business", i.e., primary care. Based upon the precepts of the Patient Centered Medical Home, VA's Patient Aligned Care Team (PACT) initiative represented an ambitious effort to move from the traditional model of primary care, consisting mainly of periodic, one-on-one visits with a single provider, to a model in which teams of health care professionals strive to coordinate care for Veterans in a proactive manner consistent with their needs and preferences. Because no other health care system had ever undertaken a transformation of this scale, VA established a companion program, the PACT Demonstration Laboratory Initiative, to conduct intensive evaluation of PACT implementation. During the past 5 years, 5 PACT Demonstration Labs (Demo Labs) and a national coordinating center conducted dozens of studies and gathered extensive information about the progress of the adoption of the PACT model at local sites and nationally. This work has been described in quarterly reports and is being catalogued in a final report.

In addition to reporting on individual projects conducted by the Demo Labs and the Coordinating Center, leaders of the Demonstration Laboratory Initiative recognized the need to summarize the consistent findings from multiple studies and present them in a way that would assist in developing and modifying policy related to PACT. This Synthesis Report represents their consensus regarding the most important themes that have emerged from the Demo Labs along with recommendations for addressing them.

Although not specifically addressed in this document, the progress of implementing PACT in VA has not been as rapid as initially hoped. Perhaps this is not unexpected given the magnitude and complexity of an effort to redesign the care delivery model at nearly 1000 sites of care, which are highly diverse in terms of size, setting and geographic location. The seven major recommendations delineated in this report reflect several of the significant challenges that have become apparent during the process of implementation although the list is certainly not exhaustive. Underlying these recommendations are some common threads. Adherence to a rigid set of policies and structures deprives teams and practices of essential flexibility in adapting to a whole new approach to delivering care. Effective teams must be nurtured with consistent leadership, stable staffing, and meaningful ways to gauge progress. There must be resources to support care teams so that they can successfully manage Veterans' medical and mental health problems. (Veterans are also members of the team.)

This report should in no way be viewed as an indictment or repudiation of the PACT initiative but, instead, a major assessment that is an essential component of a quality improvement cycle. During the next phase of the Demonstration Lab Initiative, we plan to continue our assessment of these themes as well as other aspects of PACT and to learn from sites that have successfully addressed the issues these challenges.

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EXECUTIVE SUMMARY

BACKGROUND

In February 2010 the Veterans Health Administration (VHA) initiated the implementation of a forward-looking, primary care model called Patient Aligned Care Teams (PACT). Based on the precepts of the Patient Centered Medical Home (PCMH), the PACT model aimed to improve Veterans' experience of care, enhance quality of care, and reduce costs through inter-professional team-based and personalized primary care. In addition to funding for clinical services, the VA funded the PACT Demonstration Laboratory Initiative to evaluate the effectiveness of PACT and to develop innovations for PACT improvement.

Following a national competition, 5 Demo Labs were established in VISNs 4, 11, 20, 22, and 23 in 2010, each with a strong capabilities in research, evaluation and innovation in primary care. Each Lab pursued an agenda that involved active partnerships between clinical leadership and Health Services Research and Development (HSR&D) researchers at regional (i.e., VISN) and local levels. A Demo Lab Coordinating Center (DLCC) was also created to facilitate the work of the Demo Labs and to lead a national evaluation of PACT implementation and outcomes.

Throughout the past 5 years, the Demo Labs and Coordinating Center have produced extensive quarterly reports detailing their activities and findings. To provide a broader context and convey the findings in more pragmatic framework, the Coordinating Center supported Demo Lab leaders in conducting a formal synthesis aimed at translating the Initiative's evaluation and innovation products into recommendations for action. The synthesis focused on evidence from the thirty peer-reviewed articles generated by the Initiative's first four years of work. The articles are based on electronic, medical record, survey and/or direct observation data and use a variety of evaluation designs. Together, the articles represent systematic data collection on PACT implementation as experienced by PACT clinicians, staff, and Veterans from across the United States. As such, the articles provide a rich description of PACT implementation, barriers and facilitators to PACT improvement, and potential innovations for achieving PACT goals.

METHODS

The Synthesis Project convened a 14 member panel consisting of Demo Lab Initiative directors and co-directors, clinical leader partners, and an outside consultant from the overall PACT Demonstration Laboratory Advisory Board. Using a modified Delphi Expert Panel approach, Panel members reviewed findings of Initiative publications and rated the importance of potential recommendations based on them. Panelist ratings provided the basis for discussing and refining recommendations during four 90 minute teleconference calls.

Identifying expected links between a program's activities and its achievement of desired goals is crucial for understanding the implications of a program evaluation. The Synthesis Project therefore developed a logic model linking PACT activities to its expected outcomes, and used this model as a framework for developing and organizing recommendations. The initial logic model, after review and revision by the Synthesis Panel, included: activities undertaken nationally to implement PACT, PACT expected outcomes, PACT unexpected outcomes, and barriers and facilitators to successful accomplishment of PACT goals (Figure 2).

The logic model, including the themes it identifies, is useable as a frame for deriving recommendations for PACT improvement. Additional input, particularly from national PACT program leaders, should be sought to further refine the model; the resulting document may be helpful for PACT program planners at multiple levels.

RESULTS

The Panel came to consensus on seven recommendations deemed highly or extremely important (Figure 1). The full report that follows this Executive Summary includes the rationale for each recommendation, a series of specific sub-recommendations, and comments from the Panel.

PACT Improvement Areas: *The Demo Lab Initiative's peer reviewed literature substantiates seven crucial areas of concern for improving PACT: adequate staffing, team functioning, engaging Veterans, performance measure improvement, primary care quality improvement, interdisciplinary leader and administrator role training, and mental health care. The Panel recommends that PACT leadership undertake improvements in these areas to advance PACT goals.*

Seven Major Recommendations for PACT Improvement

1. **Adequate Staffing**: Develop methods and resources for improving alignment between PACT staffing models, measures of PACT staffing, and the workforce configurations needed for achieving PACT goals.

2. **Team Functioning**: Develop new approaches to promoting, structuring, and encouraging team culture and improved function; includes team training and role development.

3. **Engaging Veterans**: Improve methods for engaging Veterans in their own care as well as in PACT care design.

4. **Performance Measure Improvement**: Improve the match between performance measures and PACT goals by undertaking a broad-based and sharp review of the measures.

5. **Primary Care Quality Improvement**: Improve the ability of primary care practices to engage effectively in ongoing quality improvement.

6. **Interdisciplinary Leader and Administrator Roles and Training**: Develop additional PACT training and role development resources for interdisciplinary leaders and administrators at the regional, medical center, and primary care site levels.

7. **Mental Health Care**: Develop structures, incentives, and measures directed at further implementation of primary care and mental health integration.

