
When a patient makes an appointment to see their physician—in most healthcare systems, their care is handled by a team.

In the Veterans Health Administration, that team is known as “PACT” which stands for “Patient Aligned Care Team.” The goal of PACT is to be patient-driven and deliver personalized, team-based care. This approach views care holistically with a focus on wellness and disease prevention.

In the private sector, the PACT model resembles the well-known concept of the patient-centered Medical Home, staffed by high-functioning teams. For the last year, the Hampton VA Medical Center took a deep dive into their patient population in correlation to their PACT teams to see how they could be optimized to better meet the growing needs of staff and patients.

Within the past 5 years, Hampton’s patient population has grown by 16.7 percent. This population includes but is not limited to, the large number of transitioning active duty members and transient patients as well as growing numbers of complex health, and chronic issues with the added components of things such as Post-Traumatic Stress Disorder (PTSD) and increased development of chronic diseases and their co-morbidities.

As the complexity and number of patients seeking care for chronic illnesses grow, primary care practices are required to optimize care and access in order to improve both care and access for these patients. With the PACT model in place, a multi-disciplinary team was put in place led by Nurse manager Lisa Amick DNP, RN which based off of evidence, designed a three-tiered system in order to enhance care, improve patient care outcomes and increase access. At Hampton, these tiers include: PACT Chronic Care, PACT Moderate Risk, and PACT Low Risk.

In turn, specific criteria will determine the panel of staff as well as patients that will be a part of each tier and team.

“It is important to ensure our Veterans are enrolled in the right level of care they need based off

Continued on Page 6
The Personal Story of a Hampton Social Worker who Volunteered
to Provide Support to Those Devastated by Hurricane Maria

Written by: Gretchen Hilburger, Hampton VAMC Social Worker

In early February, I spent 10 days in the tropical Caribbean paradise of Puerto Rico with the non-profit organization, All Hands and Hearts - Smart Response program. When the Island of Enchantment was hit by Hurricane Maria on September 20, 2017, it had just been downgraded from Category five to a four, suddenly, Puerto Rico was thrown into darkness and disarray. Exacerbated by pre-existing conditions, five months later, many parts of the island remained without power. The people in those parts felt largely neglected and forgotten.

This was my third time to Puerto Rico in the past 27 years, and it was fascinating to see differences from my previous visits, especially in the wake of disaster. While I was not arriving immediately after the storm and some areas had recovered well, there was still a lot of evidence of the intense winds and rains of Maria.

Flying into the capital of San Juan, blue Federal Emergency Management Agency (FEMA) tarps could be seen on rooftops everywhere. While lush vegetation had begun to return to the hillsides, many of the trees still had branches naked of leaves and the normal green was speckled with whitish brown branches and trunks.

The metropolitan San Juan area largely had electricity restored, but once we ventured down Highway One, toward the southeast coast, we hit a traffic jam due to traffic lights as well as construction repairing the roads, and we could see downed power lines and damaged buildings all over. Thankfully we were traveling in the daytime and not venturing into total darkness.

On a day off, when I inquired about the typical plantain dishes at the beach (mofongo, tostones, sweet plantains, etc.), I was told the few dishes they had would cost extra due to importing them from the nearby Dominican Republic and other islands not affected by the storm, since all the plantain and banana trees had been destroyed and would take another season to grow back.

In the small coastal towns of Yabucoa and Humacao, where I spent most of my time, telephone poles were often lying on the side of the road or leaning against buildings, and non-active power lines were in ditches on the side of the road, crumpled up like excess yarn from a knitting project. The residents had been without power since the storm, and they sometimes had a generator they would share with neighbors and power up for an hour or two each day to run machines in their homes – maybe to keep the fridge and freezer cold or to run a washing machine or charge a cell phone. Due to the excessive cost of
gasoline, largely these people were living as pre-electricity days, hand-washing clothing and dishes, buying ice every few days to keep food cold, and forgoing TV and other amenities we might take for granted.

I cannot speak for the rest of the island and know other parts have recently had power restored, but the area I explored was thrown back into darkness each night with the sunset. Pitch black evenings began around 6:30 or 7 p.m. and were accompanied by the singing coquí frog lulling you to sleep, until the rooster with the messed up internal clock began to crow around 4:30 a.m. and sometimes even 3 a.m. and would continue throughout the morning.

