Cyberseminar Transcript

Date: October 21, 2020

Series: Patient Aligned Care Teams (PACT) Demonstration Labs

Session: Defining the Role of the RN Care Manager in PACT

Presenter: Bonnie Wakefield, PhD, RN

*This is an unedited transcript of this session. As such, it may contain omissions or errors due to sound quality or misinterpretation. For clarification or verification of any points in the transcript, please refer to the audio version posted at* [http://www.hsrd.research.va.gov/cyberseminars/catalog-archive.cfm](file:///C%3A%5CUsers%5CVHASLCMyersK%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.IE5%5C73RXHSNF%5Cl)

Dr. Bonnie Wakefield: As Rob identified we’ll be talking about the role of the RN care manager in PACT. But first I want to acknowledge my collaborators on the primary care analytic team at the Iowa City VA Health Care System; Monica, Michelle, and Heidi, and I have been working on these projects, this series of projects now for probably three or four years. And Greg is our leader of the PCAT team at Iowa City, so I want to make sure they get acknowledged.

So today, like I said, we're going to focus on role clarity of the RN care manager in PACT and I'll be talking about a series of projects where we used existing documents and data from the national PACT survey to look at issues of role differentiation of the RN care manager within PACT teams. And this series of projects, a couple of them are finished but are, it's a really an ongoing focus and so at the end, or throughout the presentation, if in the QA box if you have thoughts, or suggestions, other things that we could look at you know we'd be more than happy to hear from you about that. So we have a poll question and I would be interested for you to answer that poll and tell us what is your VA role and here are the choices. I won’t, I don't think I need to read them to you, and I'll have Rob tell me when I should start talking again.

Rob: Okay, so the poll is running, and we are getting answers in rapidly. But I will read the answer options. Answer option A I’m on a PACT teamlet. And by the way if you answer that one there's another question coming up right after this for you. Answer option B, I am a PACT neighbor meaning pharmacist, dietitian, social worker, etc. Answer option C, administrative supervisor, manager. Answer option D, it is 4, right? A, B, C, D, right. VA investigators. And answer option E, other. It looks like things are pretty much slowed down to a crawl so I'm going to go ahead and close the poll and share out the results. And let you know that I'm on a PACT teamlet, got 48% of those who responded, I'm a PACT neighbor only 4%, administrative supervisor, manager received 22% of those responding, DA, VA investigator receive 5%, and other received 15%. So I will close that poll now. Should we move right onto the second one, Bonnie?

Dr. Bonnie Wakefield: Sure.

Rob: Okay. And that poll is up. And this is for people who answered I'm on a PACT teamlet. Bonnie, you could move ahead one slide, if you wanted to. So people who answered, if you answered I'm on a PACT teamlet please tell us are you a PCP, RN, LPN, HCT, clerk or other? I'm not sure what HCT stands for.

Dr. Bonnie Wakefield: It’s a health care tech.

Rob: Oh. And this is a little bit slower, so I guess we'll just leave it open a little bit longer. But it does seem to have leveled off so I’m going to go ahead and close it and share out the results. And I think, not surprisingly, only one person answered PCP, but over 100 or 42% of your respondents answered RN, zero answered LPN, zero answered HCT, and 5% answered other. So now we're back to you.

Dr. Bonnie Wakefield: Okay, great. Well I'm happy to see that half of the audience is on a PACT teamlet and that a lot of those are RNs. So great. Hopefully, we'll get some good feedback from you all. So I think if you are, since half of you are on a PACT teamlet you know this, that the PACT model in the VA is based on the patient centered medical home model, that the PACT teamlet or team is a group of health care professionals providing comprehensive primary care, and that should be in partnership with the Veteran and their personal support person, such as their spouse or other, significant other typically. So it's really looking at the Veteran as part of the team. The goal is to manage and coordinate comprehensive health care services consistent with the goals of care to ensure that the Veteran receives the most appropriate level of care in the most appropriate setting. Get my slides moved up here. So it's been about a decade now that PACT is being implemented within the VA. And I have been on the PACT demo lab team lit since 2010 in Iowa City. And it was implemented nationally across all medical centers and Community Based Outpatient Clinics. Other health systems or clinics have implemented the patient centered medical home, but the VA implementation is the largest implementation in the country. And primary care is delivered by a core team often referred to as a teamlet and they are listed here.