FIGURE 1. Seven Major Recommendations for PACT Improvement

PACT DEMONSTRATION LABORATORY INITITIATIVE

SYNTHESIS PROJECT FINAL REPORT

OVERVIEW

What is the PACT Demonstration Laboratory Initiative? Patient Aligned Care Teams (PACT) represents a major transformation of VA primary care into a patient centered model based on the concepts of the Patient Centered Medical Home (PCMH). This transformation, initiated in February 2010, represents the largest effort in the U.S. to date to implement PCMH principles. At the same time, in line with VHA's commitment to function as a learning organization, VHA's Office of Patient Care Services initiated evaluation of the transformation's process and outcomes through funding of the PACT Demonstration Laboratory Initiative. The Initiative, funded in June 2010 based on competitive proposal review, includes five regionally-based Demonstration Laboratories and a Coordinating Center. The Coordinating Center also led national across-region evaluations of PACT. The selected Laboratories (Demo Labs) each have engaged researcher/clinical leader partnerships in a VA administrative region (Veterans Integrated Service Network, or VISN) to support PACT-related innovation and evaluation. The five regions are geographically diverse, representing both coasts and the Midwest (VISNs 4, 11, 20, 22, and 23). The analysis presented here focuses on studies conducted as part of the initiative during its four years of funding, through September 2014.

What is PACT? PCMH and PACT principles aim to produce continuous, coordinated, accessible, comprehensive and patient preference driven care through redesign of the primary care workforce into multi-functional teams serving designated patient panels. In PACT, all Veterans registered for VHA care are assigned to a primary care provider panel at one of 923 VHA owned and operated sites at which primary care is delivered or at a VHA-contracted primary care practice. Catchment areas for these practices cover the entire US. Some practices are located in VHA hospitals but most are located in local communities ranging from rural to urban or suburban settings. Primary care practices are administrated by local healthcare systems. Administration for local healthcare systems runs through VHA medical centers; nearly all medical centers are located on the grounds of a VHA hospital. Medical centers in turn are grouped into 22 administrative regions (VISNs) through which funding and other regional functions flow. The PACT model was simultaneously initiated in all regions beginning in February 2010.

Within PACT, care for each panel is organized around teamlets with a three to one ratio of staff to providers. Teamlets were intended to include a full time equivalent primary care provider who is a physician, nurse practitioner, or physician-assistant along with a registered nurse, a health technician or licensed vocational nurse, and a clerk. Five or six teamlets constitute a team, with a pharmacist, a social worker, a health coach, and a dietitian. A given primary care practice may include as few as one teamlet, and access a larger practice for team resources, or may include several teams. Teamlets were intended to provide the broader continuity needed for increasing access by reducing unnecessary face to face visits with providers, and to enable pro-active and preventive panel management based on identifying issues needing nurse care management. Teams were intended to provide access to key services such as pharmacy and social work, also in continuity, as well as to promote Veteran engagement through coaching. Additional detailed information on PACT is available in the PACT Handbook 2014 (Appendix F).

What is the Demonstration Laboratory Synthesis Project? The Synthesis Project's process was based on review of rigorous, published scientific evaluations conducted by Demo Labs as well as on the broader PACT-related expertise acquired by the Demo Lab Initiative investigators. Through the Synthesis Project, Demo Lab leaders aimed to make the knowledge gained by the Initiative more accessible for PACT improvement. The Project built in part on a peer-reviewed supplement to the Journal of General Medicine focusing on PACT (July 2014) that ultimately included many Demo Lab Initiative publications, on quarterly reports submitted by Demo Labs, and on a comprehensive electronic repository of Demo Lab publications, tools and innovations.

What is included in the Synthesis Project Report: The Demo Lab Initiative products identified many opportunities for PACT improvement, as viewed through systematically collected and analyzed qualitative and quantitative data from PACT providers, staff, and patients. Problematically, the potential lessons learned from the Initiative had to be gleaned from diverse publications and synthesized into a cohesive and readily understandable format. The Synthesis Project's overall goal was therefore to develop and refine recommendations based on peer-reviewed Initiative work in a format that would be easily accessible to VHA's clinical program and operations leadership.

Recommendations included in this report are intentionally based on the implications of published Demo Lab findings. The innovation and evaluation activities that produced this body of work grew out of the initial questions and assumptions that framed PACT's early years. The resulting recommendations do not reflect all possible issues affecting PACT, but rather those that the Initiative collected data on and analyzed. While many additional aspects of PACT will be critical to evaluate and improve over the coming years, the Synthesis Project recommendations substantively address many fundamental links between key components the PACT model and how they were implemented as well as the results they intend to achieve. In so doing, the recommendations provide a framework for action, as well as for continued discussion and investigation.

METHODS

Pre-Panel Preparation: The Synthesis Project Committee first identified eight overall themes the Committee thought were addressed by Demo Lab Initiative work, as well as multiple sub-themes. These themes became the basis for an online survey of Demo Lab Initiative investigators in October 2013 to identify all work conducted relevant to the themes, and any additional themes not covered by the initial theme set. This included identification of articles, innovations, tools, and relevant analyzed but not published data. The full set of products organized by themes is available on SharePoint by contacting the DLCC.

The initial themes identified by the Committee addressed diverse aspects of PACT that were difficult to conceptualize as recommendations. This led to the development of a draft logic model linking the themes to the key activities and expected outcomes of the PACT initiative. The Committee then asked authors to identify implications of their peer-reviewed, published or in-press articles that related to the themes and logic model.

Modified Delphi Panel Process: After identifying the themes and constructing the logic model, the Synthesis Project convened a 14 member expert Panel consisting of Demo Lab directors and co-directors, clinical leader partners, National Evaluation investigators, as well as one outside consultant from the overall PACT Demonstration Laboratory Advisory Board. The Project purposely limited Panel membership to high level experts who were familiar with Demo Lab Initiative work, in order to avoid either the reality or the perception that the process aimed to

address all PACT stakeholders and their views. Instead, the Project aimed to focus specifically on the Initiative's scientific products.

The Synthesis Panel members carried out a Modified Delphi panel process. Panelists met four times during 90 minute teleconferences between March 2014 and June 2014. The first two calls split Panelists into two groups, enabling wide-ranging discussion; the final call included all Panelists together. Between calls, Panelists completed two on-line surveys.

During the first panel call, Panelists reviewed and evaluated the themes and the logic model developed in preparation for the panel process. The Panel then successively reviewed and rated author-generated implications of Demo Lab publications within theme areas. The Project considered these implications to be precursors to a final list of potential key recommendations.

During the final survey (Appendix E), Panelists rated seven main recommendations addressing theme areas and their associated 20 specific sub-recommendations (Appendix A). The seven-point rating scale for each recommendation or sub-recommendation ranged from 1 (little or no importance) and 7 (extremely high importance). The Project statistician analyzed the ratings using means, medians and standard deviations for each item, and developed results with and without adjustment for reviewer effect (the tendency of some reviewers to review more harshly or leniently than others).

We presented analysis results to the final Panel. We identified and discussed ratings that indicated greater disagreement, based on higher standard deviations. With Panel concurrence, we established a mean rating of 5.0 or greater on the 7 point importance scale indicating support was strong enough for the recommendation to go forward to leadership while a rating of 4.9 or less indicated a recommendation's support was insufficient for presentation as a priority. We used the discussion of each recommendation with the Panel to identify sources of disagreement, validate survey rankings, and determine whether lower ranked recommendations merited any mention in the synthesis report. Among specific sub-recommendations, any that Panelists deemed important during discussion are mentioned in the text.