The community had graciously lent us an old abandoned school to use as a base during recovery efforts. The program had been hard at work fixing it up prior to the volunteers arriving. It also had generators constantly running to keep our program working, but we were the exception to the rule.

Despite all these setbacks, the people of the area were immensely positive, cheerful, and agradecida (grateful) for the presence of volunteers helping them clean up and rebuild their damaged town. They would interact with us and help where they could. At all the homes I was tasked with interpreting so I usually got the story of what the family had experienced and heard their deep appreciation for our presence. At one home I helped wheel an elderly woman’s, adult disabled son, in his wheelchair outside, to watch us do our work. We gave him a bottle of water and joked around with him, and he seemed pleased to have our interaction and support. One family was hired to cook dinner for us every night and have an employee on staff with the program and gave out candy on Valentine’s Day.

A local Laundromat gave us a good deal to help with laundry for those staying long-term. One 80-year-old widow we had been helping clean and seal her roof, gave us hugs every morning and wanted to play parachute (childhood game where you hold onto edges of parachute and catch the air and run underneath to sit altogether under the tent-like air bubble you created) with us as we were folding up a tarp after sealing her roof. As we walked through neighborhoods, residents would wave and shout “thank you!” At, one of the houses where I helped a 73-year-old widow, a neighbor, who was a strong and determined famous marathon runner/cyclist for the region, took us into her home and showed us her wall of trophies and medals. She also had helped construct the second story around 30 years ago, wanted to help take it down. She was also the evening security guard at our base, keeping watch to help keep the volunteers safe. Every day she would meet us at 8 a.m. to help with breaking down the structure with crowbars and sledge hammers until the job was done.

A semi-pro baseball player, who had returned to the island to help his mother repair their home, which has a beautiful view of the Caribbean and Vieques in the distance, offered us the most refreshing fruit punch I ever tasted. Other community members would get up on roofs with us to help with patching holes or other aspects of the projects or offer refreshments or homemade dishes. There was a constant outpouring of warmth and love. Even in the airport on the way home I was stopped and thanked by a Puerto Rican heading back to the states who recognized my tee shirt indicating I was a volunteer who had helped with recovery efforts.

Whenever I would travel outside of the area to go to other towns or the beach, I often saw bucket trucks, from the states, out doing repairs along roadsides. One day in particular there were about 15 to 20 trucks heading in the opposite direction, journeying to affected areas to fix downed poles and wires. We also saw FEMA’s barge with mini apartments lined up by the beach, still in the area working hard to restore the island. While many residents were frustrated they had not yet heard from FEMA or received checks, it is evident although the process is long, arduous, and slow – poco a poco (little by little) it is getting there.

All Hands and Hearts has a two year plan to do immediate as well as long term work to help Yabucoa and Humacao get back on their feet. I went during their first few weeks of the program, so they were still getting organized and setting up the communal living area for volunteers and still identifying needs and resources in the community. Volunteers are from all over the USA and world and range from 19/20 year olds figuring out next steps in their lives to 60+ year old retirees giving back.

The first wave of projects, in which I participated, was helping to muck and gut and demolish severely damaged (irreparable) parts of homes and seal roofs to prevent continued leaking. They also had other related projects of using chainsaws to cut back trees continuing to lie on homes and across yards, do minor repairs of doors, windows, and cracks in homes, sanitize and clean up homes where mold and other dangers exist, and start to engage the community in other projects including re-

Continued from Page 2
doing a baseball field the town sees as central to their community.

Of the six homes where I volunteered, plus the countless other homes I heard about, the pattern I seemed to hear in this part of Puerto Rico seemed to be elderly homeowners who had lived in their houses for 50 plus years and raised families who had since lost their adult children and grandchildren to migration to the states even before the storm. The elderly parents had remained in their homes and not been able to keep up with the maintenance, so many of the homes were already in disarray before the storm hit. They were often two story homes that had originally been built as one-story concrete homes, then a second wooden story with corrugated metal roof added on in the last 40 years. The second stories had largely been obliterated in the storm, sometimes completely blown off, other times still standing but busted up to the point of no-repair. The goal of the organization was to clear off these destroyed upper floors and clean, repair, and seal the top of the first floor to be the new roof to the structure. Eventually in a later phase of the project they may do rebuilding, but this phase is primarily aimed at stopping the leaking and giving people a dry, safe place to live. It was a challenge some days to do this successfully with passing tropical rain showers that would interrupt the painting and drying process, sending us back to re-do the work we had just nearly completed.

