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The Effect of Organizational Climate on Patient-Centered Medical Home Implementation

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Abstract

Organizational climate is a key determinant of successful adoption of innovations; however, its relation to medical home implementation is unknown. This study examined the association between primary care providers' (PCPs') perception of organization climate and medical home implementation in the Veterans Health Administration. Multivariate regression was used to test the hypothesis that organizational climate predicts medical home implementation. This analysis of 191 PCPs found that higher scores in 2 domains of organizational climate (communication and cooperation, and orientation to quality improvement) were associated with a statistically significantly higher percentage (from 7 to 10 percentage points) of PCPs implementing structural changes to support the medical home model. In addition, some aspects of a better organizational climate were associated with improved organizational processes of care, including a higher percentage of patients contacted within 2 days of hospital discharge (by 2 to 3 percentage points) and appointments made within 3 days of a patient request (by 2 percentage points).

Keywords

medical home; organizational climate; veterans; primary care delivery

For decades, the fields of management and organizational behavior have understood that adoption and implementation of new organizational practices depends on both the social context and a technical process.¹ Researchers have coined the term *organizational climate* to describe the social context, which links and mediates organizational characteristics to the attitudes and behaviors of an organization.² Understanding an organization's climate can help determine what types of interventions will be chosen, how these interventions will be

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implemented, and how problems with the interventions will be solved.³ Although this construct is similar to organizational culture, often referred to as the shared values of an organization, organizational climate focuses on the measurable perceptions of an organization's workforce at a given point in time.⁴ In fact, a meta-analysis supports the view that there is a relationship between organizational climate and customer loyalty, turnover, and productivity in a variety of business settings.⁵

In the health care setting, improving the safety climate of hospitals is a key component of strategies to reduce the number of medical errors experienced by patients. An observational study of 91 hospitals found that an improvement of 1 standard deviation in an aggregate measure of safety climate was associated with a 10% lower risk of a hospital experiencing a patient safety incident.⁶ In addition, hospitals in which personnel reported more problems with fear of shame and fear of blame—2 domains of the safety climate—had significantly greater risk of experiencing patient safety incidents. A corollary to this finding is that improvements in the safety climate can affect patient safety. Indeed, a recent systematic review found that interventions to improve safety climate can improve patient safety related to error reporting, adverse events rates, and mortality.⁷

In primary care settings, research has linked elements of organizational climate with both chronic and preventive care outcomes.^{8,9} For example, research at the Veterans Health Administration (VHA) found that clinics with higher scores in relational climate (ie, staff were more team and cooperation oriented) were associated with higher quality of diabetes care.⁹ In fact, similar research found that although increases in physician workload are negatively associated with patients' perceptions of care, this effect is moderated by a clinic's orientation toward a relational climate.¹⁰

Despite prior work in the area of organizational climate in health care, the extent to which organizational climate predicts successful adoption of new delivery systems is unknown, particularly in primary care. Yet this relationship is important, given the widespread adoption of the patient-centered medical home (PCMH), which has emerged as a centerpiece of improving primary care delivery.¹¹ The PCMH model shifts the focus from individual provider-based care to team-based care, focusing on improving continuity and coordination and enhancing access to primary care services. Although previous research has investigated the influence of organizational climate and primary care outcomes, there are no studies on organizational climate and determinants of successful implementation of the PCMH.

This article investigates the relationship between organizational climate and successful implementation of the medical home. In April 2010, the VHA launched implementation of the medical home, an ambitious initiative to transform primary care.

Methods

Overview

To address whether organizational climate was associated with implementation of the medical home, the study team examined provider perceptions of 4 elements of organizational climate at the start of VHA's medical home implementation (based on

responses to a 2010 survey administered to all primary care providers [PCPs] within a regional VHA network) to see if they predicted successful medical home implementation over the subsequent 2 years (measured as organizational structure and processes of care related to the medical home model). Multivariate regression was used to test the hypothesis that organizational climate was associated with medical home implementation.

Setting

Implementation of the VHA's medical home model (also known within the VHA as the patient-aligned care team model or PACT) began in April 2010. The PACT model focuses on transforming primary care in 3 areas: practice redesign, access to care, and care management and coordination. Practice redesign focuses on encouraging PCPs to work in PACT teams to improve communication and teamwork; a team consists of a PCP, a registered nurse, a licensed clinical associate (eg, licensed practical nurse, medical support assistant), and an administrative clerk. Access to primary care focuses on improving same day appointments and shifting work from single face-to-face visits to group or telephone-based visits, thus freeing up provider time for urgent visits and for non-visit-based work. Care management and coordination focus on identifying, managing, and coordinating care of high-risk patients as well as improving transitions of care between the primary care setting and other settings such as inpatient care or specialty care.