RESULTS

Logic Model: Identifying expected links between a program's activities and its achievement of desired goals is a key to understanding the implications of a program evaluation. In the logic model Column A lists the types of activities undertaken nationally to implement PACT. Column B lists the expected PACT design elements these activities aimed to produce. Column C lists the clinical features expected to be achieved by PACT through implementation of the PACT design elements, and Column D lists the patient, provider, and economic outcomes expected as a result of the entire set of program activities and clinical process improvements. Below the columns are underlying barriers and facilitators to PACT implementation. Finally, the Panel added Column E for unexpected outcomes. The Panel views the logic model as a work in progress, likely requiring further refinement, but useful as a reference for identifying and linking themes by which recommendations could be grouped. Not all theme areas listed in the logic model were addressed by Demo Lab publications.

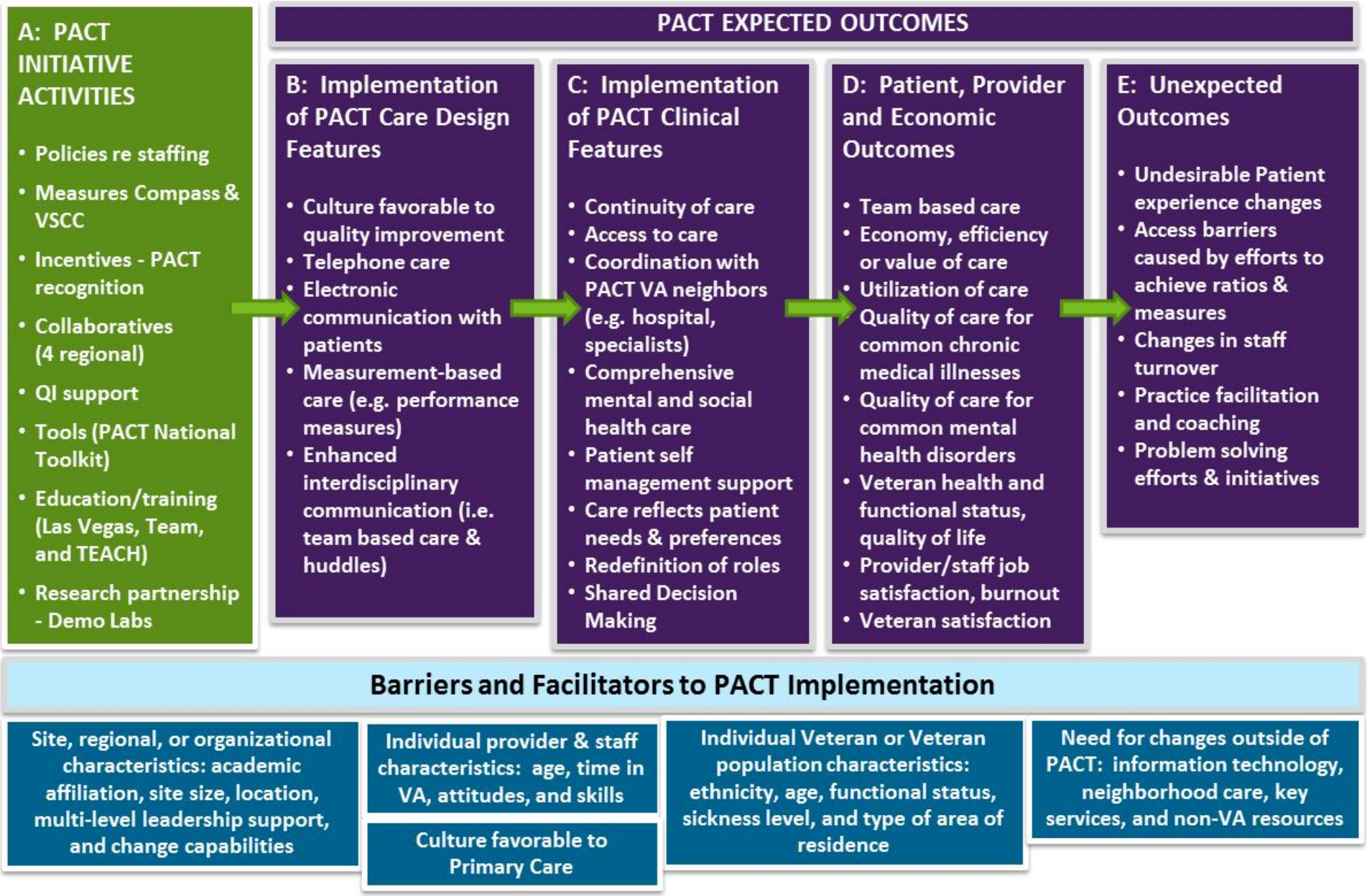

FIGURE 2. PACT Early Implementation Logic Model

Relative Importance of Major Areas for PACT Improvement: The relative importance of key areas for improvement addressed by the Demo Lab Initiative is shown in the seven major areas for improvement that were endorsed by the Panel as very or extremely important. Figure 3 lists the improvement areas in order of importance as ranked by the Panel, the mean ratings on a scale from 1 (not important) to 7 (extremely important), and the standard deviations for each improvement area. The standard deviations indicate a relatively low level of disagreement among Panelists on these recommendations, with the rating on the importance of the mental health recommendation showing the greatest dispersion. No major recommendations were dropped (all had means of five or more).

***Targeting PACT Improvement Initiatives**: Achievement of PACT clinical care and outcome goals depend upon successful implementation of key elements of PACT care. The Panel recommends that VHA target seven key improvement areas. The set of recommendations are interconnected and have implications for achieving the outcomes set forth in the PACT logic model (Figure 4). These target areas can be used as a basis for developing new strategies and activities at national, regional and local levels for achieving PACT goals.*

Seven Major Areas for PACT Improvement	**Panel Rating Mean ± SD**
1. Adequate Staffing	6.32 ± 1.05
2. Team Functioning	6.29 ± 0.70
3. Engaging Veterans	6.17 ± 0.59
4. Performance Measure Improvement	6.12 ± 1.07
5. Primary Care Quality Improvement	6.06 ± 0.87
6. Interdisciplinary Leader & Admin Roles Training	5.66 ± 0.46
7. Mental Health Care	5.54 ± 1.23