Yabucoa is known for its involvement in Little League baseball. There are more than 500 kids on 40 teams in the region, and they have made it to the Junior League Baseball World series eight times, winning it one of the years. Unfortunately, this year they may not make it due to being down to only two functioning fields of the 20 they usually have. They are way behind in their practice schedule and are struggling to catch up. All Hands and Hearts had a generous donation from Travelers Insurance to repair the baseball field right behind the school where I was staying and brought in many tons of dirt to begin repairs on the field. In just the two days I was there during those repairs, the community was out helping mow the lawn, pull weeds, push around dirt, and sit in the stands and cheer on the activities.

My short stay on the Borinquen island passed too quickly and before I knew it, the time had come to say goodbye to the cute abandoned dogs, that reminded me of miniature versions of my dog (Thor), running the streets, Medalla beer and Capri-Sun style wine coolers, cold showers, like-minded volunteers re-storing and re-invigorating the area, and the appreciative and loving community. But despite the end to my time with this project, they will remain in my heart and prayers.

Upon arriving back to Norfolk after my layover in Charlotte, my airplane was cast into darkness for approximately two minutes as the pilots hooked the plane up to the passenger boarding bridge. Passengers around me moaned and groaned about the lack of electricity and began to panic. If only they could have stopped for a moment and realized two minutes is nothing compared to our brothers and sisters in Puerto Rico experiencing five plus months without power.

Since my time there, my tan, from rooftop repair in the tropical sun has since faded, but my hope for the people of Puerto Rico is strengthened.

I wish All Hands and Hearts much success with the next phases of their projects as they continue to help restore the lives of the people of Yabucoa, Humacao, and Puerto Rico.

¡Que Viva Puerto Rico!

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Continued from Page 6

What is VEText?
An automated, interactive text message system to remind Veterans of upcoming VA appointments. Veterans can respond to confirm or cancel an appointment.

Why is VA introducing VEText?
For one reason or another, Veterans miss more than 9 million health care appointments each year. Sometimes it is hard to keep track of the times or it may be difficult to cancel appointments. This program will send timely text alerts. Veterans can confirm or cancel the date and time with a simple text back. VA will then offer any newly opened appointment times to other Veterans.

What does VEText do?
• Reminds Veterans of appointments.
• Allows Veterans a useful cancellation option if desired.
• Allows a download of the reminder to a calendar file.

When will VEText start?
The program began late March

What do Veterans need to do to get started with VEText? What can they expect?

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Update or provide an active cell phone number to VA staff

No need to opt-in; text reminders will occur automatically

Veterans may STOP the texts by following the instructions within the texts

No cell phone? No problem. VEText does not replace other reminders. It simply improves the experience

VEText does not show personal information—just a simple reminder of an appointment and offers tools to manage the appointment

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The COST of Excessive Alcohol Use

A Drain on the American Economy

Healthcare $28 billion
Workplace Productivity $179 billion
Collisions $13 billion
Criminal Justice $25 billion

$249 billion loss

Resources
Veterans Health Library
www.veteranshealthlibrary.org
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
https://www.niaaa.nih.gov/alcohol-health
VHA National Center for PTSD

www.cdc.gov/alcohol
Continued from Page 1

of their healthcare needs. “The right team will allow for better access, improve their health and help them be a more proactive decision maker regarding their care; ultimately returning them to the highest level of functioning possible,” said Amick.

The PACT Chronic Care panel will include a Medical Doctor or Doctor of Osteopathic Medicine, Advanced Practice Provider, a Registered Nurse, Licensed Practical Nurse and a Health Technician. The team will also include PACT support members such as a Nutritionist, Clinical Pharmacist, Primary Care Mental Health Integration, and Home Telehealth. This team will incorporate alternate methods of care such as, Video Connect which will allow the veteran to be seen from the comfort of their home via a smart device or computer.

According to the Center for Disease Control and Prevention, one in four Americans has multiple chronic conditions, those that last a year or more and require ongoing medical attention or that limit activities of daily living such as hypertension, blood pressure and diabetes. That number rises to three in four Americans aged 65 and older. At the same time, the average patient panel in the US is 2,300 and includes acute, chronic, and preventive care. Studies suggest a primary care physician would need to spend approximately 20 hours per day to provide all recommended care for such a panel.

