

Patient Aligned Care Teams (PACT) Demonstration Lab Initiative

Research-Clinical Partnerships to Evaluate and Enhance VA PACT Implementation

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VA
HEALTH
CARE

Defining
EXCELLENCE
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National Implementation of VA Patient-Centered Medical Homes: Patient-Aligned Care Teams

Richard C. Stark, MD

Director of Primary Care Operations



Primary Care in the Veterans Health Administration

Largest integrated health care system in the US

Comprehensive electronic medical record

>850 sites of Primary Care

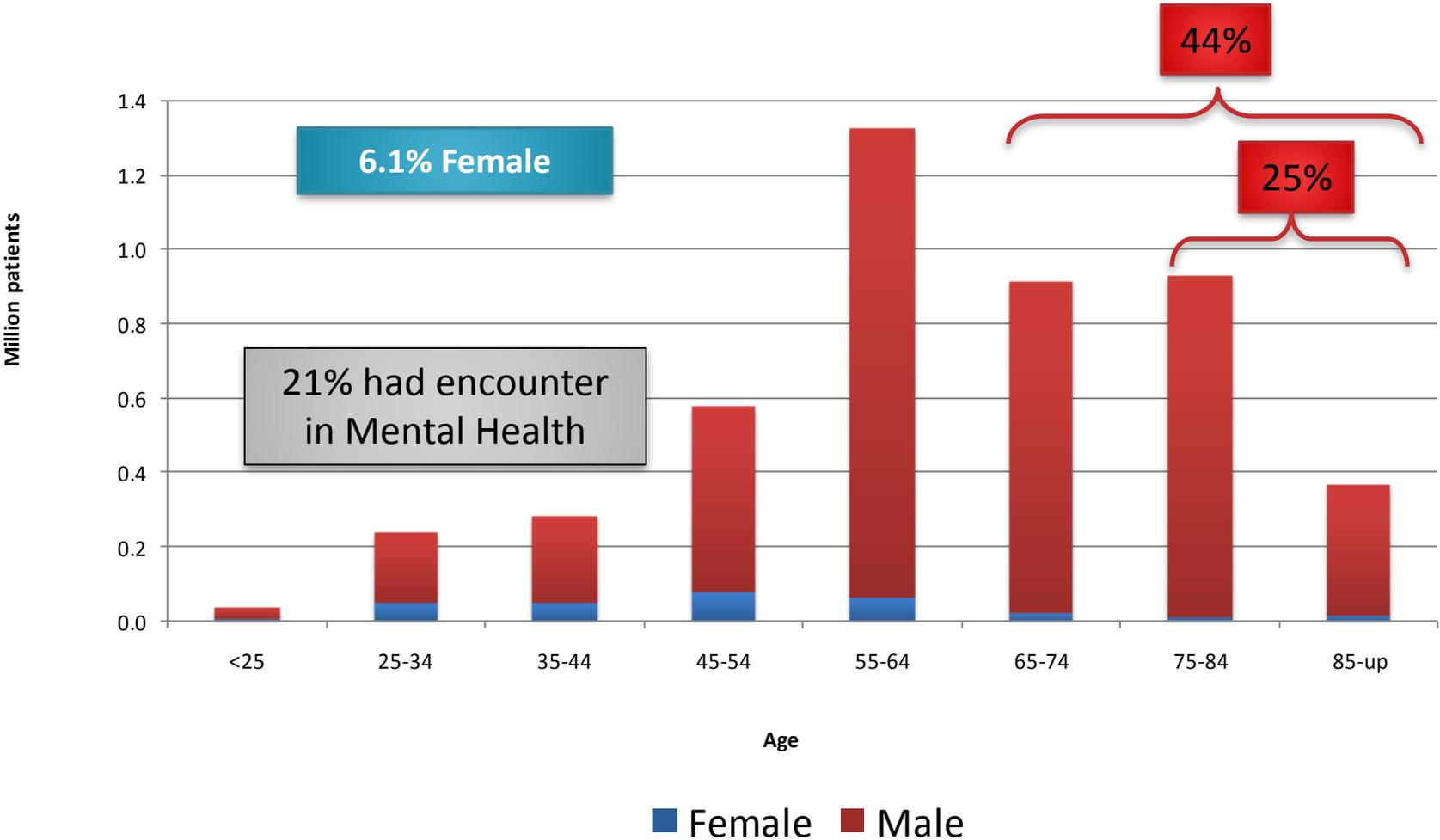
- 152 Medical Centers
- >700 Community Based Outpatient Clinics (CBOC)

4.8 million primary care patients-each assigned to an individual primary care provider