FIGURE 3. Relative Importance of Improvement Areas

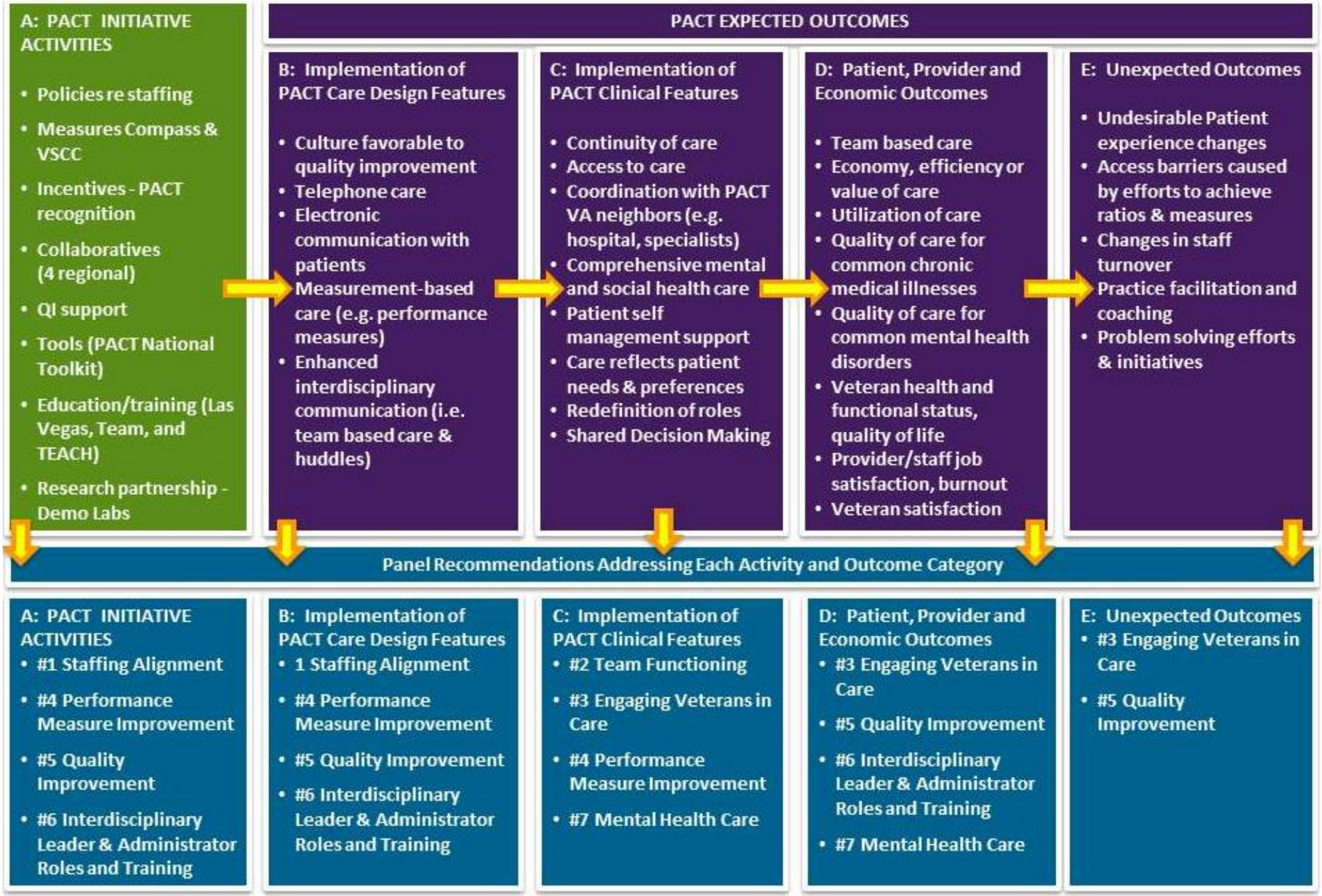

FIGURE 4. The PACT Logic Model Links to Each of Seven Key Synthesis Panel Recommendations

These quotes are from the Panel members' comments recorded at Synthesis Panel Meetings.

"This recommendation reflects the underbelly of PACT implementation and evaluation -- if the PACT teams and teams are not fully staffed, there's no way to really know whether the model works and what it may accomplish. Further, without such staffing level achievement over time, the support to get there will wane and the initiative may falter, as staffing gets pulled away for new initiatives (e.g., access over continuity, coordination, comprehensiveness, etc.)."

"This will require offering a range of possible solutions and strategies to support field based action and a multi-level engagement of a range of leaders responsible for individual team members from a disciplinary perspective. Hopefully these strategies are based on PACT Demo Lab insights.

"These issues are also related to the medical neighborhood which does not necessarily see itself as accountable to PACT or as a neighborhood in the first place".

"It seems more emphasis should be placed on fixing the underlying problems of hiring delays."

"Another recommendation for which inaction is high risk, current hiring experiences for clinicians and non-clinicians, easily result in a 9-12 month delay. The model is not sustainable given its susceptibility to even minor gaps in staffing, let alone the major ones experienced in the field."

Recommendations: The following sections of the Synthesis Report show and discuss the final recommendations that were rated highly by the Panel (5.0 or above). These have been reviewed after revisions based on Panel discussion by all Panel members.

Recommendation #1
Adequate Staffing

Adequate Staffing Recommendation: Ensure PACTs are adequately staffed, and measure PACT staffing using consistent and clear definitions.

Rationale: Sites with more sufficient staffing show lower burnout. Insufficient staffing poses threats both to the achievement of PACT patient care goals and to the morale of clinic teams under pressure to achieve PACT goals that may be unrealistic in the absence of sufficient staffing. Qualitative and quantitative findings from the Demo Lab Initiative show that staffing for PACT is routinely not sufficient or is unstable within local primary care sites, and direct observations often reveal incongruities with Decision Support System (DSS) staffing information. These direct observations suggest frequent failure to meet the recommended PACT 3:1 team member/provider ratios.

Panelists identified 5 contributing factors to insufficient staffing:

1. Definitions of staffing assignments for documentation in DSS are neither clear nor uniformly applied. Thus, a primary care nurse who spends half time supporting a smoking cessation group or covering specialty clinics administrated by primary care may be counted as full-time on a PACT patient panel (i.e., meeting the 3:1 ratio), even though he or she is not actually supporting a patient panel for the full indicated FTEE time recorded in DSS. Variations in local interpretations of DSS reporting standards markedly reduces the ability of evaluators to learn what level of team staffing is sufficient in differing contexts.

2. There is no measure, supportive development, or training that promotes stability of staffing at the teamlet level. This means that the impact of prior team development work is significantly reduced.

3. Nursing, clerk, and provider staffing decisions are often made by different service lines and different managers, with none having overall responsibility for ensuring adequate staffing.

"The Compass 3:1 ratio measure encourages administrators to hire the provider first, then the rest of the team. Hence, the provider has to wait for the team to come on board after his/her hire."

"I am not convinced that the issue [for staffing stability] is the need for greater incentives to ensure stability; the evidence points towards adequate staffing as the main barrier to continuity."

"Pharmacy should have contingency staffing."

"Emphasis on pharmacists, social workers, and mental health providers benefits contingency staffing."

4. Hiring of replacement providers and staff begins only after an individual has left, often leaving staffing gaps of months or years due to hiring delays.

5. Academic practices with part-time clinicians may require a higher staffing ratio or different practice arrangements, while small sites may find that different combinations of staff roles can be shared across teams.

Specific sub-recommendations on Adequate Staffing	**Panel Rating Mean ± SD**
1. Encourage and monitor proactive hiring	6.32 ± 1.07
2. Alternative staffing models for part-time and trainee providers	5.92 ± 1.39
3. Measure teamlet staffing in uniform ways	5.52 ± 1.10
4. Encourage and monitor staffing stability	5.38 ± 1.75
5. Develop teamlet level staffing measures	5.32 ± 0.81
6. Develop processes to determine contingency staffing needs for core team staff	5.15 ± 1.58
7. Develop cross-coverage guidance	5.12 ± 1.07

FIGURE 5. Specific Sub-Recommendations on Adequate Staffing

Specific sub-recommendations for adequate staffing: Panelists rated proactive hiring as the most critical improvement for achieving adequate staffing. Accurate measures for teamlet staffing should also be developed, as well as alternative staffing models that could take account of the needs of part-time and trainee providers. Cross coverage arrangements and contingency staffing to cover hiring delays and other staff vacancies would also be helpful (Figure 5).