Unfortunately, this is often limits a Primary Care Providers time and in turn limits the focused care chronic patients require. This focused care is essential in disease management, as studies show those with chronic conditions tend to use the Emergency Room, specialty services, prescription drugs, and home health visits, more than those without chronic conditions. Additionally, typical appointments may last for approximately 15 minutes. According to the US National Library of Medicine National Institutes of Health, a chronic patient requires, at minimum, around 10 minutes per disease, as well as several visits throughout the year.

This is where PACT steps in. The goal of this optimized PACT model is to ensure patients receive high quality care, as well as the right amount of recommended chronic and preventive services through distribution of care amongst the interdisciplinary team members.

“The original design of PACT was meant for chronic disease management,” said Amick. “However, with such a variant and growing patient population, many things can distract from its original intent. Prevention is a very important aspect of providing care to patients.”

By optimizing PACT (putting the right patients with the right team) each team will be able to better facilitate consistent and effective medical practice for their specific patient population. For example, better disease monitoring and delivery of preventive services for chronic patients to improve health outcomes.

First, this means determining the right size patient panel for the Chronic Care Teams, approximately 1,200 per team (this encompasses a provider and advanced practice
practitioner) and will include patients with multiple chronic disease processes as well as those who may have PTSD or mental illness such as severe depression. Patients will also learn how to be a more proactive member on their team.

“It is important chronic patients are involved in their care and understand how to identify and manage symptoms, self-monitor conditions, avoid things that trigger acute episodes, reduce stress and comply with medications, diets and follow-up regimens,” said Amick.

Another important component to the Chronic Care Team is Telehealth. Because travel may be more difficult for chronic patients and getting treatment can be complex and inconvenient, patients identified as ideal candidates, will be provided with technologies to help manage their care. The technology can do things such as check on symptoms and measure vital signs in the home. The VA provides devices or home Telehealth technologies that can do this and are easy to use. They connect a Veteran to a VA hospital from their home using telephone lines, cellular modems and cell phones.

The devices can also provide information about health, the conditions and the various treatments that may be offered and provides a way for patients to understand their medical care and how they can be a part of the care process. A care coordinator, who is part of the PACT Chronic Care Team, will work with the Veteran to help them learn how to use the devices as well as ways to self-manage their care needs.

The PACT Moderate Risk Team will be staffed according to the level of care required. These teams will also include PACT support members such as a Nutritionist, Clinical Pharmacist, Primary Care Mental Health Integration, and Home Telehealth when needed. An important component to care for these teams will be shared medical appointments and an interdisciplinary approach to care.

“These are patients that may have some chronic disease processes who need attention, but the focus will be on preventing the development of multiple chronic conditions,” explained Amick.

“The goal for these patients is to delay or prevent them from becoming chronic, so the focus will be on prevention education and wellness management.”

Shared medical appointments will be key for the PACT Moderate Risk Teams, which is an innovative and interactive approach to healthcare. Shared appointments bring patients with common needs together, with one or more providers, on subjects such as hypertension or asthma. These interactive appointments can last more than an hour and allow patients to learn from the provider as well as each other. The appointments promote healthcare improvement and sustainability through knowledge and camaraderie.

The PACT Low Risk Team will also be staffed according to the needs of this population but keeping in mind, these patients are healthy and do not require chronic disease management. Prevention is key for these teams.

The goal for the PACT Low Risk Teams is to help them maintain a healthy lifestyle through recommendations of programs such as smoking cessation through the VA’s Healthy Living program and Whole Health which focuses on improving health through wellness, resilience and how we engage in our everyday lives.
focusing on the physical, emotional, and social well-being of the whole person, from a healthy diet, active lifestyle and spirituality.

Another aspect is educating Low Risk patients on how to utilize resources the VA has in place, that will enable them to take care of their needs with minimal interruption to their lives. This includes things like online appointment scheduling or cancelation, secured messaging to their provider and prescription refills through My HealtheVet.

“The patient panel for these teams will be typically healthy Veterans who come to the medical center maybe once a year” said Amick.