So if we look at team member roles, the provider can be a primary care physician, nurse practitioner, a PA and we think they provide typical primary care activities that a provider would do. Examining patients, talking about care, prescribing treatment, coordinating care, and preventive care. The role of the RN care manager should focus on health promotion activities for patients, disease prevention, and I think one of the primary roles is clinical management in support of chronic disease management. And of course care transitions for their panel of patients. The clinical associate which is, at least in my experience, typically the LPN is responsible for managing clinic workflow, working with care manager, and primary care manager, or primary care provider, excuse me, providing self-management support for patients, and also supporting care coordination. And the administrative associate, as the name implies, provides administrative support.

So the registered, let's talk about the RN care managers since that is the focus of this presentation and they are responsible for deployment of care coordination and care management strategies. And in my experience in the VA, which I have a lot, many years of experience in the VA, and worked some with the telehealth program as well, these terms kind of get thrown around a bit so I'm defining them here so that you know I'm looking at them. That care coordination is really that administrative process that helps the patient and the system navigate both within the VA let's say primary care and specialty care when a patient gets referred across the VA, when they might be going to another VA for care. And of course non-VA care settings the dual users. So help coordinating that care with those health care providers. And then other services such as community programs. Care management, in contras, is the process in which the patient's personal health plan and their ability to perform self-care are assessed and analyzed and optimized for the individual patients desired health and well-being. This can be for an individual patient or a cohort of patients. And for a cohort of patients that's often referred to as population health management. And this is different from case management, which is a specialized and highly skilled component of care management where you have patients who have sort of, I always think about is their health care is overwhelmingly impacted by one condition. Let's say people with spinal cord, Veterans with spinal cord injury, and some patients, for example, with heart failure need a more intensive care management approach.

So the RN care manager plays critical roles in implementing several components of the PACT model. The national PACT evaluation effort has been evaluating PACT implementation since almost day one. And I believe 2012 was the first national survey that was administered plus there were interviews and focus groups to evaluate the implementation. And those data identified issues surrounding role clarity among all members of the PACT teamlet. However the care managers, it was found, faced the greatest challenges regarding role clarity and transformation. And in 2016 the national survey data show that those role clarity issues continued to affect team performance and satisfaction.

 So this slide shows the nurse role effectiveness model just to review and provide some context for what it is that nurses do. And this is based on the Donabedian model a structure process and outcomes. The structure of course includes the patient population, and the types of patients you have. Nurses who have levels of education, varying levels of education and experience, and then of course the organizational variables of staffing, staff mix, and the workload. The process here is looked at in terms of kind of what nurses do. So there’s an independent role and there are nursing interventions that nurses do. So for example patient education is probably the most commonly recognized independent intervention for nurses but there are others. Then there is medically related care of carrying out medically directed care under physician orders such as medication administration. And then this also gets a bit into the expanded scope of nursing practice, but we aren't talking about that today. And then the inter- dependent role, which we are talking about today, in terms of working with other members of the care team to coordinate and manage care for patients. And then there are a number of what what are called nursing sensitive patient outcomes, being the patient outcomes that shouldn't, let’s see, sensitive to nursing care. But nurses interventions can affect the patient. And the source is down at the bottom of this slide.

So specifically today I'm going to talk about these four projects that we've been carrying out over the past four years. A policy document analysis, a review of literature, and some qualitative data from the 2016 survey, and then what we are analyzing currently for the 2016 and 18 surveys. Okay, here, my slides here, okay, so project one was to identify elements of the RN care manager role in VISN 23. That's where we're located which is really the upper Midwest; Minnesota, Iowa, Nebraska, North Dakota, South Dakota. So during initial implementation of PACT there weren't many protocols or guidance. I mean like in 2010 right out of the box there weren't many. And that may have contributed some of the difficulties experienced by RN care managers because their role was a bit unclear to them. And then since implementation both local and national PACT managers have developed policies and procedures to divide these, define these roles as well as protocols for primary care team. So we wanted to take a look and see what these policy stated. So we invited the leadership of the eight VA sites in VISN 23 via email for policies procedures and other documents that they had locally that define RN care manager roles and tasks at their medical center. We evaluated each using a modified content analysis and individual tasks were extracted and the individual responsible for the tech, task was identified. We then looked at the number of sites who included each task in the protocol and the sum of each type of staff assigned to tasks across sites.