- 53% in CBOCs

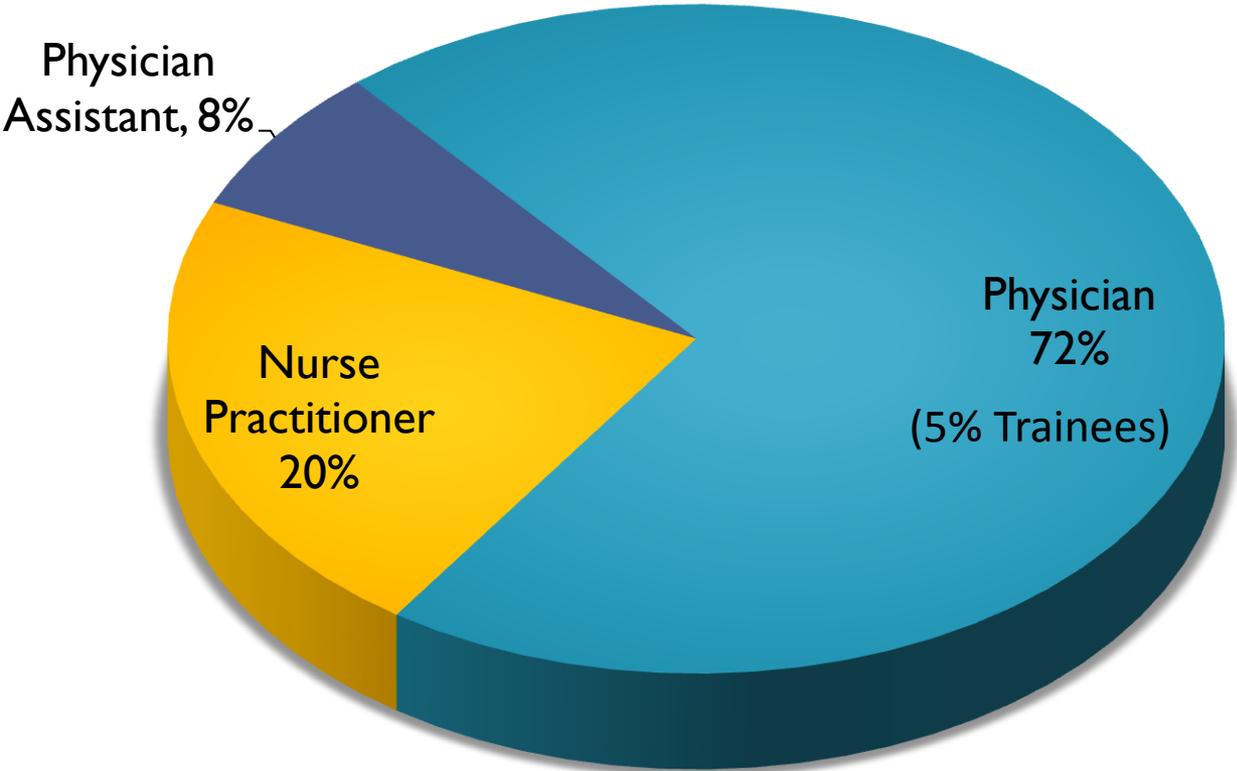
12 million encounters/year

VHA Primary Care by Age & Gender



VHA Primary Care Providers

7371 Providers, 5008 FTE (Avg. 0.69 FTE)



VHA Primary Care Milestones

1993 Under Secretary for Health's Letter, Primary Care as a VHA Priority

1994 Guidance for the Implementation Of Primary Care in Veterans Health Administrative (VHA)

1995 Primary Care in VA Primer

1996 Kizer's Vision for Change and Journey for Change

1998 Guidelines for Implementation of Primary Care

1998 Primary Care Management Module

1999 CPRS (EMR)

2004 Guidance on Primary Care Panel Size

2006 Primary Care Standards

2009 Universal Services Taskforce Report

VHA Primary Care

Strengths

Weaknesses

**Primary Care Model
Team Concept**

Provider oriented, not “patient-centered”
Interdisciplinary decision making unusual
Some employees not working at "top of competence”

**Access: Delays for primary care
visits infrequent**

Poor phone service; secure messaging proceeding slowly; Focus on face-to-face visits

**Service agreements
implemented to support
specialty care interface**

Efforts to manage chronic disease to optimize outcomes still limited

**Support programs and services
(Home telehealth, HBPC)**

Limited coordination available to manage crucial transitions of care

**Comprehensive Electronic
Medical Record**

Sub-optimal CPRS user functionality
Minimal Decision Support

Preventive Care Program

Large burden of chronic diseases; Poor health behaviors contribute
Health behaviors often not addressed and interventions often not provided
Healthcare staff need additional training

PATIENT CENTERED MEDICAL HOME

Replaces episodic care based on illness and patient complaints with coordinated care and a long term healing relationship



Takes collective responsibility for patient care



Is responsible for providing all the patient's health care needs



Arranges for appropriate care with other specialties

THE PRIMARY CARE TEAM

Principles of the Medical Home

Patient-Driven

- The primary care team is focused on the whole person
- Patient-preferences guide the care provided to the patient

Team-Based

- Primary care is delivered by an interdisciplinary team led by a primary care provider using facilitative leadership skills

Efficient

- Veterans receive the care they need at the time they need it from an interdisciplinary team functioning at the highest level of their competency

Comprehensive

- Primary care is point of first contact for a range of medical, behavioral and psychosocial needs, fully integrated with other VA health services and community resources

Continuous

- Every patient has an established and continuous relationship with a personal primary care provider

Communication

- The communication between the Veteran patient and other team members is honest, respectful, reliable, and culturally sensitive

Coordinated

- The PCMH team coordinates care for the patient across and between the health care system including the private sector.