Ultimately the three-tiered PACT Optimization teams, right size panels which in turn tailors care and treatment to each Veteran, said Amick. For example, it enables Registered Nurses to work with as care coordinators with a case management mindset coordinating patient care and ensuring optimal treatment.

“One of the initial benefits of the optimization design is that it provides better access,” said Amick.

“The benefit of this is seeing less Emergency Room visits and hospitalizations with the goal being less multiple chronic disease development, because patients have the ongoing care and treatment they need,” she said.

The re-design also included opening an Immediate Care Clinic (ICC) late February. The ICC provides same-day care for non-emergent issues and helps alleviate overuse and misuse of the Emergency Room.

Although the ICC is currently offsetting ER use, there are plans to also support Primary Care sick patients who don’t need to be managed by a team at a future date.

“This concept would be similar to the ‘sick call’ concept Veterans have known during their active duty days,” said Amick. “In turn, this will create even more same-day access in the Primary Care Clinics for other needs.”

To ensure patient care is undisturbed and the PACT optimization transition is seamless, the Hampton VAMC decided to take a phased approach, with the ICC opening as phase one. Phase two will include the stand-up of the first PACT Optimization team which includes the three team tiers, Chronic, Moderate and Low, sometime in May. Phase two and three will stand up the remaining PACT Optimization teams.

During the transition staff are being educated on everything from the basics of PACT to utilization of the PACT support team members such as pharmacy, as well as recent technologies such as Video Connect. Amick and her team are also doing several things to keep patients informed such as letters, calls, town hall meetings and various other marketing efforts. She is also establishing a team which will be able to answer patient questions and concerns on an ongoing basis.

Amick said it is important Veterans to understand Hampton wants to change the way they perceive their care and the changes are being established to enhance their care experience and provide better access.

“We want our Vets to know that when you spoke we heard,” said Amick. “We understand one size does not fit all and that everyone has different healthcare needs.”

“At the end of the day, what we really want is to meet their needs and help them to live a more optimal, healthy life; to serve those who served and to provide the very best care.

That is what our Nation’s heroes deserve.”

Understanding Medical Terminology

MD stands for “Doctor of Medicine,” and is the most common type of degree earned by doctors who practice medicine in the United States.

DO stands for “Doctor of Osteopathic Medicine,” and refers to a doctor who practices medicine whose medical school training included a focus on the muscular and skeletal systems to treat problems throughout the body.

‘Advanced Practice Provider’ is a general title used to describe individuals who have completed the advanced education and training that qualifies them to (1) manage medical problems and (2) prescribe and manage treatments within the scope of their training. Some specific types of APPs include clinical nurse specialists, Nurse Practitioners (NP), and Physician Assistants (PA).

Health care technicians or technologists are skilled personnel who work in a specialized area within the health care industry. Becoming a health care technician requires focused training and education in a particular specialty. Health care technicians work under the supervision of physicians and other health care professionals who hold more advanced degrees in health care.
LEARN THE FACTS
ABOUT SEXUAL VIOLENCE

1 IN 2 WOMEN have experienced sexual violence other than rape in their lifetime.¹

1 IN 5 WOMEN have experienced completed or attempted rape in their lives.¹

1 IN 5 WOMEN experience physical or sexual violence by an intimate partner.²

1 IN 3 WOMEN have experienced completed or attempted rape in their lives.¹

Women have a 50% TO 95% chance of developing post-traumatic stress disorder after being raped.⁵

41% OF WOMEN reported experiencing physically aggressive street harassment.⁴

18% OF MEN reported experiencing verbal street harassment.⁴

1 IN 6 BOYS are sexually abused before age 16.⁶

Nearly 1 IN 67 men in the United States have experienced rape or attempted rape.¹

67.5% OF INSTANCES OF RAPE ARE ESTIMATED TO GO UNREPORTED.³

FEWER THAN 5% of completed or attempted rapes against college women were reported to law enforcement.²

Among college women, 9 OUT OF 10 victims of sexual assault knew the person who sexually assaulted them.²

SEXUAL VIOLENCE THRIVES WHEN IT IS NOT TAKEN SERIOUSLY AND VICTIM BLAMING GOES UNCHECKED.