Seven of the eight sites in VISN 23 responded with information and the content analysis identified 208 individual tasks, and we categorize those under 7 headings: patient assessment, labs, screenings, and vaccinations, standing orders for new patient labs, ordering consults, protocols for specific disorders, medication management, and communication. There were no, not one individual task was addressed by all seven sites and almost half of the tasks listed about 47% were only included by one site, and 65% were addressed by two or three sites. So you can see there was some variability across seven medical centers within the same VISN. We also found that most tasks could be done either by an RN or an LPN across the sites.

One exception we found was for protocols that were specific to certain diagnosis or clinical presentations and most of those were written as protocols that were limited to RN care. So some examples are listed here are patient presenting with active chest pain, hemoptysis, dehydration, hyperglycemia. Although I find it interesting, but not hypoglycemia, blood pressure elevation, and so on. So those were protocols that were limited to RN care.

Move my slides here. We then reviewed the national guidance these two documents that are both dated December 2017, and I think similarly to what we found in VISN 23 in the tasks, and were sort of worded a little differently, and more compact, I guess I would say. But we found that almost all of the tasks in those two documents could also be carried out by various team members including RN's, LPN's, unlicensed, assistive personnel, pharmacist, or dietitian. So there is some variability in the policies and protocols that guide PACT activity.

So looking at the literature, this finding is very consistent with a study conducted by Best et al. and published in 2006, and all of these references are at the end of the presentation. On PACT overlap and this was conducted prior to PACT implementation. They use focus groups to create 243 unique task statements and surveyed primary care staff across six VA facilities. They found substantial overlap across primary care providers, RN's, and LPN's. So of the 140 tasks that physician said they did, LPNS said we also do 85 of those, quite a high number. And of the 133 tasks the LPN said they did, RN said 129 times, we also do those. So it, while primary care provider or an RN can do all LPN's activities it's not really clear who should be primarily responsible for that task, based on these data. Okay, I’m going to get a drink.

And we're, this project to the literature review on the role of RN an ambulatory care is still ongoing, so I'm just going to talk about it briefly. You can see the search criteria we used looking at nursing in primary or ambulatory care roles, dual duties, and responsibilities and either RN or LPN. We did not review the literature on care management roles outside of primary care. So for example telehealth nurses are providing care management to their panel of patients or some hospitals have discharge coordinators who take care of that we searched four databases, found 424 initial results, whittled that down using criteria, and found 80 articles and six position statements. And like I said we're still looking at that, most of, most all if not all of the literatures from these four countries and particularly Canada, who seemed to be sort of struggling with the role of RNs in primary care and what they should do, not do, you know, what's the model? It really didn't seem like they were implementing prime patient centered medical home model but again, like I said, they're kind of struggling I think similar to us in the VA, in terms of what this role is really about.

Our third project was to identify barriers and facilitators to enacting the RN care manager role. And I'm not pretty sure how to pronounce this person’s name, Ladebue, in 2016 published findings from a study that they did in 2012 and used a survey to set the, let me back up, the national PACT survey in 2012 to look at experiences of implementation of PACT and becoming a teamlet is how they termed it. So if you've done the national PACT survey you know that there's an open text sort of general comment portion of the survey and in 2012 little over 3800 people responded to that with the comment. And what they found is sort of consistent, well maybe not consistent, lack of clear expectations in roles and responsibilities for all team members. So all four members of the PACT teamlet were a bit unclear about what their roles were. And it was both, you know, working up to their level of competency, feeling underutilized, and you'll see some comments too about feeling overutilized.

So our project, in project 3 the purpose was to look at the perceptions and experiences of clinicians implementing care management and care coordination as part of the, that should say PACT model, sorry. So we did a qualitative analysis of data from the 2016 national survey. Similar to the prior investigators we conducted a content analysis of the open-text general comment portion of the survey. And in that 2016 survey over 5000 people responded and about half of them actually put something in the open-ended question part.

We were interested in the primary care PACT teamlet, so we looked at people who provided a comment and indicated that the majority of their time was spent working in primary care. And that's a question that's early on in the survey and demographics. So we're really trying to get to the teamlet level. So we came up with the final sample of 461 individuals or about 17% of those completing the survey. As you can see there were 250 primary care providers, 144 RN care managers, and 67 clinical associates, and of those 64 were LPN's.