What the Evidence Indicates:

**Cost neutral or cost savings
(modest)**

Decreased ED/Urgent Care visits

Decreased hospital admissions

Improved:

- **Quality of Life**
- **Quality of Care**
- **Functional Autonomy**
- **Access**
- **Patient-centeredness**
- **Coordination**
- **Safety**

Less disparity

Less Staff Burnout

Involving External Subject Matter Experts

SGIM

Society of General Internal Medicine
To Promote Improved Patient Care, Research, and Education

ACP AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | Doctors for AdultsSM



AMERICAN OSTEOPATHIC ASSOCIATION



AMERICAN ACADEMY OF
FAMILY PHYSICIANS

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDRENSM



GEISINGER

STRONG MEDICINE FOR AMERICA

Patient-Centered
Primary Care
COLLABORATIVE



DUKE UNIVERSITY SCHOOL OF MEDICINE

Department of Community & Family Medicine

cfm.mc.duke.edu

FOR PATIENTS

FOR PROFESSIONALS

RESEARCH & CLINICAL TRIALS

November 29, 2009

School of Medicine » Department of Community & Family Medicine

For Professionals

Welcome

About the Department

Faculty

News

Calendar

Educational Programs

Residencies/Fellowships

Research Activities



ANCC

AMERICAN NURSES
CREDENTIALING CENTER

President Obama cites
Geisinger as Reform Model



KAISER PERMANENTE

TransformMEDSM
TRANSFORMING MEDICAL PRACTICES

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Home » Partners & Projects » Johns Hopkins Lipitz Center

Johns Hopkins Lipitz Center

The Robert Wood Johnson Foundation Center for Integrated Health
John A. Hartford Foundation
CMS's three-year Model of Health Care Act.

E. Boulton, MD, MPH, Director of the Center for Integrated Health Care, and technical assistance provided to the Center for Integrated Health Care model, a chronic care model, and chronic care services. Early results of the center's work are being shared with other centers.

Incentive-based care. Practices will be required to provide services through the use of health information technology, and support...

ANA Nurses
AMERICAN NURSES ASSOCIATION
The largest nursing organization

IHI INSTITUTE FOR
HEALTHCARE
IMPROVEMENT

GGM

IBM
Home Solutions Services Products Support & downloads My IBM
Welcome [IBM Sign in] [Register]

A Smarter Planet Healthcare

Robert Wood Johnson Foundation



The American Organization of Nurse Executives

American Association of Colleges of Nursing
ADVANCING HIGHER EDUCATION IN NURSING

GUIDED CARE

Smarter Healthcare
To build a smarter system, healthcare solutions need to be instrumented, interconnected and intelligent

VISN 23 Chronic Disease Model

10,847 patients

October 2007 – August 2009

COPD

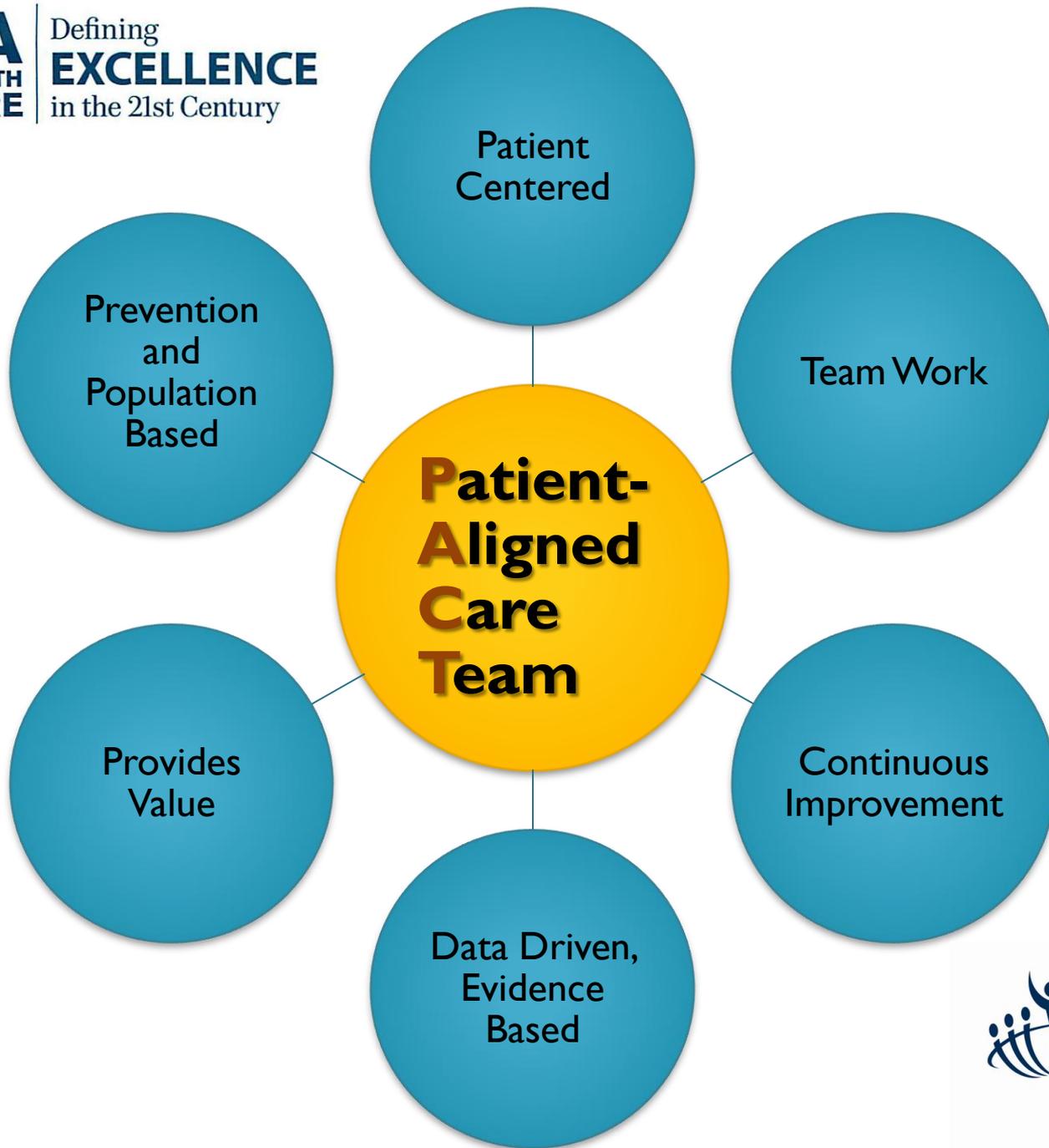
- ↓ RR ED visits 51%
- ↓ RR Admissions 31%
- Mortality per 100 patient yr 10.1/ vs. 13.8