Rationales for specific sub-recommendations for adequate staffing:

Encourage and monitor improved approaches to proactive hiring for PACT teams and teamlets: These approaches might include

"The kinds of team focused metrics currently in use set up unintended consequences for cross team coverage and support, undermining the kinds of collaborative, broader benefits of team based care. Prior VA primary care transformations noted the value of informal curb siding among providers, RNs supporting each other's work, and the like."

"These [academic] groups must organize differently to survive, the traditional model doesn't work."

proactive replacement for turnover; for example, hiring a replacement before a provider leaves. A team-based proactive approach to hiring, where all positions on the team are posted and filled as simultaneously as possible, would be an improvement over the current common practice of hiring providers first and then filling team positions. This practice undermines opportunities for team training (as the provider is initiated independently of the remaining team members), and creates an initial period of understaffing as the new providers must share team staff with others. Additional considerations include interdisciplinary engagement in recruitment and hiring decisions, improved communication with Human Resources, and others to be determined.

2. *Develop alternative staffing models for part-time providers and trainees:* Teams that include several part-time providers to make up a full panel must perform more coordination and provide more coverage than teams with providers who are consistently in place. Because of VA's statutory educational mission, teams may include trainees from various disciplines and at various levels, most commonly internal medicine residents. The faculty supervising these trainees have variable portions of time allocated to direct clinical care, supervision, and other duties. To be effective, Demo Lab data shows that teams with residents or other part-time providers likely require new organizational approaches. These approaches may include different or additional staffing arrangements particularly in the clerical and clinical associate roles.

3. *Measure teamlet staffing in uniform ways:* Measure teamlet staffing based on the amount of time each type of teamlet member (MD, NP, RN, LVN, or Clerk) is assigned to patient panel care activities, excluding time allotted for other activities that may occur as part of primary care. These activities can include working with call centers, primary care and mental health integration, and others. Train Primary Care Management Module (PCMM) Coordinators in using the measure.

4. *Encourage and monitor staffing stability:* Prior to PACT, nursing, clerical and physician leaders often independently moved their staff, including reassigning or switching personnel across providers or teams. This was typically done without consulting each other or communicating with staff delivering care. In PACT, a teamlet can lose 30% - 50% of its staffing this way from one day to the next; this is a potential patient safety issue as well as an overall threat to optimal team functioning.

5. *Develop a team level staffing measure:* Measure team staffing (for five or six patient panels) based on the amount of time each team member (e.g. pharmacist, social worker) is assigned to the team's combined patient panel (i.e., across the five or six panels) care activities, excluding other primary care or non-primary care activities. Separately identify and define time spent in group visits or patient education classes as additional team activities.

6. *Develop processes to determine contingency staffing needs for core team staffing at the local facility level*: Staffing gaps occur for teams when members leave, become ill, etc. These gaps can last a year or more under current hiring conditions. Shorter gaps still cause stress and safety issues in practices with high demand. Contingency staffing, meaning availability of unassigned providers, nurses, or other team members to fill vacant positions without disrupting another team, has been tested and observed to improve team functioning. Further evaluation of staffing needs and contingency staffing models may be useful.

7. *Develop cross-coverage guidance:* Cross-coverage refers to the negotiation that occurs within departments or within teams when staff members are missing due to leave or shortages. Demo Labs observed successful cross-coverage arrangements that responded to local constraints and resources. For example, team members were paired with members of other teams for coverage purposes, or team members took on the roles of missing members. However, cross-coverage sometimes created dissention, pitting team or teamlet loyalties and responsibilities against needs outside the team, or raising issues of fairness. These issues lowered job satisfaction. Panelists suggested general guidance encouraging primary care practices to develop cross-coverage plans that take into account the different implications for large and small clinics and other unique aspects of the clinic settings.

"VA initiatives, including PACT, have seemed to severely underestimate the importance of ongoing training and education, including in-person opportunities to communicate and learn, which are more effective than adding another dozen webinars. Few teams appear to have opportunities to learn together or develop cohesion, which the non-VA literature has demonstrated is essential to improved function, team processes, and ultimately quality and outcomes."

"I think that team training should emphasize practical facilitation of teams working through specific challenges and issues, at least as much as abstract skills and concepts training. Because so many teams have not received such training, the (VA) evidence is weak on the effectiveness of such training, but our qualitative data suggest that it is this kind of hands-on facilitation that employees want."

"Who's on first for what" is one of those fundamental elements of team-based care."

"Currently, it does not appear that local PACT teams/teams have any strategies, other than severe HR reactions to dysfunctional team members; even that recourse is not easy to apply in severe cases. Again, this is in part an issue related to lack of investment in interdisciplinary team training, which was a part of the primary care reorganization of the mid-1990s."

Recommendation #2
Team Functioning

Team Functioning Recommendation: Develop new approaches to promoting, structuring, and encouraging team culture and functioning, including team training and role development.

Rationale: High level team functioning is the foundation for PACT, yet is frequently not achieved. PACT needs to take account of the high level of cultural change required to fully adopt new PACT team roles. These recommendations address team functioning as a core concept at all levels (e.g., larger team, teamlet, leadership).

Specific sub-recommendations for Team Functioning: Panelists rated developing and testing approaches to improve role clarity, team training for cultural change, and guidance for team roles as the most important specific sub-recommendations (Figure 6). Panelists thought it would be worthwhile to successively implement and evaluate strategies that address these sub-recommendations.

Specific sub-recommendations on Team Functioning	**Panel Rating Mean ± SD**
Develop and test:	
Role clarity improvement approaches	5.89 ± 0.98
Team training for cultural change	5.69 ± 0.75
Team roles guidance	5.69 ± 1.26

FIGURE 6. Specific Sub-Recommendations on Team Functioning

Rationales for specific sub-recommendations:

1. *Approaches to Enhance Role Clarity*: Lists of who should do what in PACT teams are not enough to clarify how teams should function. Additional development is needed to create new approaches to identify and address team strengths and weaknesses across the different roles needed for PACT. These can include the need for the exchange of tasks across a team.

2. *Team training for cultural change:* Training can address different sets of skills needed such as communication methods, working as a team, team development, how to bring patients

into the team, etc. Unique and specific needs of PACT teams and members should be welcomed as part of the training curriculum; these needs should then be inventoried and addressed through existing and new programs.

3. *Guidance on Team roles:* Panel members considered this nearly synonymous with role clarity (sub-recommendation #1 above). Here, however, Panelists focused on the method of communication from leadership at national, regional, and local levels regarding team roles to PACT teams. Panelists strongly endorsed communication from leadership that gives guidance on team roles, not mandates. Guidance enables needed flexibility for team functioning. Panel members agreed that guidance from Central Office on roles, in particular, would be highly valued, whereas central mandates would produce rigid definitions of roles and perpetuate current issues with inter-professional functioning.