So we found through our qualitative analysis four themes. The first was the importance of teamwork and optimized team member roles. So some of the things that we found under that theme in general was, while people acknowledged that a really strict division of labor is not probably feasible the RN's and LPN's both acknowledged the role of the PACT team's primary care provider knowledge and preferences in the scope of practice between the RNs and LPNs. And in some cases not understanding the difference in scope of practice between RNs and LPNs lead to some, in particular LPN, sort of functioning above their license level according to the feedback from the LPNs. Furthermore we found, again, significant overlap in the performance of work tasks among those in the PACT model. Second theme was the need for adequate prioritization of care management and care coordination. And there was a lot of feedback about care management and care coordination being quote, put on the backburner, due to the priorities of creating same day access slots and completing required phone calls. So clearly we all understand the importance of access to care and at the VA has struggled a bit with that. But they felt it really somewhat defeated the concept of the PACT team. And then in this results, and also in an earlier survey, staff reported feeling overwhelmed by walk ins. Third, the need to refine tools and resources supporting care management. And the specific tools addressed in the survey were things like view alerts, clinical reminders, and secure messaging. They, I think the summary statement is they feel like there are just too many of them. The thing to kind of, I think, maybe dig more deep and we won't do it in this presentation about that, is that view alerts and clinical reminders were there before the PACT team got implemented. So and I think clinicians found those burdensome prior to PACT. So it's unclear whether it's just the multiplicative effect of PACT and the tools, and how that works together. And then finally, care management and care coordination within and across complex system. I mean that care coordination is an issue outside of the VA as well. I mean how do you coordinate care across settings? And the VA, at least within a system, of course you know you have a shared electronic record, E-consults, telemedicine, but it's still challenging to coordinate care within the system. And of course I mentioned earlier across complex system with dual users who who may use other systems for primary or specialty care, respondents found that to be a challenge.

And I just want to highlight a couple of direct quotes from these open-ended comments. The PACT model is extremely efficient, if everyone is working within their scope. And that was by an RN care manager. And it was I think kind of nice to see, a lot of these comments were negative. But it wasn't infrequent that people said they thought that the PACT model was a really good idea. It's just some of these issues kind of present a challenge to getting it implemented. Some respondents voiced a lack of knowledge about roles, like who is supposed to do what? This is what one PCP noted that the leadership had clarified what difference between an RN and LPN was. And this is also echoed by respondents in other team member roles. Our team struggles every day because there seems to be a not a definitive outline of what is expected from each member.

A couple more quotes, many participate, many participants talked about not working to the top of their competency. And how that prevented them from completing task for care coordination and care management. This physician, as I mentioned, PACT works beautifully when everyone is performing to the top of their competency as a, and these all caps are from that person writing that. I didn't do that for emphasis. As a physician I am often doing the work of the LPN. Conversely an RN care manager said, I'm not overworked here. I am underutilized and that causes its own sort of burnout, called lack of satisfaction with my job. I don't want to talk myself out of a job here, but if the RN's aren't going to be utilized in this clinic they should probably be replaced by less trained and less expensive staff. So the competency issue seems to go both ways.

So lastly project four focuses on interprofessional team task allocation. You can see sort of a theme here with our projects. A prior study conducted in 2011 and 2012 in VISN 22, basically Southern California, focused on 14 primary tech care tasks and they aren't all listed here but they are sort of consistent with some of the things I've been talking about. Taking a history, patient education, tracking lab data, handling referrals and forms and messages. Their response to these 14 tasks, the response says that they were asked to respond to you as, I am relied upon, and that would be the RN care manager, the clinical associate, or the administrative associate. And then the providers were asked, I rely on other team members. And what they found is for 12 of their those 14 tasks fewer than half of the providers reported relying on staff. So more than half of providers say that for 12 of these tasks, I don't rely on anyone, I do them myself. But for all 14 tasks more than 85% of the RNs reported being relied upon. So there is a disconnect there. And also for 12 of 14 tasks greater than 50% of the LPNs reported being relied upon. So I believe these have been these 14 tasks, well I don't believe I know that that's been incorporated into the national survey, so we're expanding this analysis to the 2016 and 2018 data which contains similar questions to this study to look at trends overtime and to see if this still holds true.

So a few conclusions. But say that the findings, these findings are not unique to VA or PACT. PACT is a work in progress and these issues of role clarity and working to the top of competency, I can say within nursing have been kind of longstanding issues. Part of this lack of clarity could be what I call conceptual functional statements, or job descriptions, versus task-based list of competencies. So I haven't looked at a functional statement for a while in the VA but I'm familiar with those and job descriptions and they’re rather broadly written because they have to be, because they cover RNs and LPNs working in a lot of different locations. So typically they aren't written at, okay here's what you, when you come to work today this is what you're going to do. They're much more conceptual. So it's somewhat, the guidance can be maybe a little bit, I don't know, fuzzy. Also had staff turnover overtime in the VA because of PACT and I think if you've worked on a PACT team you know that when it first came out some people, you know, just really didn't like it they just didn't feel comfortable in that model and so they left. And then others enter the model and have been trained to do that.