CHF

- ↓ ED visits 35%
- 1.02 fewer ED visits for CHF/15 months after
- Admissions
- 0.15 fewer for CHF/15 months after

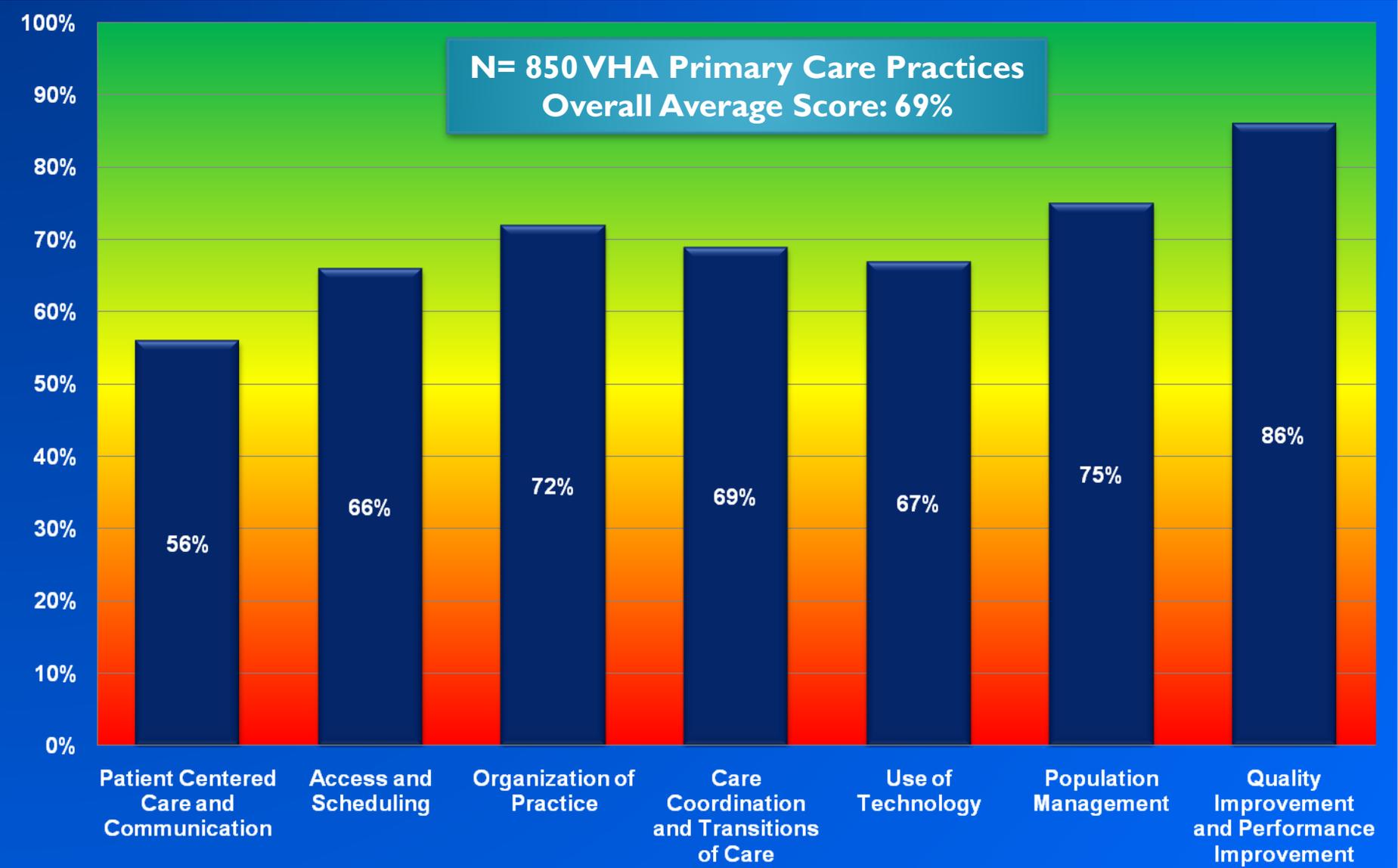
DM

- HgbA1C < 8.0% and LDL < 100 and BP < 130/80
- >2x usual care (22.3% vs. 10.4%)