While role flexibility is essential for team functioning, Panelists recognized that flexibility is bounded by established professional competencies. Increased clarification of the inflexible boundaries regarding which professionals can carry out which common clinical tasks would be helpful. These boundaries are based, for example, on discipline, training, competencies, and regulatory limits. Within boundaries, flexible guidelines will then enable PACT providers and staff to share responsibility for their panels across the full ranges of skills and training each has, while focusing most on those tasks that use their highest level skills.

The need for flexibility is intrinsic to the demands of team level functioning. For example, an RN or MD/NP provider each can take blood pressures, and should, if necessary, for the team and its patients. However, since less trained individuals can perform that function, little of the time of the RN or provider should be used for taking blood pressures. Similarly, face to face visit time with providers is usually the tightest resource constraint for enabling access. Thus, provider time should be focused primarily on face to face visits, while still performing a variety of other tasks as appropriate or needed. In this way, individuals can work across multiple PACT team roles, contributing "cross-over" skills to enhance team functioning, yet maintain maximum efficiency by matching personnel to the specific tasks that call on their unique role-related skills, competency and training.

"Using 'TEACH for Success' classes as an example; this process is extremely resource intensive and it is not clear whether it has any impact without motivational interviewing and individualized coaching."

"TEACH for Success, MI and Coaching can help us communicate better with Veterans and their caregivers, but how will we improve their health literacy? Seems like a laudable but incredibly lofty goal."

"Involving patients in local quality improvement is very important and worthwhile! But requires some sort of screening to match the right Veteran with the needs of the individual committee or QI project."

"Local VA facilities often do not have access to tools like Truthpoint or the resources for internal evaluation."

Recommendation #3
Engaging Veterans

Engaging Veterans Recommendation: Improve methods for engaging Veterans in their own care as well as in PACT care design.

Rationale: Providing Patient Centered care requires actively engaging patients. Currently, methods for doing this are still largely developmental, and may require concerted focus to advance. The Demo Lab Initiative had less data on this topic than on many others. Panelists, however, felt it was essential to advance Veteran engagement.

Specific sub-recommendations on Engaging Veterans in Care	**Panel Rating Mean ± SD**
Engaging non-employee Veterans in improvement	5.47 ± 1.04
Engaging patients in their own care	5.47 ± 0.73
Improving Veteran health literacy	5.07 ± 1.46

FIGURE 7. Specific Sub-Recommendations on Engaging Veterans in Care

Specific sub-recommendations: Panelists identified engaging Veterans in improvement, engaging Veterans in their own care, and improving Veteran health (and health care) literacy as top priorities (Figure 7).

Rationales for specific sub-recommendations:

1. *Engaging non-employee Veterans in improvement:* Veteran patient involvement in care design provides a critical perspective on VA processes that is often lost or overlooked. Engaging patients in care has the potential to enrich and enhance engagement in PACT improvement efforts. New methods of gaining patient feedback and of engaging patients in quality improvement make further advances even more possible.

2. *Engaging Veterans in their own care:* While providers and staff have received training about PACT, patients generally have not, yet are expected to take on new roles. More development

in the area of engaging Veterans in their own care is needed to enhance the impact of care management, coaching, and more.

3. *Encourage growth in assessment and improvement of patient knowledge about their own health and health care:* Meaningful participation in care requires that Veterans understand key aspects of their health, their care, and the care system. Among other approaches, PACT should provide templates for local sites for outreach materials on PACT for Veterans. These materials might include how the system is changing to meet patient needs, what Veterans can expect from care providers, and how Veterans can participate in achieving PACT goals.

"Politics around performance metrics can be fierce, and would require a strategic planning effort, interdisciplinary and multi-level engagement, and a serious commitment of time and resources."

"Introduce training and materials not only prior to introducing measures, but also when there is a change in how the metric is measured."

"Since RNs do a LOT of telephone encounters, these should also be included in a metric and recorded as workload. (The post-discharge RN encounters are included as a metric, but the other phone calls are not.)"

"Do we want to be more specific here and call out access and continuity measures? These are the measures that cause the most difficulty in the academic centers?"

"I tend to favor some kind of barometer or set of metrics that gets at how a team is functioning and performing, meaning "team health". As noted previously, this goes with the VA having a census or registry of all teams, which is required first before setting out to score the fidelity of each team."

"Include reward for providers but also all other members of the PACT team."

Recommendation #4
Performance Measure Improvement

Performance Measure Improvement Recommendation: Improve the match between performance measures and PACT goals by undertaking a broad-based review of the measures, including their strength of association with clinically-relevant outcomes and their relative importance; their potential and actual impacts on providers, staff, and patients; and their interrelationships and interactions with each other.

Rationale: The fundamental purpose of performance measures is to gauge the progress of the PACT Initiative in achieving its goal of improving the quality of care and patient experience through effective team-based care. The Demo Lab Initiative documented strong uncertainty among PACT leaders, providers, and staff about the strength of the links between current PACT performance measures and the goals of PACT. While sites acknowledged the importance of the measures, and their actual and potential benefits, they felt that the incentives provided by specific PACT metrics were not always consistent with the desired outcomes. Measures were difficult to work with at the primary care practice site level, often not providing the level of granularity needed to support targeted local improvement efforts.

The sense that PACT metrics were being used in a heavy-handed fashion to manipulate clinical sites with top-down unidirectional communication (rather than bidirectional communication) appeared to lead to apathy and resentment among many PACT participants.

Specific sub-recommendations:

Panelists recommended the top priority to be a renewed focus on continuity and access as core measures. Panelists also emphasized pacing the rollout of PACT metrics for performance improvement to reduce burnout among providers, developing more effective measures for assessing PACT implementation fidelity at local sites, and re-examining executive metrics and associated recognition or rewards (Figure 8).

FIGURE 8. Specific Sub-Recommendations on Improving Performance Measures

Rationales for specific sub-recommendations:

1. *Renewed focus on continuity and access as core performance measures:* Panelists recommended that all levels of leadership undertake a renewed focus on continuity and access together as core performance measures for achieving the goals of PACT. Continuity and access interact at the practice level; both are critical. Demo Lab Initiative publications document the important associations among continuity, access, and patient satisfaction. Yet the current metrics do not fully align to provide a balanced measure that reflects the full set of activities affecting the combination of continuity and access, such as whether non-face to face care is delivered by continuity or non-continuity providers. In addition, access measures in particular need further validation and refinement as they appear not to perform consistently across sites and VISNs and have inconsistent relationships to other related measures in Lab analyses.

To support improved access and continuity, the measures themselves require improvement. This includes: a) development of methods for counting non-face to face encounter time towards measures of productivity, access and continuity; b) development of methods to capture data on all patients who want a visit, to assess their preferences for access (including non-face to face encounters), and to match actual access to patient preferences and needs; d) improvement of methods for capturing and rewarding access and continuity at the full team level, not just based on the assigned primary care provider; and e) validation of final measures at the primary care practice level, such as determining whether measure results match observed continuity and access or relate in expected ways to outcomes such as hospitalization or emergency department use.