And some support for the fact that maybe RNs and others are becoming kind of more entrenched parts of the team rather than the kind of solo practice PCP model, is that there was some work out of Ann Arbor published in 2018 looking at the encounter rates. And the number of encounter rates shifted over a five-year period of time, I think it was 2013 to 2018, from primary care providers to RNs and social workers. So what they looked at were the numbers but it's unclear, they did not look at, it's unclear sort of what work got shifted from the primary care providers to these other clinical staff. So I think it's moving in the right direction but maybe we need to dig a little deeper on that. I think also maybe we'll see this with our analysis from project four that experience overtime maybe diminishing the unknowns of the model, you know, creating an environment where nurses feel more comfortable with moving from what is most nurses are trained for, the very hands-on care live delivered in an inpatient environment, to managing care for individuals or groups of patients who are at an outpatient setting. And it's much less hands on an more managing, so hopefully nurses are getting more comfortable with that.

And I guess these would be the conclusions. Successful implementation requires adequate support for teamwork and ensuring team members can work according to their competency. Now I don't claim to have answers for that, but I do but you have to be supported to do this. And nurses practicing in these, really the RN care manager role, is an expanded role and they need clear role guidelines and adequate training support and time to function in these roles. There has, was a survey published in Nursing Outlook in 2017, where because there's increasing amount of literature, nursing literature about RNs in primary care. And they surveyed the schools of nursing about the extent to which they've implemented primary care sort of training and education in the curriculum. And we just aren't there yet. Some people have implemented some content. Some, according to this article, found it challenging. And some people, some schools just haven't done it at all. So we have to also look at that, that nurses coming out of nursing school, you know, what are they prepared for these sorts of roles? And I will just say as an aside the school of nursing that I'm in at the University of Missouri the RN care manager role preparation is at the master’s level. So we have to, again, kind of think about outside the VA as well. To what extent are nurses being prepared for these expanded roles in primary care?

So here are the references for this presentation. And I'm open for questions, thoughts, discussion, input, ideas. I'll turn it back over to Rob.

Rob: Thank you, we do have a number of questions and comments queued up in the Q&A. Thank you attendees. First off, this one came in early, would you please address the interaction with regulatory requirements with performance measures HEDIS and TJC? Thanks.

Dr. Bonnie Wakefield: That question would have to be more specific. I'm not sure I can answer that question.

Rob: Okay, we’ll move on.

Dr. Bonnie Wakefield: And I should say, and I didn't put my email on here, I am in Outlook, at the VA Outlook so if you want to follow up with me with some questions I cannot answer, you can email me maybe we could have an email discussion. So okay. Thanks, Rob, go ahead.

Rob: Sure. I can put that into the chat when I get a chance but quite simply it's Bonnie spelled, I-E with an I-E dot wakefield@va.gov but I'll put it into the chat when I get a chance.

Dr. Bonnie Wakefield: Okay.

Rob: This is a comment. Fulfilling regulatory requirements has been our driving educational focus for primary care nurse managers and PACT RNs.

Dr. Bonnie Wakefield: Would that be performance measures? I think when they're talking about regulatory requirements I think that's probably beyond the scope of this presentation, but I do understand that, and I have seen that in the PACT surveys focus on performance measures and meeting those. And that's I think part of when I talked about prioritization of things like same day access which pushes care management and care coordination to the side. And other performance measures it does create a barrier to doing the role.

Rob: Thank you. Are RNs in PACT expected to be care managers or case managers?

Dr. Bonnie Wakefield: Care managers.

Rob: Thank you. Great topic, thank you for presenting. Interesting to see the underlying theoretical models for nursing with structure process into the disciplinary work in PACT and outcomes. What about adding measures inter-disc satisfaction, that [unintelligible 42:14] etc.?

Dr. Bonnie Wakefield: I I think those would be great. I definitely think they’re nursing sensitive, and I think the model was that I showed was showing some examples of nursing sensitive outcomes and there's a big literature on those as well. So I think mortality and satisfaction within the team would be good to add.

Rob: This looks like it might be a little bit of a follow up by the same person. How might role clarity be helped by primary roles/tasks by professional training of PACT members?

Dr. Bonnie Wakefield: Oh how might, could you repeat that?