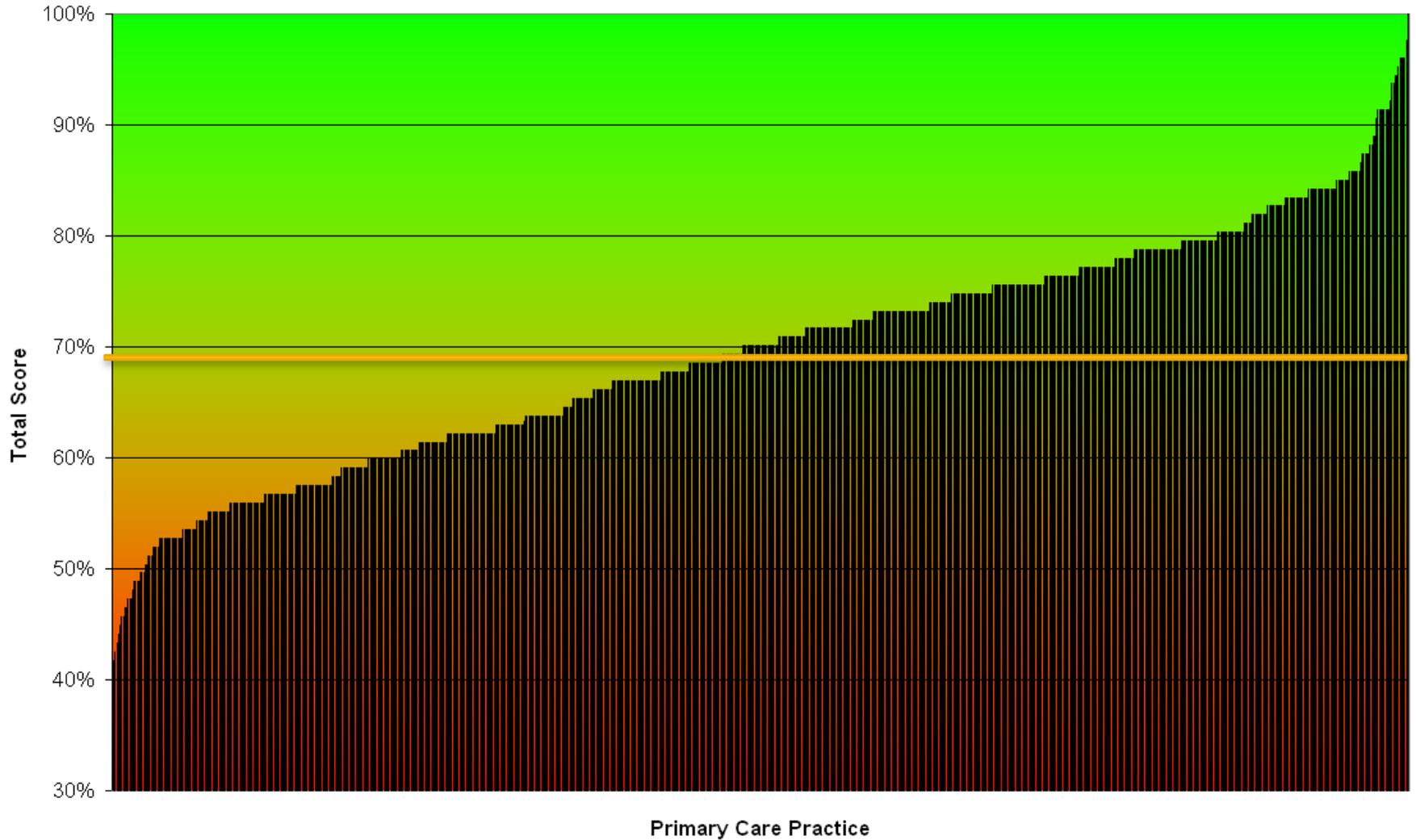
First Step: October 2009

American College of Physicians Medical Home Builder

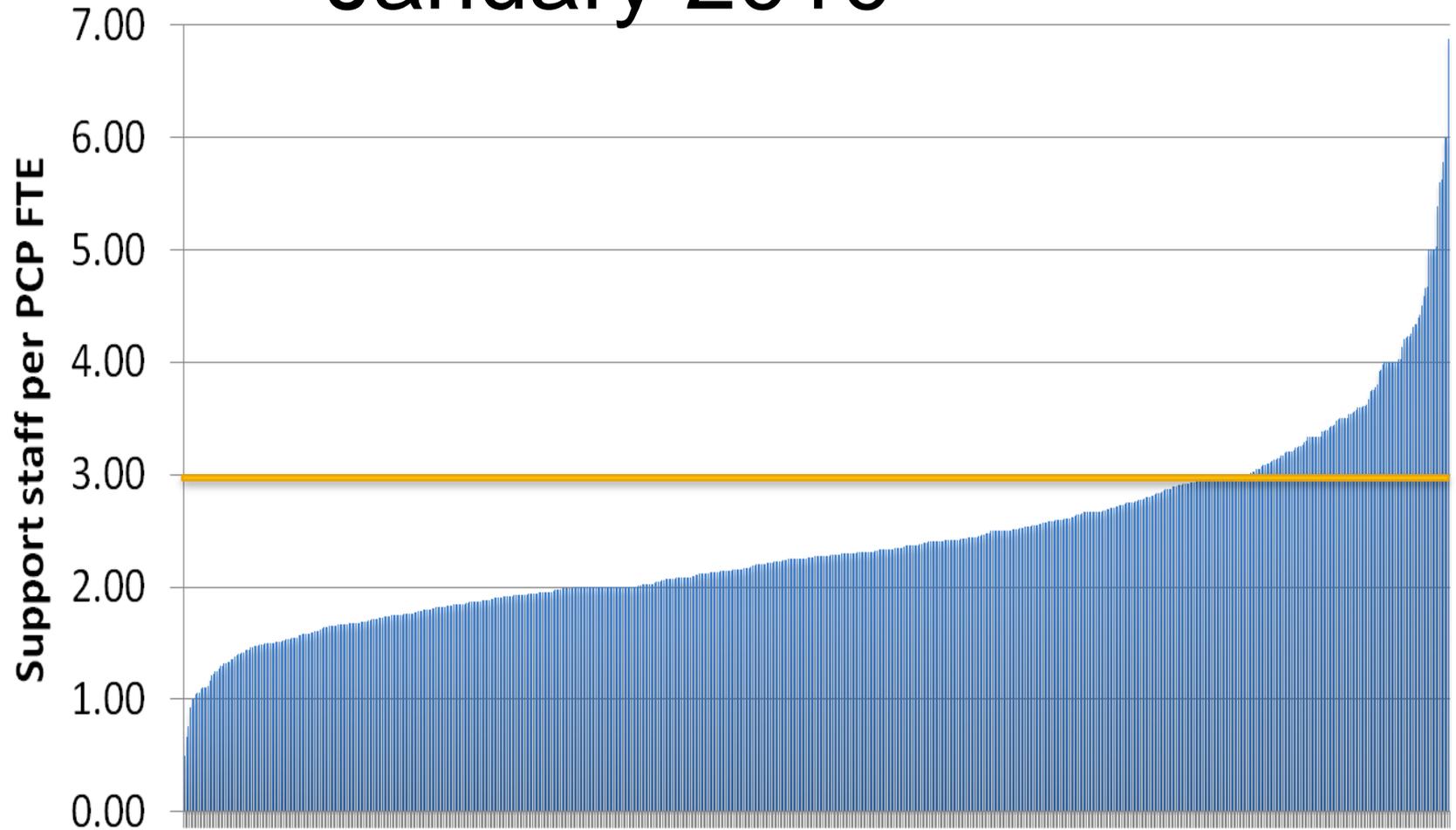


Total Score

VHA ACP Medical Home Builder Scores, October 2009



Support Staff Ratios January 2010



VHA Primary Care Sites (n=712)

Other Team Members
Clinical Pharmacy Specialist:
± 3 panels
Clinical Pharmacy