2. *Pace performance improvement to reduce burnout:* Identify methods for helping primary care practices pace the rollout of PACT metrics for performance improvement in order to reduce burnout through: a) staged needs assessments; b) reduced total number of PACT performance metrics, prioritizing metrics based on the PACT key principles; c) providing guidance on integrated, paced approaches to improving performance at a site across a set of measures. It may also be important to set appropriate targets for PACT related performance that account for the type of primary care practice, such as academic practices or small rural practices.

3. *Develop more effective measures for assessing PACT implementation fidelity:* Current methods commonly mix implementation of PACT features, such as teamlets, huddles, etc., with achievement of PACT quality measures or other outcomes. Current methods are also based substantially on self-report alone, which is highly susceptible to bias.

4. *Re-examine executive metrics:* Re-examine executive metrics and associated reward to assess impacts on staff. Consider incorporating staff satisfaction and its determinants in executive metrics. Currently there is no price paid, and no reward for, the effects of regional and local PACT implementation on staff. This recommendation would reflect important issues such as the need to improve communication with leadership and the need to provide follow-up on action items brought to the attention of leadership.

"Are primary care practices the same thing as teams? Shouldn't the teams be engaged in quality improvement?"

"Modern QI departments are not well-suited to lead or develop primary care based QI (e.g., overt focus on inpatient/acute care areas, focus on JCAHO continuous readiness, are not well integrated into strategic planning initiatives). System redesign should theoretically be an additional resource but expertise, implementation, skill mix and resources are highly variable and not necessarily dedicated to primary care and PACT needs. "

"Historical (pre-PACT) data has demonstrated the value of primary care based QI (2+ process improvement teams vs. 0-1) related to primary care performance benefits. Other pre-PACT organizational data results point to major gaps in PC access to needed informatics expertise, support, and data analytic capacity for answering questions about their practice, workflow, quality, etc. Without these resources and skills, primary care is left with the lion's share of performance measure burden without the tools to solve them."

"Incorporate 'systems redesign' personnel for leading the work needed on QI initiatives."

Recommendation #5
Quality Improvement

Recommendation on Quality Improvement: Improve the ability of primary care practices to engage effectively in ongoing quality improvement.

Rationale: Demo Lab data demonstrates that current VA investment in resources to support primary care site level quality assessment and improvement is insufficient to meet the needs of PACT transformation. Furthermore, methods for sharing performance issues and solutions across practices are limited. Demo Lab data results also show that access to additional quality improvement support is a strongly perceived need in PACT primary care practices. Practices particularly perceive the need for help that will enable best use of performance data as the basis for quality improvement. In addition, primary care practices often lack organized approaches to targeting, developing, documenting, tracking, and completing quality improvements, functions that can be assisted through quality improvement facilitation.

Without this support, once a quality improvement is undertaken, local sites often do not have the expertise to measure its effects. Methods for engaging different stakeholder perspectives, including patients, and for allocating release time for quality improvement participation are typically absent at the primary care practice site level but well-received when provided. Practices also often lack access to existing information from the literature that is relevant to their proposed improvements.

Specific sub-recommendations on Effective Quality Improvement	**Panel Rating Mean ± SD**
Develop methods regarding PACT tools	5.46 ± 0.83
Support and encourage early adopter primary care sites regarding developing and spreading innovations	5.36 ± 1.19
Develop methods for engaging VA researchers and analytically trained experts in PACT improvement	5.26 ± 0.88

FIGURE 9. Specific Sub-Recommendations on Effective Quality Improvement

"A systematic process for tool development and publication would help the local innovator in sharing their tool. If it is too much work to put it on paper or share in another way, it won't happen. This needs a dedicated process and/or teams that work strategically and efficiently with the innovator."

This recommendation [on supporting early adopter practices] gives me the notion of the "rich get richer" potentially. Without the other training and education activities recommended above, they [early adopters] are limited by their placement in the organization to influence spread in organizations and practices beyond their own. I am supportive of this recommendation but it is more complex and inter-dependent on other actions being taken in parallel (or series).

"Spread is more of a problem than early adoption."

"To what extent do VA researchers have expertise in PCMH and PACT team care and quality improvement? Do the VA researchers have the expertise to recommend what quality improvements to perform?"

"Job description classifications [for data savvy facilitators for local PACT quality improvement] would have to be high enough to reward employees for their skill set in order to keep them in primary care."

Specific sub-recommendations: Panelists rated the development of additional methods for developing and spreading tools for assisting PACT to achieve its goals as the top priority for quality improvement, followed closely by encouraging and supporting early adopter primary care practices in spreading their successful innovations. Panelists rated highly the development of additional methods for engaging VA researchers and other analytically trained experts in PACT quality improvement (Figure 9).

Rationales for specific sub-recommendations:

1. Develop additional methods for assessing the value of tools, as well as documenting and spreading tools to assist practices in achieving PACT goals: Effective methods for spreading innovations could leverage the efforts of many PACT participants. Current methods for achieving the sharing and implementing tools and innovations are not optimally effective.

2. Encourage and support early adopter primary care practices to fully develop and spread innovations. This includes providing the time necessary to participate in practice improvement and access to needed expertise: This recommendation incorporates supporting demonstration practices within medical centers and VISNs. It may not be feasible or productive to support active PACT quality improvement innovation development across all primary care practices. Yet engaging PACT team members, seen as the front line providers, in developing the approaches needed to operationalize VA national policy on PACT, is essential. The Demo Labs' work brought to light critical disconnections between central policy and the ability of local primary care practices to achieve underlying policy goals, as well as the capabilities of these practices for designing innovations that addressed PACT metrics or goals. Methods for enabling "early adopter" or improvement-savvy practices to assist others may be an approach for reducing current PACT performance variations.

3. Develop additional methods for engaging embedded VA researchers and other analytically trained subject matter experts in PACT improvement: The VA invests substantially in embedded VA researchers and other experts. Methods for enabling these individuals to participate effectively in PACT improvement in their areas of expertise, without discouraging their ongoing involvement in investigation, may leverage both the research investment and the clinical leader and clinical manager investment in VA. Additionally, this recommendation touches on additional sub- recommendations (rated slightly lower but still as important) that focused on primary care practices' needs for data savvy facilitators for local quality improvement. Data experts, if placed in positions for supporting PACT, may benefit from working with more analytically trained implementation researchers.

"While I think 'interdisciplinary leadership' training is a step in the right direction, I feel we are side stepping around the real problem with verticality, which is that it is about hierarchical rather than collaborative decision making. It is possible to be interdisciplinary while still advocating a clear chain of command in decision making and prioritizing, and I fear this is how VA would implement this recommendation [hierarchically]. I don't know what wording could be a little more direct without making the feasibility of getting this recommendation adopted even lower."

"I don't think lack of training is the major impediment here. I think it is more related to the hierarchical and silo structure of the VA which makes interdisciplinary work difficult. I am unconvinced that training itself will be effective, though it may be necessary but not sufficient."

"While I rate it [primary care site autonomy within guidance] high on importance I'm not sure about feasibility."

"The evidence [for primary care site autonomy] is lower here because there's been an absence of such guidance."

