The Group Practice Manager in the VHA: A View From the Field

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The Veterans Health Administration implemented the group practice manager position at 5 diverse prototype sites to improve clinical practice management and increase access to care.

The Veterans Health Administration (VHA) provides care for 9 million veterans at 1,255 health care sites linked to one of 170 local medical systems.[1] Recognizing that providing timely care requires effective access management, the US Congress mandated training of VHA staff to manage and improve access to care but did not provide additional local funds for new positions.[2] In response, the VHA created the group practice manager (GPM), a new position responsible for improving clinical practice management and unifying access improvement across leadership levels, professions, and services within each local medical system.

In May 2015, the VHA began hiring and training GPMs to spearhead management of access to services. The US Department of Veterans Affairs (VA) Office of Veteran Access to Care spearheaded GPM training, including face-to-face sessions, national calls, webinars, and educational materials. Five local medical systems were selected by the VA Office of Veteran Access to Care to implement the GPM role to allow for an early evaluation of the program that would inform a subsequent nationwide rollout. Implementation of the GPM role remained in the hands of local medical systems.

Longer wait times are shown to impact patient health.[3,4] Open access scheduling and other patient-centered access management interventions have been shown to improve availability of primary care appointments.[5] However, little empirical evidence exists regarding the managers who focus on clinic access interventions. While the nonpeer-reviewed literature includes references to such roles, including GPMs, the empirical literature has focused on external practice facilitators,[6-8] "mid-level managers,"[9] and clinic staff.[10] We found no peer-reviewed articles on the needs and experiences of practice managers who are focused on improving access. The purpose of this study was to examine GPM prototype sites to both enhance subsequent nationwide implementation and to advance empirical literature on managing patient access within health care.

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METHODS

In 2015, the VA identified 5 prototype sites representing diverse geographic locations, size, and complexity for the implementation of the GPM role (Table 1). These sites self-identified as having clinical practice management experience. GPMs attended 4 training sessions between February and August 2015.

Data Collection

Participants from each prototype site included GPMs, national trainers, clinic leaders, and frontline staff. Table 2 includes the roles and sample size. Participants were recruited through purposive sampling followed by snowball sampling until thematic saturation was reached (the point at which subsequent data fail to produce new findings across sites and roles of interest).

Guided by the Consolidated Framework for Implementation Research (CFIR), the research team developed semistructured interview guides tailored to participants' roles to elicit rich descriptions regarding overall impressions, practice management strategies, goals, activities, relationship to clinic roles, data analytics usage, challenges, barriers, and facilitators.[11] These guides included open-ended questions and structured

TABLE 1 Prototype Site Characteristics

Variables	Site A	B	C	D	E
No. of providers FY 2016, mean[a]	40	15	55	60	20
No. of unique patients FY 2016, mean[b]	25,700	9,800	13,500	10,000	16,000
Academic affiliation?	Yes	No	Yes	Yes	Yes

Abbreviation: FY, fiscal year.
[a]Rounded to the nearest 5.
[b]Rounded to the nearest 100.

TABLE 2 Completed Interviews by Role

Roles	Total, No.
Group practice manager	10[a]
Directors, chief of staff, associate directors	14
Clinical leads, service level chiefs, quality control managers	10
Analytics/data managers	4
Medical doctor, nursing positions	7
Front line schedulers	8
National support trainers, advisors	3
Total	**56**

[a]Count reflects group practice managers interviewed at 2 points in time and additional interviews required due to some changes in personnel.

prompts utilizing participant language for follow-up probes to minimize interviewing bias (eAppendix, available at www.mdedge.com/fedprac). Confidential telephone interviews were conducted between October 2015 and August 2016 by non-VA interviewers and scribes at the University of Washington (UW), recorded with permission and transcribed verbatim. The study protocol was approved by the UW Institutional Review Board.

Data Analysis

Data were analyzed using iterative deductive and inductive content analysis.[12] Deductive content analysis consisted of identifying quotes that fit within preidentified categories (ie, perceptions of national effort, organizational structure for GPM, challenges, facilitators, metrics and tools, and mobilizing access culture) developed by the interdisciplinary research team. Further content analysis entailed open-coding and iteratively revisiting and reconciling codes associated within each preidentified category as new codes emerged. The team analyzed the resulting codes to inductively and iteratively identify and stabilize themes regarding the GPM role: roles and tasks, GPM characteristics, issues, and challenges. Through this process we moved coded data to reconciled descriptions suited to addressing the purposes of this study. Dedoose 7.0.23 software was used for qualitative data management and analysis.