anticoagulation:
± 5 panels
Social Work: ± 2 panels
Nutrition: ± 5 panels
Case Managers
Trainees
Integrated Behavioral Health
Psychologist ± 3 panels
Social Worker ± 5 panels
Care Manager ± 5 panels
Psychiatrist ± 10 panels

Other Team Members

For each parent facility
Health Promotion Disease Prevention Program Manager: 1 FTE
Health Behavior Coordinator: 1 FTE
My HealtheVet Coordinator: 1 FTE

Teamlet: assigned to 1 panel (±1200 patients)

- **Provider: 1 FTE**
- **RN Care Mgr: 1 FTE**
- **Clinical Associate (LPN, MA, or Health Tech): 1 FTE**
- **Clerk: 1 FTE**

Panel size adjusted (modeled) for rooms and staffing

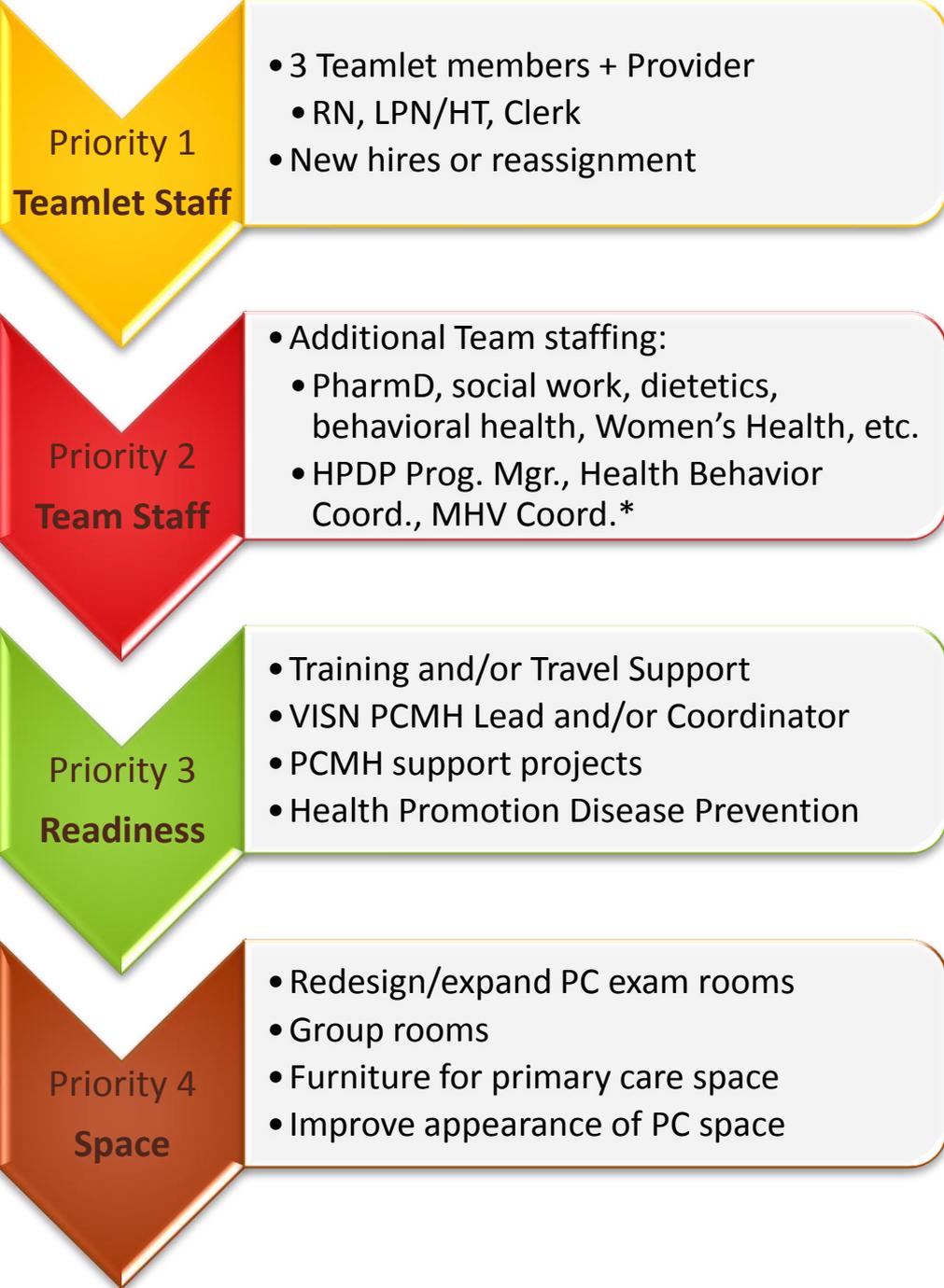
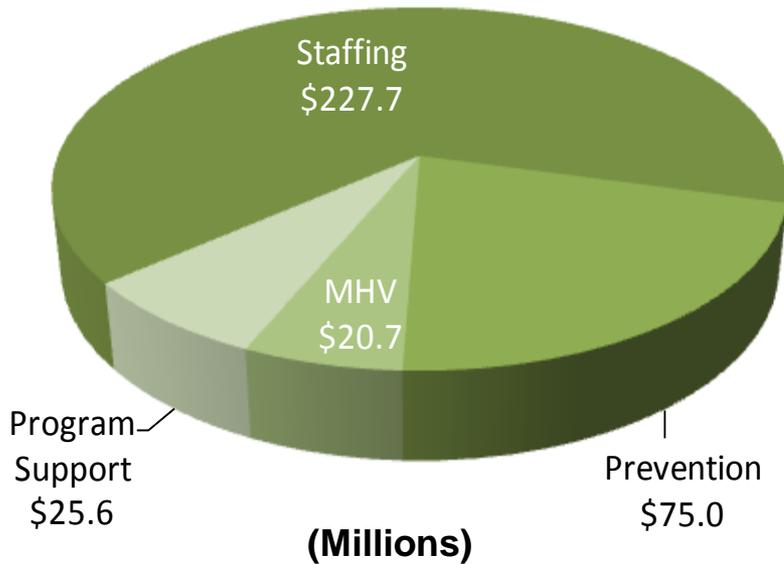
Monitored via Primary Care Staffing and Room Utilization Data