Recommendation #6 Interdisciplinary Leader & Administrator Roles and Training

Interdisciplinary Leader and Administrator Roles: Develop PACT training and role development resources for interdisciplinary leaders and administrators at the regional, medical center, and primary care site levels.

Rationale: Multiple Demo Labs observed qualitatively and quantitatively that expecting teams to function horizontally as interdisciplinary teams while leadership at sites, medical centers, and regions operates vertically creates a major impediment to achieving PACT goals.

Specific sub-recommendations on Interdisciplinary Leadership, Administrative Roles, and Training	**Panel Rating Mean ± SD**
Promote team autonomy within interdisciplinary guidance	5.76 ± 0.94
Promote primary care site autonomy within guidance	5.66 ± 0.78

FIGURE 10. Specific Sub-Recommendations on Interdisciplinary Leader/Admin Roles/Training

Specific sub-recommendations: Panelists thought that promoting team autonomy within interdisciplinary guidance was the most important specific recommendation, followed closely by promoting primary care site autonomy at the division (primary care site) level, within guidance from the Medical Center, VISN, and Central Office (Figure 10). For promoting interdisciplinary leadership, Panelists considered the most important targets to be (not shown, but rated by Panelists and listed in order of importance): a) site-level primary care interdisciplinary leadership, b) other site level leaders, c) medical center service line leaders, and d) nursing leaders. Panelists also rated a sub-recommendation about training for interdisciplinary leadership at slightly below the cut off score for inclusion here. As illustrated by their comments (see left bar), Panelists thought training was important, but fell behind, largely due to a focus on overcoming the verticality of the system through other means (e.g., rethinking of management systems and

implementation of new policies, procedures, or best practices) in terms of potential impact.

Rationales for specific sub-recommendations:

1. *Promote team autonomy and problem-solving within the framework of guidance from interdisciplinary leadership:* Demo Labs observe that the most successful teams are within environments that support and guide key functions, and promote creativity and problem-solving.

2. *Promote autonomy and problem-solving at the primary care site and division level:* Panelists considered primary care practice autonomy within the framework of guidance from the Medical Center, VISN, and Central Office to be a critical component for achieving PACT goals. The Demo Labs observed that disconnected or non-aligned, unidirectional communication across different levels of leadership frequently disrupted PACT progress at local sites. Communication to sites often came across as overly specific mandates that did not allow sites to make best use of their unique characteristics. The additional burden of disconnected communication contributed to disempowerment of local nursing, administration, and physician leadership, and thus to reduced site level ability to act effectively to solve local problems. Yet site level capabilities for problem solving are essential for achieving PACT goals given the complexity of the PCMH model and of the PACT transformation. PACT needs improved and nationally recognized strategies for achieving a balance of local autonomy within a framework of national and regional guidance. We have included comments (in the left bar on previous page) that illustrate the need to develop strategies and methods to move toward autonomy and problem solving at the local level and away from a strictly hierarchical model.

"This is an important recommendation. But I think that PACT itself has to put its own house in order first, before PACT can build better links with mental health"

"These [primary care/mental health integration] metrics need to be informational only."

Recommendation #7
Mental Health Care

Mental Health Recommendation: Develop structures, a supportive format, and measures directed at further implementation of primary care and mental health integration, including more and improved communication between mental health specialists and primary care, and a focus on substance use.

Rationale: The primary care and mental health integration initiative has advanced substantially but is not yet fully part of PACT care. Achieving PACT goals of avoiding unnecessary costs as well as improving the functional status and quality of life for Veterans will not be achieved without further advances in the level of this integration. This is particularly true in the area of substance abuse care.

Specific Sub-Recommendations for Mental Health Care	**Panel Rating Mean ± SD**
Guidance and training to better integrate primary care and mental health	5.74 ± 0.86
Develop targeted measures and metrics to identify primary care and mental health integration gaps	5.04 ± 0.63

FIGURE 11. Specific Sub-Recommendations on Mental Health Care

Specific sub-recommendations: Panelists recommended developing guidance and training to better integrate primary care and mental health providers into effective patient care teams as the most important step. This is followed by developing targeted metrics, not performance measures, for assessing primary care and mental health integration (Figure 11).

Rationales for specific sub-recommendations:

1. *Develop guidance and training to help integrate primary care and mental health providers into effective patient care teams:* Neither primary care nor mental health providers and staff are trained in integration methods. Current observations in the field suggest that there is low understanding of the scope, targets, and operational methods for primary care and mental health integration, and that substance abuse care in particular lags behind. In addition, Demo Labs have documented deficits in methods for bi-directional communication between mental health and primary care providers. The Demo Lab Initiative has published data on the strong relationship between ambulatory care sensitive conditions admissions and emergency department visits and a mental health diagnosis, with mental health diagnoses contributing substantially to the likelihood of these potentially avoidable costs. This is particularly true of depression or substance abuse diagnoses.

2. *Develop targeted measures and metrics that identify gaps in primary care and mental health integration*: Metrics and measurement in general, provide a basis and foundation for the decisions made by the VA's policy makers and care providers alike. Improved primary care and mental health integration necessitates modifying the existing PACT measurement set to reflect this area. Panelists agreed, however, that the field is not ready for mandatory performance measures in this area. Rather, metrics should be systematically developed, rolled out, tested, and monitored as an initial step.

CONCLUSIONS

The Synthesis Report shows the high level of commitment by VHA to transformation to a Patient Centered, team-based model and to learning from and improving the transformation in real time. It also illustrates the challenges intrinsic to implementing patient centered primary care models. These challenges are well documented in other settings. The VHA's experiences, however, provide an opportunity to test and improve the model in a very large, geographically diverse, multi-level system.

This report indicates potentially high yield areas for action. The recommendations within are directed first and most directly at VA's national leaders, followed by leadership at the regional, healthcare system, and local primary care practice levels.

The report shares the results of four years of work from the DLCC and the five Demo Labs. It illuminates areas of success in achieving some and not all of the PACT implementation goals. The additional value of the report is that it shows areas of lesser success in reaching PACT goals, and reasons for the faltering of the success trajectory. Additionally the Synthesis Panel contributed excellent work in the summation and streamlined reporting of solutions and areas that require further focused attention. The recommendations and themes will be presented with the unique, in the field, Demo Lab perspective in the upcoming PACT Demo Lab Virtual Conference 2014 on 9/10/14. The Synthesis Report can provide direction for new and existing work in PACT implementation and renewed enthusiasm for the second round of funding of the PACT Demo Lab Initiative in FY15-FY19 and success in achieving PACT implementation goals.

APPENDICES

A. Complete list of Recommendations and Sub-Recommendations
B. Demo Lab Themes and Sub-Themes
C. Bibliography
D. Demo Lab Themes Survey
E. Panel Recommendations Survey
F. PACT Handbook 2014

APPENDICES ARE AVAILABLE ON THE SYNTHESIS PROJECT SHAREPOINT SITE:
HTTP://VAWW.INFOSHARE.VA.GOV/SITES/PRIMARYCARE/DEMOLABS/PACT%20DL%20SYNTHESIS%20PROJECT/SITEPAGES/HOME.ASPX