Rob: Sure, it’s [unintelligible 43:04] This person writes, so of PACT tasks, much overlap of what I can do. So that’s the comment part.

Dr. Bonnie Wakefield: Okay.

Rob: Then then he writes how might role clarity be helped by primary roles/tasks by professional training of PACT members, RNs, LPNs, pharm, MD, MSA?

Dr. Bonnie Wakefield: I agree, I think there is some lack of understanding and I think one of the comments by the one of the primary care providers that I presented really addressed that. And I think, like I said, between RNs and LPNs I think that's been a long-standing problem in nursing, not the VA per se, but in nursing in terms of role overlap, and who does what, and and those sorts of things. And I would say most primary care providers because of the models historically have not had worked on a team with nurses. They would have if you go to private practice, an MSA, a support clerk, but not necessarily nurses RN or LPN in their clinics. And I think as we transition to that providers need to learn the capabilities of RNs and LPNs and the differentiation between the two. So one of the in our project three, which is coming out in publication in the Journal of Nursing Administration in November, you know, the comment was that the role differentiation really depended on what the provider thought each person could do, or and I think this sometimes happens too, well I'll just you know tell a nurse to do it. I don't care if you're an RN or LPN just please, you know, I just need this done kind of thing. So I think some clarity or training at all levels would help, yes.

Rob: Thank you. What recommendations would you have for administrators to be able to provide more structure to their PACT teamlets? Have you found whether PACT teamlets are more driven by physician or administrator guidance?

Dr. Bonnie Wakefield: That's hard to say. I wish some of my collaborators were able to answer some of these questions, I think it depends on the team. I think in some respects within the within the teamlet it's probably driven more by the provider. Outside of the teamlet and in the primary care clinic it's probably driven more by administrators. So probably some communication between those two, you know, the teams and the administrator would help but it's hard to say. I don't have any data on that.

Rob: Thank you would it be possible to get PACT RN job specific functional statements? Or do these exist? Here we have the same functional statements as our inpatient RN counterparts and everyone else sort of a nurse is a nurse is a nurse mentality.

Dr. Bonnie Wakefield: And I'm familiar with the functional statements in the VA and they are, when I was talking earlier about sort of conceptual job descriptions, that is how they’re written and I'm thinking back, that there was some guidance we did collect some job descriptions. There was some PACT specific guidance, but it's for RN care managers. But that was, it's quite a while ago and I'm really having to dig through my brain to remember that. So I don't want to say that there are or there aren't. But if there are that the office of nursing service would probably have copies of those.

Rob: Thank you. For additional measures of PACT can staff turnover of members besides RNs be added and trended? I'm only familiar with RN turnover in easily extracted data.

Dr. Bonnie Wakefield: I think turnover can be measured by the other teams or other team members, yes. Just because HR system has those kind of data.

Rob: Thank you. This one came in at 12:40 so shortly before you finished. This person asks, what is the article you just referred to? Do you have a reference?

Dr. Bonnie Wakefield: It is in the, let me pull it up here, this very last if you can see the slides the very last one on the references.

Rob: Wakefield, Lampan, Paez, and Stewart?

Dr. Bonnie Wakefield: Yes, and it's, like I said, it's coming out in the November issue of JONA.

Rob: Thank you. Do you have a copy of lists of roles? Of a list of roles?

Dr. Bonnie Wakefield: A list of roles. List. I'm having a hard time interpreting that question. So I have what I presented in the slides earlier for each role kind of generally what they do. But I see Kathleen wrote that question. If you want to email me after this with a more specific question, I'd be happy to send you what I have.

Rob: Great. This person asks, wow if masters prepared is the basis for case managers you'll see that role separate out in clinics possibly as a consult role. I guess that was more a comment in question. Could you comment on the tasks that could be done by the MSAs but is being done by other team members?

Dr. Bonnie Wakefield: Well again I think that goes back to role negotiation within the team. So if an MSA, you know, there are certain things that they can do then that should free up, let's say, the RN care manager to do more care management roles, and population health management, and individual care management for patients. So I think um that needs to be clarified.

Rob: Okay, shall we move on?

Dr. Bonnie Wakefield: Yes.

Rob: How does this translate over to the home-based primary care nurse?

Dr. Bonnie Wakefield: I think, into my understanding of that role, I don't see it as a lot different in terms of the care management, the health promotion, and disease prevention, you know, assisting those individuals with their chronic disease management, sort of what I call those upper level skills. You know how as I understand home based primary care is for you know patients who are you know little maybe a little more homebound, but they still need the same kind of care management that someone might get in the clinic. But it just might be different issues that need to be addressed.