RESULTS

The study identified participants' overall impressions of the GPM initiative and key themes within 4 major domains regarding implementing the GPM role: roles and tasks (implementing clinic practice management, leading patient access, supporting data analytics, and enabling self and staff); GPM characteristics (familiarity with clinical services, knowledge of VHA systems, ability to analyze patient data, communication skills, and the ability to work with others); and issues, and challenges (technical, social, and structural).

Overall Impressions

Interviewees perceived the GPM initiative as a consolidation of existing distributed responsibilities into one role that directly reported to local top-level management with indirect reporting to national leaders. Many of the sites reported that they had designated or planned to designate a role resembling the GPM prior to the initiative. "There are staff who've been doing some of this work all along," a GPM noted. "We just didn't have them grouped together. They weren't necessarily all working in the same type of service under the same type of structure."

Whether the GPM position was new or not, participants referenced the importance and challenges of engaging the local facility in recognizing the agency associated with the GPM position. According to national support, the staff are trying to get the facility to understand "why the group practice manager is so important… we've got to embed that standard position in the system."

While the GPM was recognized as the hub of access management, respondents recognized that transformation regarding access involved many players. "We have to create [an] orchestrated team inside each facility," an advisor argued.

Respondents discussed how the initiative allows local facilities to appoint a specific

person with a specific title and role who helps facilitate, organize, and legitimize an access focus at their sites. One GPM interviewee noted how the initiative helped refocus some of their previously less centralized efforts. "We've always looked at productivity; we've always looked at access; we've always looked at efficiency. I think the bigger difference is now there are individuals identified in the clinics, as practice managers as well…I interact with them. They interact with individual clinic staff, and it's more of a group process than a single individual."

The value of having tools available and being able to track and manage patient care as a specific example of the positive impact of this new role was noted by participants. A GPM noted that many health care providers will be happy to have tools to better manage their services and a process "that flows from a service level all the way up to executive management, where there is a common interest in making those things happen—I think that's going to be a tremendous help."

Participants expressed concern that the national GPM rollout would be a one-size-fits-all approach. These respondents emphasized the need to have the flexibility to customize their activities to meet their unique site and patient needs.

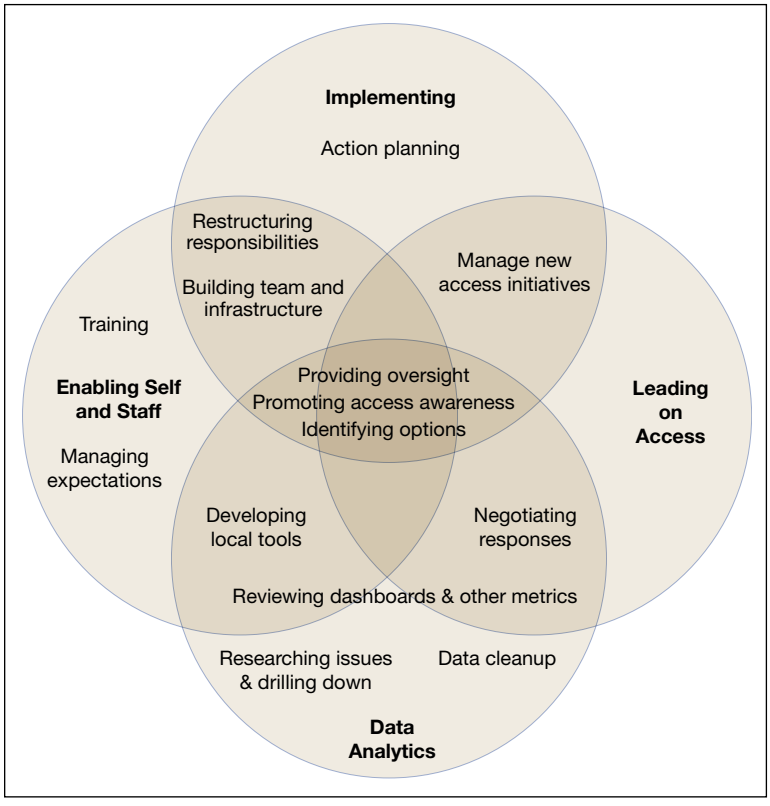
GPM Roles and Tasks

Participants described 4 primary roles that the GPM was expected to fill: implementing clinic practice management, leading patient access, supporting data analytics, and enabling self and staff. Some activities overlapped in that they served to support multiple role areas (Figure 1).