The VHA has dedicated more than \$1 billion nationally to the medical home transformation. It continues to devote financial resources and efforts to implementing this transformation as well as training of all primary care staff and collaborators (eg, pharmacists, social workers, behavioral health providers) to support spread and sustainment of the model. Implementation of this model is expected to continue through 2014.

Study Population

This study focused on 1 VHA regional network (also called a Veterans Integrated Service Network, or VISN): VISN 4. This network covers 104 counties, including the majority of Pennsylvania, Delaware, and West Virginia, and parts of Ohio, New York, and New Jersey. It includes 10 regions, each of which has 1 hospital-based clinic and associated community-based clinics. This includes a total of 56 primary care sites—10 hospital-based and 46 community-based outpatient clinics. At the beginning of the study, VISN 4 had 347 PCPs delivering care to more than 300 000 veterans.

Main Independent Variables

The study team created a 32-item organizational survey using questions adopted from the VHA's 2007 Clinical Practice Organization Survey (CPOS), designed to measure organizational-level characteristics of primary care.¹² For brevity, 4 subsets of questions were selected from the original CPOS survey—provider perception of clinic communication and cooperation, orientation to quality improvement, barriers to change related to competing demands and stress, and personnel and financial resource insufficiency. The survey was delivered to 347 PCPs in VISN 4 between July 2010 and October 2010; a total of 211 responses (60% response rate) were received.

Based on previous factor analysis of the 2007 CPOS, 5 of the 32 questions included did not correspond to 4 major elements of organizational readiness and were thus excluded from this analysis.¹² In addition, prior to analyses, 2 of the questions were dropped because < 80% of respondents answered these 2 questions. Of the remaining 25 questions, 6 questions addressed providers' perception of clinic communication and cooperation, 6 questions addressed an orientation to quality improvement using established processes, 5 addressed personnel and financial resource insufficiency, and 8 addressed barriers to change related to competing demands (see online Appendix A at <http://ajmq.sagepub.com/content/by/supplemental-data>). Two domains—communication and cooperation, and orientation to quality improvement—have a positive assessment of organizational climate. The other 2 domains—personnel and financial resource insufficiency and barriers to change—have a negative assessment of organizational climate.

Most questions asked the respondent to rate their perception on a 5-point Likert scale; 7 questions used a 4-point scale. Those on a 4-point scale were converted to a 5-point scale prior to analyses by multiplying the response by 5/4. Questions within each domain were combined by taking the mean rating for the questions within the domain, creating 4 domain-specific scores for each respondent. The Cronbach α coefficients were greater than .75 for each domain.

Outcome Variables

Two groups of measures of PACT implementation were included: structural changes in primary care delivery to support the PACT model and organizational processes of care that were targeted by PACT implementation.

Measure of Structural Change to Support PACT Implementation.—To measure structural changes in primary care delivery, the study team conducted site visits and structured interviews with key informants at each site, with the goal of identifying key structural elements of PACT implementation. Key informants were identified as the person at each site who was tasked with day-to-day responsibilities related to PACT implementation. In cases where the initial contact was unable to answer all of the questions, a second contact was identified.

Structured interviews were based on an interview guide asking about structural changes to support PACT implementation in the following 10 areas: (1) accessing and using data for orientation to quality improvement, (2) care management of high-risk patients, (3) nurse medication protocols, (4) transitions from the emergency department, (5) transitions from the hospital, (6) alternatives to single provider face-to-face visits, (7) changes to enhance access, (8) multidisciplinary teams, (9) team communication and functioning, and (10) using patient-centered methods (see online Appendix B for the interview guide <http://ajmq.sagepub.com/content/by/supplemental-data>).

Four sets of interviews were conducted at 6-month intervals over the 2-year period of this study (July 2010 to June 2012). For many of the community-based clinics, there was 1 key contact who was knowledgeable about PACT implementation at more than 1 site; thus, it was not necessary to interview 1 key contact for each site. As PACT activities spread to

additional primary care clinics over time, the number of key contact interviews increased; the number of interviews ranged from 10 for the first 6-month follow-up period to 42 for the final 6-month follow-up period. During the 2-year period, a total of 118 key informant interviews were completed.