Rob: Thank you what kind would you give to the PACT teams, to PACT teams that are looking at more definitive role definitions.

Dr. Bonnie Wakefield: Well, I think first talking to each other and determining you know, who's going to do what and what sorts of things. Obviously, you know, sometimes days in the clinic everything you know, excuse my language, goes to hell in a handbasket. But that shouldn't, shouldn't be everyday so I would start with just communication within the teamlet and start thinking about, like I said, who's going to do what. I don't think it's that's not going to happen with one discussion and it's going to take some time to kind of figure that out, but I think once people feel comfortable with that discussion and those decisions, in my opinion, the team will work more efficiently.

Rob: Can you please repeat what you said about masters level in relation to NCM.

Dr. Bonnie Wakefield: Oh I was saying at the School of Nursing that I am in the University of Missouri, I think it was last year, we implemented a master’s degree option for care management and care coordination. So I’m going to give an opinion, I do think it's a bit of an advanced role. It requires a whole different kind of approach to patient care than what most people get in a nursing undergraduate program. And I think that's part of the challenge that some of the PACT nurses have encountered is that they really haven't been trained for this role. And it and it is an advanced role.

Rob: Thank you. How do you feel OCC has impacted the PACT model as more and more care is completed through civilian and it requires a great deal of time to find lab results, get physician notes, etc.?

Dr. Bonnie Wakefield: I'm trying to think what OCC is an I think what you're talking about here is care coordination in terms of the dual users. I think that’s kind of above my pay grade on how to figure out how to get the VA to coordinate better with the private sector. There's going to have to be some sort of electronic record integration to make that easier. But I see if Jean asked that question. I'd be, like I said, with any of these questions, more than happy to discuss it further to make sure I'm understanding the question properly.

Rob: Thank you. This is a comment at my facility the educator has a section on PACT nursing which she has one of us come down and inform new nurses. To explain what PACT works.

Dr. Bonnie Wakefield: That’s a great idea.

Rob: I find most of my efforts are in case management or assisting with acute issues rather than care management and managing chronic illnesses.

Dr. Bonnie Wakefield: And I think that's not uncommon. Especially with trying to facilitate same day access and people walking into the clinic. So I think that needs to be this, again is my opinion, that needs to be looked at in terms of how that can be better planned and anticipated knowing that these acute issues and walk-ins are a part of primary care.

Rob: Thank you. I think the San Diego VA is working towards improving the care manager role. as a CM I feel empowered to work at the top of my license and feel I have the support of management. Now do you feel, do you know if the scope is going to be the same for all the VAs?

Dr. Bonnie Wakefield: I don't know but I feel like, I'm happy for you and I would like to see that for all the nurse care managers across the VA.

Rob: The conclusion that clear rule guidelines, training support, and time to function are needed. How would you suggest to begin to define the roles?

Dr. Bonnie Wakefield: Again I think there needs to be some, maybe a working group, there needs to be communication, and discussion about what these roles are, particularly the RN care manager. Who I say is kind of sandwiched in between the primary care provider and the LPN. So I think you know in part that's why they reported more problems with role clarity. But some communication beginning either at the teamlet level, the Medical Center level, or beyond and it's you know again it's not something that's going to happen overnight. But I think the more clarity there is, the less frustration there will be.

Rob: Dr. Wakefield, I apologize if you answered this already, can you explain the difference between case managing and care managing for RNs?

Dr. Bonnie Wakefield: So care managing is more broad based. So you have, might have a population of patients in primary care and they all have sort of different diagnosis. You know you'll have certain number of people with diabetes, and people with heart failure, and people with rheumatoid arthritis, and of course multiple ones of those diagnosis. But they generally are managing those but may need some additional support and help in terms of doing that. So case management is really much more of an intensive focus on a particular population of patients. And I will say that this is kind of my differentiation between the two. So if you have a group of patients with spinal cord injuries, they're going to, that's case to me is case management because they have intensive care needs related to their spinal cord injury and they'll all have kind of similar issues across that disease. Now of course they still need primary care management because they might still have other diseases. But that the spinal cord injury, for example, or I think this is also true for like patients with heart failure, it's kind of it sort of overtakes all of all of their health needs relate to that single diagnosis. So it's just much more intense for a particular diagnostic group of patients.