Implementing clinic practice management. In the early stages of the initiative, the GPM's primary role was to prepare the facility to implement a standardized set of clinic practice management (CPM) team processes. Part of standardizing the CPM process was defining the scope and tasks of the GPM, which requires significant planning for the implementation. "My big job is to finalize what we think group practice management is going to look [like] here," a GPM reported.

Each prototype site had latitude to interpret the GPM initiative in a way that would work in their context within given

FIGURE 1 Group Practice Manager Roles and Tasks



VHA boundaries and ongoing initiatives. To achieve the high-level vision and purpose, the GPM first had to develop action plans that accounted for the operating environment of the facility. According to one GPM, VA national officials are "constantly" asking for action plans, which required significant time by specific deadlines. "They want an action plan [and to] clean up all your consults, [and to] clean up all your recall reminders."

Leading on improving access efforts. Participants saw the GPM as the central staff member responsible for providing oversight of any activities and people involved in improving access. "I ensure everybody is doing what they're supposed to do," one GPM reported. When the GPM sees areas that are not being addressed, the individual tries to develop a process or training to "close those gaps."

GPMs promoted an awareness of their goals, changes in process, and new tools accompanying the initiative. However, other access initiatives were occurring simultaneously creating confusion for health care providers and patients; thus GPMs found they were

managing a wide array of related initiatives.

GPMs have to negotiate with leaders across the VHA facility, many of whom operated at a higher leadership level and had different priorities, to address access problems.

"I'm a lieutenant as a GPM in a clinic, a GPM noted. "How is the lieutenant going to talk to a major or a colonel in the clinic and say your clinic has problems. How['s] that lieutenant...going to do that? With people skills!"

Managing expectations about the speed and to what extent a problem could be resolved was an important part of the GPM leadership role. "I see myself as managing expectations both up to the leadership and down to the frontline," a GPM explained. "I find myself talking to leadership [about] our progress. But at the same time, we have to say, 'not everything can be fixed overnight.'"

Providing leadership on access-related issues included developing a range of options for addressing patient access problems. One analytics manager recounted how the GPM role led to evaluating how physical space limited efficiency in clinic flow. The first step was identifying possible additional rooms to improve clinic flow. This required working with the space committee to "get someone to look at our overarching space and find someplace else for them to sit" to avoid adding to congestion in the clinic area.

Supporting data analytics. Given the importance of data analytics, GPMs had a critical role in helping to ensure that the data were accurate and clean. At one facility the GPM and the business managers, "are doing a tremendous amount to clean up our data to make it accurately reflect what it is that we're doing," reported a community clinic director.

GPMs routinely immersed themselves in the data to understand access issues. GPMs worked with clinic leaders to identify the underlying causes and various solutions. The GPMs maintained access through administrative scrubbing of the data and finding "smart ways to get patients scheduled," a GPM explained. "I don't think our facility would have taken care of as many veterans in the time frame as we did....We've cleared over 4,000 consults that were older than 90 days. We have cleared thousands and thousands of weekly reminders."

GPMs expressed the need for aggregated (ie, dashboard) and standardized information to efficiently address access issues. "I would like to have some more standardization on what's being reviewed; it seems to change frequently, and so [to] be able to track and trend and have something given to me to review," one health care provider requested. On the other hand, participants also described a need for decision support tools that would lead to action aligned with best practices. "Instead of a dashboard or something that's just measuring their performance, it's more something that they can look at and take action" a national support staff advisor suggested.

Enabling self and staff. GPMs felt they were most effective if they enabled themselves and stakeholders through training and by cultivating relationships and team building. Figure 2 illustrates the various stakeholders GPMs reported engaging with. The GPMS should be building relationships, bridging relationships, developing trust, and then providing a higher level of hands-on management. However, "that doesn't really happen right now, day to day," one member of leadership reported.

Key topics in GPM leadership training included both soft skills (change management, culture change, and negotiation skills) and crucial analytic/technical training (understanding each metric and dashboard available, data analytics, and supply/demand balancing techniques). The GPMs not only wanted to understand metrics as part of their training, but also want to know what to do about them.

An "operationalization" training approach (discerning the meaning of data, data-based decision making, and determining action from multiple options) inspired by real-life situations was preferred by participants. Other effective learning structures included job aids in the form of templated Gantt charts, process maps to guide GPMs through implementation of new processes, formalized peer learning (accumulated field insights shared during training courses), and informal peer sharing of direct experiences during calls.