The study team summarized the interview data by creating binary variables for 9 of the 10 structural changes, indicating whether the site used any of the specific structural changes about which the team asked (responses to queries about accessing and using data for orientation to quality improvement were not included because respondents were often confused by this question). For example, in asking about changes to support-enhanced access, the study team created a variable equal to 1 if a clinical site answered yes to any of the following questions in each time period: Are any strategies in place for enhanced access? Are you extending visit intervals when appropriate? Are you using any other methods to enhance access?

Measure of Organizational Processes Related to PACT Implementation.—The study team used data from the VHA's Corporate Data Warehouse, a data repository of clinical and administrative systems with data on all patient encounters within the VHA, to identify all PCPs in the VISN during the 2-year study period (from the Primary Care Management Module [PCMM]) and all primary care visits within the VISN and to measure the outcome variables of interest.

PCMM data in each 6-month period were used to assign patients to PCPs. For patients who had primary care encounters but no PCMM-assigned PCP, a standard attribution rule was used to assign patients to the PCP they saw more frequently in each period. In cases of ties (where a patient saw 2 PCPs the same number of times), the patient was assigned to the tied PCP seen most recently.

These data were used to create 3 PCP-level organizational process measures (all of which are closely tied to the planned structural changes from PACT implementation): percentage of primary care visits that were telephone-based, percentage of appointments within 3 days of the desired appointment date, and percentage of patients contacted within 2 days of hospital discharge.

These variables were created based on data indicating whether each eligible veteran had the outcome of interest in each 6-month period of the study. Thus, telephone-based visits, measured for all veterans with a primary care visit in a 6-month period, equals 1 if the visit was by phone and 0 otherwise. Appointment within 3 days of the desired date, measured for all veterans who requested a primary care appointment in each 6 months, equals 1 if the appointment was within 3 days of the requested appointment date and 0 otherwise. Contact within 2 days of hospital discharge, measured for all veterans with an inpatient discharge from a VHA hospital, equals 1 if the veteran was contacted within 2 days of hospital discharge and 0 otherwise. These measures were then aggregated as PCP-level measures of percentage of each PCP's patients with the outcome of interest.

Covariates

The study team controlled for both PCP-and clinic-level characteristics, including PCP sex, type of provider (medical doctor/doctor of osteopathy vs nurse practitioner/physician assistant), years in practice at VHA, panel size for each PCP, type of clinic environment (community vs hospital based), and number of patients seen at the clinic (Table 1).

Statistical Analysis

A provider-level analysis was conducted using a linear probability model with regional fixed effects to test whether provider perceptions of organizational climate were associated with PACT structural markers or organizational processes measures related to implementation. The following general form was used to test the hypotheses:

$$\text{Outcome}_{i,j,t} = \alpha \text{PCPORC}_j + \beta X_{i,j} + \gamma \text{Region}_{i,j} + \varepsilon_{i,j,t}. \quad (1)$$

In this regression, the outcome variable is one of 12 defined outcomes (9 structural measures or 3 organizational process measures), indexed to PCP (i), site of practice or clinic (j), and 6-month time period (t). These outcomes are estimated as a function of PCP perception of organizational climate at baseline (PCPORC), PCP-and clinic-level covariates, and a mean zero random error component. Regional fixed effects (for the 10 regions in VISN 4, each of which has 1 of the 10 hospital-based clinics) also were included to control for time-invariant unobserved characteristics across the 10 sites included in the study. All standard errors are adjusted for clustering within PCP using Huber-White estimators of variance. The coefficient of interest is α , which represents the effect of a PCP perception of organizational climate on the outcome of interest.

Results

This study included 191 of the 211 PCPs who responded to the survey at the start of PACT implementation. The remaining 20 survey respondents (9%) were dropped from the study because they could not be identified in the existing data used to create the outcome measures. Descriptions of the PCPs and primary care settings involved in the study are shown in Table 1. Table 2 describes baseline survey measures of physician perception of organizational climate in the 4 domains. On average, providers rated communication and cooperation, orientation to quality improvement, personnel and financial resource insufficiency, and barriers to change related to competing demands and stress between 3 and 4 on a 5-point scale. As seen in the standard deviations, there was variation in the responses for each domain.