USE YOUR VOICE TO PREVENT IT

BELIEVE SURVIVORS  CHALLENGE VICTIM BLAMING  RESPECT BOUNDARIES


©2017 National Sexual Violence Resource Center. All Rights Reserved.
DIVERSITY AND INCLUSION: April is Sexual Assault Awareness Month

The VA provides free care to Veterans who experienced sexual assault or sexual harassment while in the military. Veterans do not need to have a VA disability rating (or be “service connected”) and may be able to receive this care even if they are not eligible for other VA care. Veterans and other individuals with questions about military sexual trauma (MST) should be directed to the Hampton VA Medical Center MST Coordinator: Debra W. Brown, Psy.D., (757) 722-9961, ext. 2724. Learn more by clicking Link.

APRIL:
Around the Campus

April 4 VSO Commanders and Adjutants Quarterly Meeting Bldg. 83, 10 - 11 a.m.

April 16 VAVS Commanders and Adjutants Quarterly Meeting Bldg. 83, 10 - 11 a.m.

April 18 Volunteer Appreciation Week Bldg. 52 11:30 a.m. A time to recognize and thank today’s volunteers for their incredible efforts and inspiring actions. It is also a time to call everyone else in our community to consider serving those who served us first. To learn about volunteer opportunities at Hampton VAMC, please call our Voluntary Service Office 722-9961 ext. 3124/3868.

April 23-27 Patient Experience Week (see Facebook)

SAVE THE DATE
May 9 Patient County Fair 12 - 1 p.m. Several Vendors will be available. Check our Facebook Page for more information.

Informational Town Hall Sessions. Representatives will be available to answer questions. You can pre-submit questions to: VHAHAMPublicAffairs@va.gov

May 16 Elizabeth City 3:30-4:30 p.m. at 1433 N. Road Street, Elizabeth City, NC 27909

August 23 Chesapeake 4 to 5 p.m. at 4060 South Military Highway Chesapeake, VA 23321

November 7 Hampton 4-5 p.m. at 122 East Melon St Hampton VA

Patient Orientation: 1st Thursday of each month YOU DO NOT HAVE TO BE A NEW PATIENT - ALL PATIENTS WELCOME! Attend a brief session to learn about VA healthcare and resources available Staff will be available to answer questions. Call to register! 757.722.9961 Press 2 for appointment then 2 for Primary Care. Tell the operator you want to enroll. Walk-ins welcome (upcoming dates: May 3 * June 7 * July 5 * Aug.

Tired of WAITING at the Pharmacy? There are THREE better options: Refills should be done -- 1. via internet, 2. telephone (757-726-6005) or 3. mail: (remove the refill request slip attached to prescription paperwork, mail to the Pharmacy or put in drop off box at Pharmacy). NOTE: Please request refills 2 to 3 weeks early. Early requests are placed in suspense and will only be released for mail when the refill is due.

Veterans, Have you?

Joined our Facebook Page, get fast facts, information on benefits and upcoming events

Hampton VAMC

Employees, Have you?

Checked out our intranet page for information on events, celebrations and more?

The Hampton Focus is a monthly publication. Articles and information should be submitted no later than the 10th of each month. Please contact the Public Affairs Office at VHAHAMPublicAffairs@va.gov

Next months focus: Behavioral Health, Suicide Prevention, PTSD, Women’s Health
Why is it So Important to Cancel My Appointment?

No-Shows actually hurt other patients. It may seem like it is impossible to get an appointment. Research shows, that in fact, appointments typically are available.

So what seems to be the Problem? According to VA studies, some 9 million patients miss their appointments annually. They simply don’t show up. In turn, patients who need to see their provider can not.

When a Veteran calls and cancels their appoint, they in turn open up a spot for another Veteran.

Just like Veterans who are frustrated when there seems to be no access, staff get frustrated as well because no-shows can easily be turned into filled spots by a simple phone call -- and now Vets can cancel via text (see page 4).

Please remember, an appointment missed by you, is an appointment missed by two!

The best time to cancel an appointment is at least four hours before a Primary Care appointment and 24-hours before a Specialty Care appointment.

The VHA has three convenient ways to cancel: (1) Online through MyHealtheVet (2) Via Telephone call to the call center and (3) now through VEText (talk to your Primary Care Provider).

The new VEText option will automatically send reminders to patients about their appointment as long as they have an updated cell phone number with the VA.

PACT Optimization should also mitigate long wait times for appointments to ensure patients, especially chronic patients, get seen when they need to (see cover story).