GPMs also emphasized training for frontline clinical and support staff, including schedulers. VHA schedulers typically have less education and experience higher

turnover rates than do other clinic staff, yet they carry out complex and critical tasks. Providing training and ensuring that any materials developed for training and education were appropriate to the level of education of schedulers was an important task for GPMs. "If they don't understand all of the scheduling principles and potential," one GPM explained, "we will not be maximizing the utilization of our parts."

GPMs also provided informal education to clinicians. Participants noted GPMs have to avoid appearing to overstep their positions or presuming more knowledge and expertise than clinicians. They "have to be able to teach a physician without being overbearing, in a way a physician will accept it as advisement," one program leader reported.

GPM knowledge, skills, and abilities. GPMs presented a complex range of knowledge, skills, and abilities, including clinical, administrative, analytics, and people skills. All interviewees reported that their prior education and experience did not sufficiently train them for the GPM role. GPMs identified a willingness to learn quickly as a critical characteristic. Many GPMs tended to have a formal education in health administration or business (eg, MBAs); others had administrative experience (eg, administrative assistance to executive leadership) or clinical training (eg, physician assistant). Detailed clinical knowledge was not expected, but clinical familiarity was helpful.

Some interviewees also mentioned previous experience and familiarity with the VHA system specifically as an advantage. This was especially true for VA outpatient flows, clinic flows, and understanding what an outpatient is in a VA context. Interviewees noted the importance of GPMs needing to be able to analyze patient demand metrics and underlying data in order to determine supply of providers and then to allocate adequate resources to complement providers. Forecasting skills were referenced as a key point. "They need to be able to be assured that they can recruit more providers if needed," a national support staff advisor noted.

Given the importance of developing effective relationships, communication skills were mentioned by most participants and underscored as critical to establishing trust between GPMs and others as the initiative was being implemented. Interviewees indicated that relationship building was further enhanced when GPMs possessed the ability to "work with" rather than command clinicians and staff; navigate politics; and were respectful of other people's knowledge, skills, abilities, and status. "They have to work with the nursing staff and teach them," a leader described, "so that people understand that we are going to a different place to achieve our primary objectives and goals."

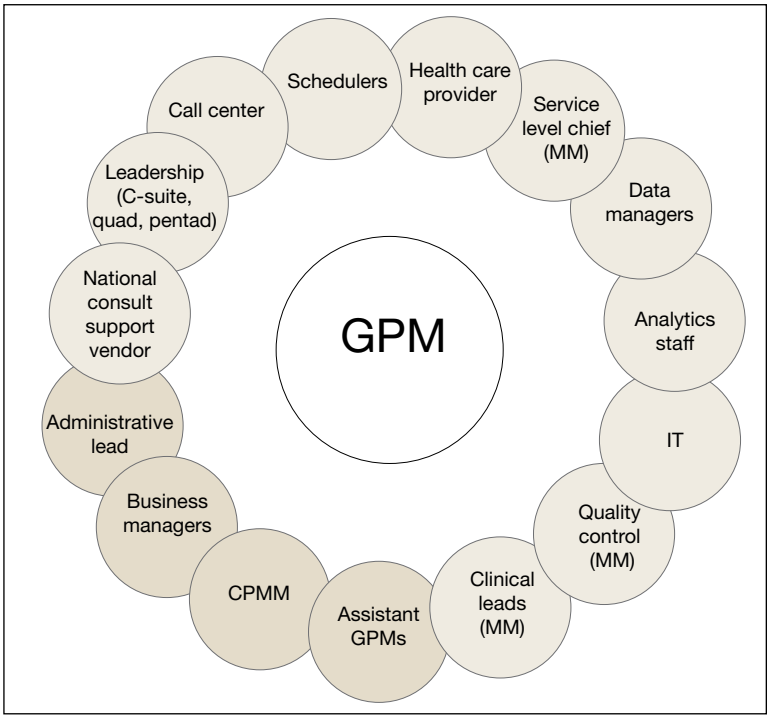
Issues and Challenges

Participants identified several technical, social, and structural challenges and barriers to successfully implementing the GPM role.

Technical challenges. Recurring themes across all phases of data analytics were GPMs' capability to challenge data use and use large volumes of information from multiple data sources (entering and accessing data; "drilling down" from summaries; generating reports; and analyzing and interpreting resulting metrics). Interviewees reported that information assessment and analytic support were not consistent. One GPM had a data analyst pulling reports needed to support clinical units while other GPMs trained staff to pull data. Even with support, some GPMs had issues due to limited information technology (IT) skills or access privileges leading to inefficiencies and delays. "Whenever I need anything from a programmer, I have to go through, you know, the IT gods in the sky," one GPM remarked. "That usually takes a few months or more."