For 8 of the 9 structural measures examined, the percentage of PCPs implementing structural changes increased over time (Table 3). For example, the percentage of PCPs with alternatives to face-to-face visits available increased from 14.7% to 76.4% over the 2 years of the study. The exception was the use of nurse medication protocols, which increased over the first 3 study periods but fell minimally during the last period. In addition, all 3 organizational process measures improved over the study period (Table 3). Over the 2 years

of the study, the rates of primary care visits occurring by telephone increased by approximately 4 percentage points, rates of primary care appointments made within 3 days of desired date increased by approximately 11 percentage points, and rates of 2-day postdischarge contact increased by approximately 49 percentage points (Table 3).

The regression models examine the effect of baseline provider scores of organizational climate on effectiveness of PACT implementation, adjusting for covariates. First, examining PACT implementation using structural measures of PACT reveals that a 1-point higher (on the 5-point scale) perception of organizational communication and cooperation score was associated with larger increases in 8 of the 9 structural measures, with statistically significant increases of between 8.0 and 10.7 percentage points (Table 4). For 1 structural measure (nurse medication protocols), there was no statistical association with perceptions of organizational climate. Similar results were found when examining provider scores on perception of organizational orientation to quality improvement. For example, a 1-point increase in perception of orientation to quality improvement on the 5-point scale was associated with an increase of 7.3 percentage points in use of high-risk registries. However, PCP scores on perceptions of resource insufficiency or barriers to change related to competing demands did not have an association with PACT structural changes. The exception was in PCP perception of resource insufficiency, for which a 1-point increase was associated with an increase of 2.7 percentage points in nursing protocols.

Finally, the study team test the relationship between organizational climate and PACT implementation using PACT organizational process measures and find that perceptions of organizational climate are not as strongly associated with organizational process measures as with structural changes (Table 5). Statistically significant results were found in both use of 2-day postdischarge contact and an appointment within 3 days. For example, a 1-point higher score on PCP perception of communication and cooperation was associated with a 2.6-percentage-point higher 2-day contact of patients post discharge and a 3.1-percentage-point higher appointment within 3 days. A 1-point higher score on PCP perception of barriers to change was associated with an approximately 2-percentage-point lower appointment within 3 days and 2-day contact of patients post discharge. Within the domain of orientation to quality improvement, a 1-point higher score on PCP perception of orientation to quality improvement was associated with a more than 2-percentage-point higher 2-day contact of patients post discharge but no relationship with appointment within 3 days.

No statistically significant relationship was observed between PCPs' perception of resource insufficiency and any of the PACT organizational process measures. In addition, no statistical relationship was observed between any of the organizational climate dimensions and the percentage of visits occurring by telephone.

Discussion

This study examined if provider perceptions of organizational climate predict medical home implementation in VHA. The study team surveyed providers on 4 major elements of organizational climate (communication and cooperation, orientation to quality improvement,

personnel and financial resource insufficiency, and barriers to change) and then measured whether these elements were predictive of key components of PACT implementation. Higher PCP perceptions of clinic communication and cooperation and orientation to quality improvement were found to be associated with the adoption of 8 of the 9 structural elements of medical home measured. However, there was no similarly strong association between PCP perceptions of resource insufficiency and barriers to change and adoption of structural elements of the medical home.

When PCP perceptions of organizational climate and PACT process outcomes are compared, several key findings are observed. First, there was no relationship between organizational climate and use of telephone appointments. Second, PCP perceptions of resource insufficiency were not associated with PACT process outcomes. However, a higher PCP perception of cooperation was found to correspond to an increased ability to accommodate patient appointment requests within 3 days and contact patients within 2 days after hospital discharge. Similarly, a higher perception of quality improvement is associated with contacting patients within 2 days after hospital discharge, but this relationship was not statistically significant for appointments within 3 days. Finally, higher provider perceptions of barriers are associated with lower ability to contact patients within 2 days after hospital discharge and ability to accommodate patient appointment requests within 3 days.

This study adds to the research literature by testing several elements of organizational climate as a way to understand what drives successful implementation of the medical home. Previous literature suggests that PCPs have varying views of barriers and resources needed to implement the medical home.¹³ On one hand, this study is encouraging that some aspects of organizational climate seem to be associated with successful implementation of the medical home. These results make intuitive sense and support the notion of high-functioning organizations.¹⁴

On the other hand, some of the other findings are puzzling. First, although it was found that perceptions of communication and cooperation, orientation to quality improvement, and barriers matter, the study also found that perceptions of resource insufficiency do not. These latter negative findings contradict previous work demonstrating that perceptions of resources affect the adoption of quality improvement efforts.¹⁵ However, other research suggests that organizations that are larger and more bureaucratic have difficulty adopting quality improvement work.¹⁶ One possibility is that within larger organizations, such as the VHA, PCPs do not have an accurate perception of resources leading to measurement error in this survey.