Rob: Thank you it's now one minute before the top of the hour, we do have a number of questions queued up do you have a few minutes to stay late or shall we\_

Dr. Bonnie Wakefield: Sure.

Rob: Okay. Will these findings be translated into the PACT 100 trainings that need to be updated?

Dr. Bonnie Wakefield: I can talk to the people who do that.

Rob: Let me take the opportunity to let attendees know if you must leave the top of the hour, please take a few moments, and provide answers to the questions in the website web page that pops up when you leave. This person writes may be good to have a section in general orientation to explain how PACT works in facility.

Dr. Bonnie Wakefield: I agree.

Rob: Within the task list that was listed protocols were mentioned for ordering consoles or diagnostic studies. Is there a compilation of VA protocols for packed RN somewhere that can be accessed, reviewed, and adapted for use that you know of?

Dr. Bonnie Wakefield: Yes that was the office of nursing service guidance in December of 2017 and if you, I think it’s Jennifer, send me an email I can get you that information.

Rob: Thank you. Do you have any comments about the lack of professional development among RN CMs emphasis on nursing sensitive indicators and receptiveness to quality monitoring?

Dr. Bonnie Wakefield: No, I don't.

Rob: More of a comment here. An issue I see are that each member of the PACT come from different service lines and all have different managers. Perhaps those management could be a management PACT because it seems like they did not all communicate with each other down their service lines. That means often with a PACT each team member is bringing in information and pieces of the puzzle from administrators.

Dr. Bonnie Wakefield: Yes, and I think that's one of the challenges of what I like to call matrix management, when you have service lines and then intersecting with professional roles. So I think it's been tried in different ways, but I don't have a good solution for that.

Rob: Thank you. I have a couple of questions here looking for the slides I put the link in the slides and, I'm sorry, I put the link in the chat earlier and you should have received an email about four hours before the webinar with the link to the slides to download them and you'll be receiving an email in a couple days with a link to the archive with the slides there. Perhaps one of my colleagues could put the slide link in the chat one more time before we wrap up, I'd appreciate that. This person writes, I have a question I missed a few minutes of the presentation due to patient duties. Was the role of nurse navigator discussed today?

Dr. Bonnie Wakefield: No, I didn't talk about that.

Rob: Thank you. This person writes, we got rid of chronic disease managers however want advanced roles from care managers with specialized training. Are we doing ourselves a disservice by asking these RNs to be a master in all chronic diseases?

Dr. Bonnie Wakefield: Well like I said earlier to a previous question, I think if you have to sort of a general, I call it general primary care population of patients, I mean some do have more issues with some diseases than others. But I, you know, let's say for someone with diabetes you might do referrals out to case managers if you have them. Or certified diabetes educators. So it kind of depends on the model you set up. The model I'm familiar with is the primary care nurse care managers but with also specialist like neurology or cardiology. More of a case manager type of approach. I think that's the ideal because you're right you can't you know be all to you can't be everything to everybody. That's a challenge.

Rob: Heidi or Whitney could you please put the slides link into the chat one more time while I'm asking Doctor Wakefield these questions? This person writes with some OCC meeting office of community care changes many nurses are doing OCC tests taking up 75% of the time. How do other locations deal with this increase in demand?

Dr. Bonnie Wakefield: Well I can't answer that question because I don't know. But I understand, it's again, you know, and part of the presentation talked about prioritizing care management and care coordination in the same way that when we had that big push for same, started with same day access a lot of things get put on the backburners.

Rob: Thank you. Could you comment on using huddles to improve teamwork/communication?

Dr. Bonnie Wakefield: I think they would be fabulous. You can't, you know they huddles don't last that long, but I think that's now part of a few a minute or so it could be used to kind of talk about roles. But I think there needs to be more focused communication time set aside, if possible, to talk about it because it's my understanding huddles really talk about that day's activities in the patients that are coming in. So you really probably don't have the enough dedicated time to do that.

Rob: Thank you and we have come to the final question. Are there any plans at the VHA to look at this research and develop a national plan to resolve the issues identified?

Dr. Bonnie Wakefield: Not that I'm aware of but maybe after this presentation there will be.

Rob: Fantastic. Well, thank you, Dr. Wakefield, for preparing and presenting today and more generally for your work at the VA. Do you have any closing comments you'd like to make before I end the webinar?

Dr. Bonnie Wakefield: No, I just want to thank all the participants for attending. And again thank my collaborators, and Greg Stewart for his leadership of our team, and we look forward to sharing our work in the future.

[ END OF AUDIO ]