Social challenges. Instituting the GPM role was a cultural change, and interviewees reported needing to address resistance to CPM model efforts. Resistance to change "is particularly hard in the VA just because it has a unique culture," one leader noted. "There is a comfort in the legacy way of doing things." The GPM initiative was introduced during a time when other national level initiatives were being implemented throughout the VHA. Fulfilling requests for information for these initiatives became the responsibility of the GPM and their team, which diverted attention from the mandate to improve access. Furthermore, GPMs were often

FIGURE 2 Group Practice Manager and Related Stakeholders[a]



Abbreviations: CPMM, clinical practice management model; GPM, group practice manager; IT, information technology; MM, middle management.

[a]Darker circles represent roles or teams developed by the GPM.

considered the "change communicators" to clinics putting them in the role of "bad messenger," which degraded trust and made it difficult to partner with clinicians.

Efforts to work through change management and build relationships included general program awareness presentation to internal stakeholders; including key stakeholders in GPM committees; pre-emptive conversations with unit chiefs; creating awareness of the GPM activities and progress through formal and informal update meetings; and identifying successes regarding access.

Structural challenges. The GPM role did not have direct supervision over clinical and administrative leaders, making it challenging to enact change. GPMs reported that "they do not always have authority over the area that they are being asked to manage," which made their work difficult, requiring strong negotiation skills and political savvy to affect change. However, as the clinic staff and providers saw how the GPM could support and positively impact their practice, these challenges began to subside.

DISCUSSION

This study provides empirical evidence regarding the implementation of a new access management strategy for health care systems focused on improving timeliness of care. First, the GPM position was seen as critical at each facility, as a single point person, to help local system leaders respond effectively to both national mandates and local context. Second, requiring the GPMs to report to the medical center director or chief of staff was important for integrating access perspectives across service lines and to facilitate a strong GPM role in strategic planning. Third, the intentional flexibility of the access management initiative, beyond the nationally specified aspects of the GPM role, was key for allowing individual sites to adapt to unique local challenges, resources, and population demands. Fourth, the initiative provided GPMs with opportunities to learn important skills and support the acquisition, utilization, and communication of a tremendous range of data toward responsive action.

According to our respondents, the GPM role demands functioning across a broad set of responsibilities; understanding the big picture as well as the complex underlying variables; engaging facility leaders, clinical and administrative staff; and prioritizing competing national and local demands. Consistent with previous findings, effective GPMs must possess a complex set of skills (interpersonal, analytic, and leadership) and the ability to create a supporting team.[13]

In practice, improving access at individual sites of care (VA medical centers and community-based outpatient clinics) poses significant challenges, especially in the early stages, even with the assistance of a GPM. For example, some respondents reported being overwhelmed by the volume of available data and dashboards, and responding to current requests for data analysis and dissemination sometimes impeded long range planning. Multiple national access-related initiatives and local pressures also generated excessive and potentially conflicting demands. Thus, while the creation of a GPM position seemed to be essential for the pilot sites to improve local access and timeliness to

care, success also requires ongoing national and facility-wide communication, education, and support. Ongoing data analysis training and support will be critical to ensuring the sustainability of the position. Last, recruiting GPMs with the needed complex skill set may prove to be challenging, and it will be important to provide resources to identify, attract, and retain well-qualified GPMs.

Limitations and Future Work

This study was based on a small initial sample of pilot sites of varying sizes and, as such, may not reflect the experience of all VHA GPMs. In addition, the use of snowball sampling, while facilitating identification of key stakeholders, may introduce bias in participant sampling. Nonetheless, the results from this study provide findings that informed the national VHA GPM initiative and can inform further studies of practice management roles outside of the VA.

Further study of the VHA GPM implementation and similar roles in other health care systems is needed. As the GPM position is fully implemented across the VHA, large scale evaluation is needed to gain a more representative picture and allow for comparison of the GPM role at various types of facilities (eg, size, rurality, complexity, ranking based on access performance metrics).

CONCLUSION

Improving access to care is a central goal for health care systems. The incorporation of the GPM role is an innovative approach to improve access management strategies. Early study of prototype sites provided VHA leadership with valuable insights used to influence further rollout of this initiative. Based on our findings, national and local support are important to ongoing success. National access mandates, training, and resources should focus on ensuring sufficient GPM authority, enabling GPMs to use data, and ensuring GPMs engage with frontline clinical and administrative staff to improve veteran access to care.

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Author disclosures

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Disclaimer

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