Second, although a consistent relationship was found between implementation of structural changes and process measures and the domains of communication and cooperation, orientation to quality improvement, and barriers, it also was found that there was no relationship with primary care visits occurring by telephone. After closer examination, this result may not be as surprising. In fact, there was only a small uptake of primary care visits by telephone among all sites—only 4% of providers were utilizing this type of appointment, most of which happened in the last 6 months. The survey may not capture the complexity of this process outcome, and other unmeasured factors are contributing to this low uptake.

Additionally, other factors such as organizational readiness may help explain successful implementation of health care delivery transformations. Theoretical frameworks such as Organizational Readiness for Change, which combines organizational climate with assessments of motivations to change, adequacy resources, and various staff attributes, may provide a more holistic assessment of an organization's ability to implement new practices. 17–20

Although the study findings that cooperation and communication and orientation to quality improvement are predictive of successful medical home implementation are important, the question remains whether these organizational characteristics can be easily changed. Although measurement of these factors can add to our understanding of which organizations will successfully implement new models of care, the ultimate goal is to have all organizations be successful. Success may depend in part on an organization's ability to improve its culture surrounding these domains, which may be a difficult task in many cases.

There are several limitations to this study. First, although the temporal nature of the data collected in the survey helps predict medical home implementation, which strengthens the study findings, the findings remain associations. The study team is unable to comment on whether provider perceptions of organizational climate caused the successful implementation of the medical home. Second, because of the need for brevity, the study team did not use the full survey to capture all the previously described categories and elements of organizational climate. Thus, it is possible that the team failed to capture elements of organizational climate that predict successful transformation. Finally, implementation of medical homes requires integration of team-based care. This involves care teams that include medical assistants, nurses, and front-desk personnel; however, this survey only captures perceptions of PCPs.

Implementing the medical home model across diverse clinical settings in the VHA is challenging. This study provides insight into how providers' perceptions of an organization's ability to execute complex health service innovations is an important predictor of success. Finding strategies to improve organizational climate may in fact lead to successful implementation of complex interventions such as PCMH.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Description of Primary Care Providers (PCPs) and Primary Care Settings.

PCP Characteristics	
Total PCPs (n)	191
Male (%)	42
MD/DO (%)	62
NP/PA (%)	38
Years in primary care at VHA, median (IQR)	8.3 (2.8–11)
Panel size, median (IQR)	785 (364–977)
Primary Care Setting Characteristics	
Hospital-based medical center (%)	62
Community-based outpatient clinic (%)	38
Number of PCPs, median (IQR)	2(1–5)
Total number of primary care patients, median (IQR)	3939 (2748–8682)

Abbreviations: MD, doctor of medicine; DO, doctor of osteopathy; NP, nurse practitioner; PA, physician assistant; VHA, Veterans Health Administration; IQR, interquartile range.

Table 2.Organizational Climate Survey Scores, Mean (Standard Deviation), 5-Point Scale.^a

Communication and cooperation	3.12 (0.73)
Orientation to quality improvement	3.09 (0.83)
Personnel and financial resource insufficiency	3.60 (0.97)
Barriers to change related to competing demands and stress	3.72 (0.81)

^aFor Communication and cooperation and Established process for orientation to quality improvement, a score of 5 is a positive perception; for Personnel and financial resource insufficiency and Barriers to change related to competing demands and stress, a score of 5 is a negative perception.

Table 3.

PACT-Related Study Outcomes Over the Study Period.

