Implementing an Integrated Team-Based Model of Care

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Team-based methods of delivering primary care were launched nationally within the US Department of Veterans Affairs (VA) through the Patient Aligned Care Teams (PACT) initiative in 2010. The most essential component of PACT is the establishment of partnerships between veterans and their health care teams. The purpose of PACT is to improve and transform the way in which veterans receive health care. This partnership is aimed at promoting efficiency and improving the quality of care and clinical outcomes by providing holistic care that embodies the whole person.

Interprofessional collaboration and shared decision-making are integral components for achieving the positive health outcomes that the PACT model is designed to achieve. Evidence supports the notion that efficient clinical practice and patient safety are improved considerably when a team-based model is effectively implemented and utilized [1].

Each team member works at the highest level of their professional scope of practice to allow for flexible staffing and operational efficiency. The role of each member of the PACT team is designed to ensure that veterans' overall experience is optimal through delivery of patient-centered and holistic care, timely check-ins at front desk and nurse intake, effective and efficient triage via telephone contact, assessment of scheduled and walk-in/unscheduled patients, and same-day appointments.

When orienting a clinical practice to an integrated model of care, it is important to consider the impact it will have on patients and their families. The greatest advantage lies in the selection of a model of care that improves patient self-management of health through informed decision-making and improved access to care, leading to positive clinical outcomes. The PACT model assists veterans in the development of individual and specific health care and treatment goals. During the implementation phase of an integrated model of care, certain process outcomes must be considered (see Table 1).

Appointments are carefully and intentionally coordinated in a way that ensures consideration of veteran satisfaction and convenience by minimizing repeated trips and decreasing unnecessary visits to the clinics and emergency rooms. Additionally, the PACT model of care delivery supports clear communication. This process augments coordination of veterans' health care among primary care and other health care providers within and outside of the VA system.

TABLE 1.
Integrated Model of Care

Process Outcomes to Consider
• Improving the overall veteran experience/customer service
• Creating a variety of ways to access care: scheduled/in-person visits, telehealth, unscheduled/walk-in visits
• Timeliness of veteran-initiated appointments
• Timeliness of follow-up and referrals
• Coordination of care within and outside of the VA system
• Space and logistics

Source. Campbell JG and Richard-Eaglin A, Duke University School of Nursing.

Veterans, their families, and their caregivers are the central focus of the PACT model, which is comprised of an interdisciplinary team of clinicians including physicians, advanced practice providers (APPs), clinical pharmacists, clinical associates/licensed practical nurses (LPNs), registered nurses (RNs), care managers, veteran experience coordinators (VECs), and mental health specialists. Success of the PACT model is highly dependent on congruence among team members regarding vision, mission, and goals. The team must be willing to compromise and work to develop plans of care that reflect the best interests of the patient and the practice model.

A fully functional PACT is most successful when roles are clearly defined and utilization of all aspects of the system and all members of the team is optimized. As the initial point of contact for the veteran, the VEC is responsible for answering incoming calls, scheduling appointments, handling customer service concerns, and handoff communication. The clinical associate/LPN performs most of the direct nursing patient care actions, which optimizes health promotion and chronic disease management of lower acuity patients. The LPN uses standardized teaching materials, along with other tools, to provide initial education to the veteran. The teaching is then reinforced by the RN and primary care provider (physician or APP).

Maximizing the contributions of the LPN allows the RN to focus on higher-acuity patient management. The RN promotes evidence-based, patient-centered care and supports the patient in self-health management through motivational interviewing techniques that guide veterans in establishing personalized health plans and goals. The RN is also responsible for discharge follow-up calls to veterans 24 to 48 hours following hospital admission. Primary care physicians and APPs evaluate, diagnose, and formulate treatment plans for veterans with varying complexities and comorbid conditions. Providers also make referrals to specialty consultants, conduct periodic health evaluations, and utilize motivational interviewing techniques for health promotion and disease prevention.

Implementation of a PACT model must consider the overall impact of all factors. A key component of orienting a practice to this model of care is to clearly define and operationalize roles to promote cohesion, improve outcomes, and increase opportunities for success. Clear delineation of roles not only contributes to best clinical practices, but also provides a framework that improves processes. In turn, veterans receive the benefit of greater efficiency in their health care experience, including improved access to care, timely follow-up, and overall improved health outcomes. NCMJ

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