	July to December 2010 (n = 191)	January to June 2011 (n = 183)	July to December 2011 (n = 173)	January to June 2012 (n = 157)
Number (%) of PCPs making structural changes to support PACT implementation in each study period				
High-risk registries	33 (17.3)	65 (35.5)	80 (46.2)	107 (68.2)
Nurse medication protocols	9 (4.7)	26 (14.2)	45 (26.0)	31 (19.7)
Enhanced access	42 (22.0)	58 (31.7)	83 (48.0)	120 (76.4)
Alternatives to face-to-face and one-on-one visits	28 (14.7)	62 (33.9)	84 (48.6)	120 (76.4)
Multidisciplinary teams	40 (20.9)	58 (31.7)	82 (47.4)	115 (73.2)
Team communication and functioning	22 (11.5)	65 (35.5)	84 (48.6)	116 (73.9)
Transitions from ED	26 (14.1)	67 (36.6)	81 (46.8)	119 (75.8)
Transitions from hospital	27 (9.3)	66 (36.1)	84 (48.6)	120 (76.4)
Patient-centeredness	7 (3.7)	63 (34.4)	63 (36.4)	117 (74.5)
Mean percentage (SD) of each PCP's patients receiving PACT organizational processes in each study period				
Primary care visits occurring by telephone	0.0 (0)	0.0 (0)	0.9 (2.6)	4.1 (7.9)
Primary care appointments made within 3 days of desired date	63.8 (16.2)	65.4 (16.1)	70.6 (16.7)	74.5 (15.3)
Acute hospital discharges contacted within 2 days of discharge	6.2 (9.2)	15.4 (15.6)	24.2 (23.1)	55.0 (20.3)

Abbreviations: PACT, patient-aligned care team; PCP, primary care physician; ED, emergency department.

Table 4.Effect of Organizational Climate on Structural Measures.^a

	Communication and Cooperation		Orientation to Quality Improvement		Resource Insufficiency		Barriers to Change Resulting From Competing Demands	
	Coefficient (SE)	P Value	Coefficient (SE)	P Value	Coefficient (SE)	P Value	Coefficient (SE)	P Value
High-risk registries	0.083 (0.04)	.02	0.073 (0.03)	.02	0.041 (0.02)	.10	-0.019 (0.03)	.56
Nurse medication protocol	0.023 (0.02)	.18	0.023 (0.02)	.15	0.027 (0.01)	.04	-0.008 (0.02)	.60
Enhanced access	0.104 (0.04)	.00	0.086 (0.03)	.01	0.031 (0.03)	.25	-0.032 (0.03)	.30
Alternatives to face-to-face	0.104 (0.03)	.00	0.086 (0.03)	.00	0.036 (0.02)	.14	-0.026 (0.03)	.40
Multidisciplinary teams	0.107 (0.04)	.00	0.080 (0.03)	.01	0.035 (0.03)	.18	-0.031 (0.03)	.32
Team communication	0.097 (0.03)	.01	0.085 (0.03)	.00	0.036 (0.02)	.14	-0.036 (0.03)	.24
Transitions from ED	0.080 (0.03)	.02	0.076 (0.03)	.01	0.029 (0.02)	.24	-0.031 (0.03)	.31
Transitions from hospital	0.088 (0.03)	.01	0.078 (0.03)	.01	0.027 (0.02)	.27	-0.030 (0.03)	.32
Patient-centeredness	0.087 (0.03)	.00	0.073 (0.02)	.00	0.016 (0.02)	.42	-0.027 (0.02)	.25

Abbreviations: PACT, patient-aligned care team; SE, standard error; ED, emergency department.

^aPACT implementation of structural changes is measured in 9 ways, and each measure is modeled separately in linear regression. The table displays the coefficient of interest from each regression model. Robust SEs are in parentheses.

Table 5.Effect of Organizational Climate on PACT Organizational Process Measures.^a

	<u>Communication and Cooperation</u>		<u>Orientation to Quality Improvement</u>		<u>Resource Insufficiency</u>		<u>Barriers to Change Resulting From Competing Demands</u>	
	Coefficient (SE)	P Value	Coefficient (SE)	P Value	Coefficient (SE)	P Value	Coefficient (SE)	P Value
Telephone visits	-0.20 (0.22)	.38	-0.12 (0.18)	.50	0.20 (0.15)	.19	0.16 (0.15)	.29
Appointment within 3 days	3.06 (0.98)	.00	0.68 (0.90)	.45	-0.46 (0.91)	.61	-2.06 (0.91)	.02
2-Day postdischarge contact	2.63 (1.01)	.01	2.43 (0.87)	.01	-0.73 (0.81)	.37	-2.49 (1.04)	.02

Abbreviation: PACT, patient-aligned care team; SE, standard error.

^aPACT implementation of organizational process is measured in 3 ways, and each measure is modeled separately in linear regression. The table displays the coefficient of interest from each regression model. Robust SEs are in parentheses.