Patient

The Patient's Primary Care Team

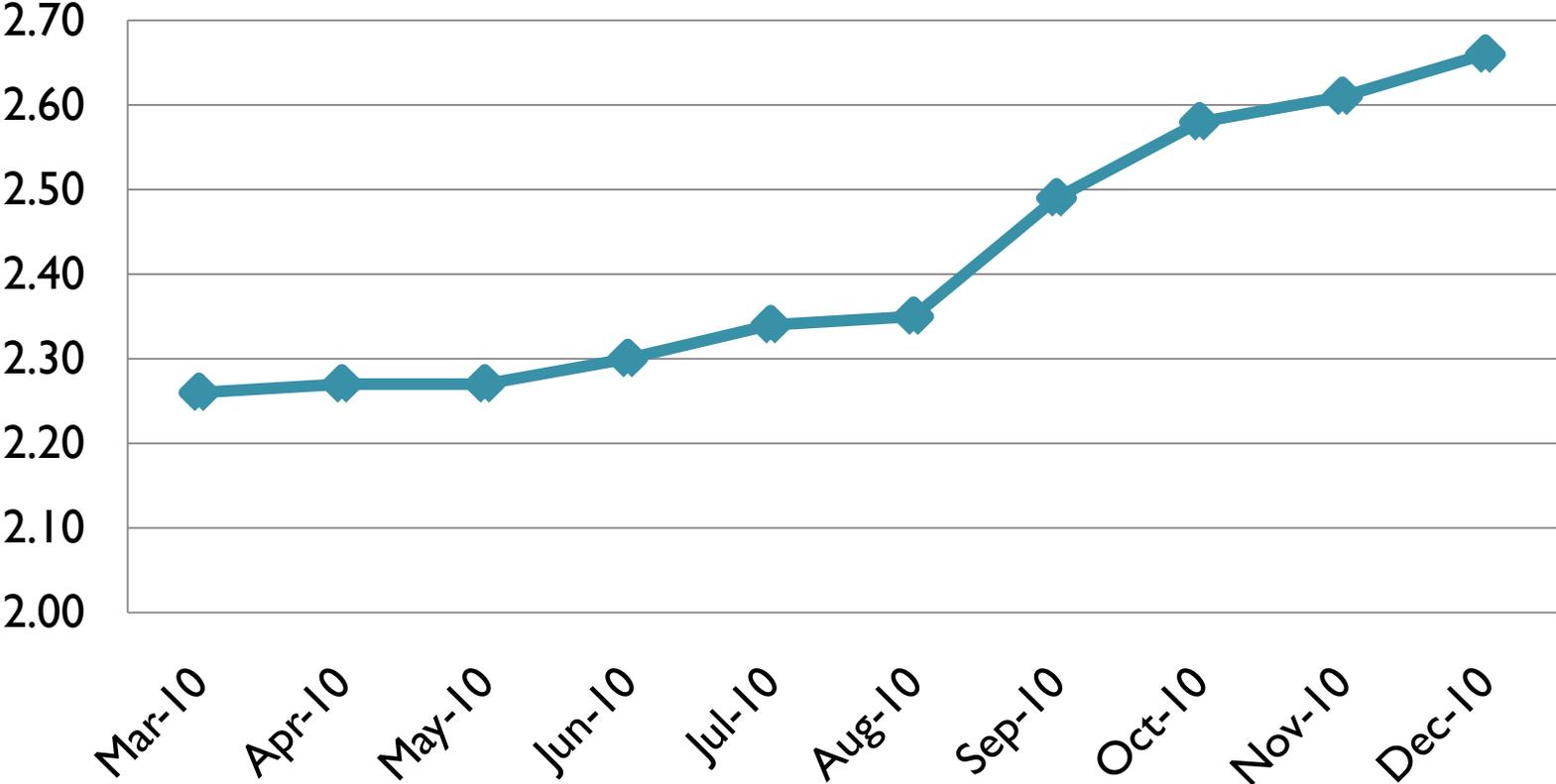


Funding Guidance

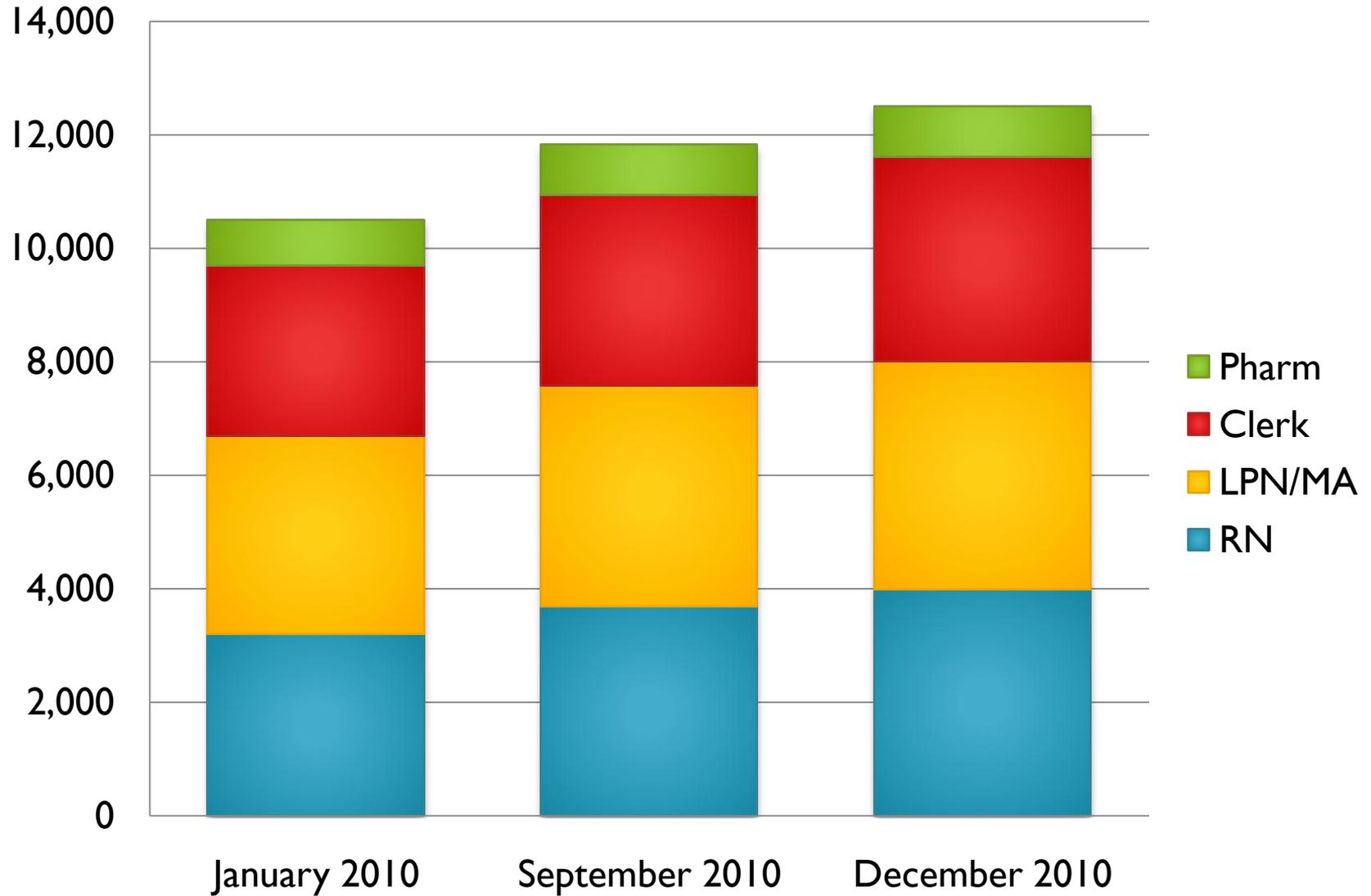


Primary Care (PCMM) National Staffing Ratio

Support Staff/PC FTE



PC Support Staff Mix



Collaborative



**Collaborative
Training: Mar
2010**

**LS 2:
Sep 2010**

**LS 4:
Mar 2011**

**LS 6: Sep
2011**

**LS 1:
June 2010**

**LS 3:
Dec 2010**

**LS 5: Jun
2011**

- Intensive training
- 6 Learning Sessions
- 18 months
- 250 Primary Care Teams



Transformation Initiative Learning Centers

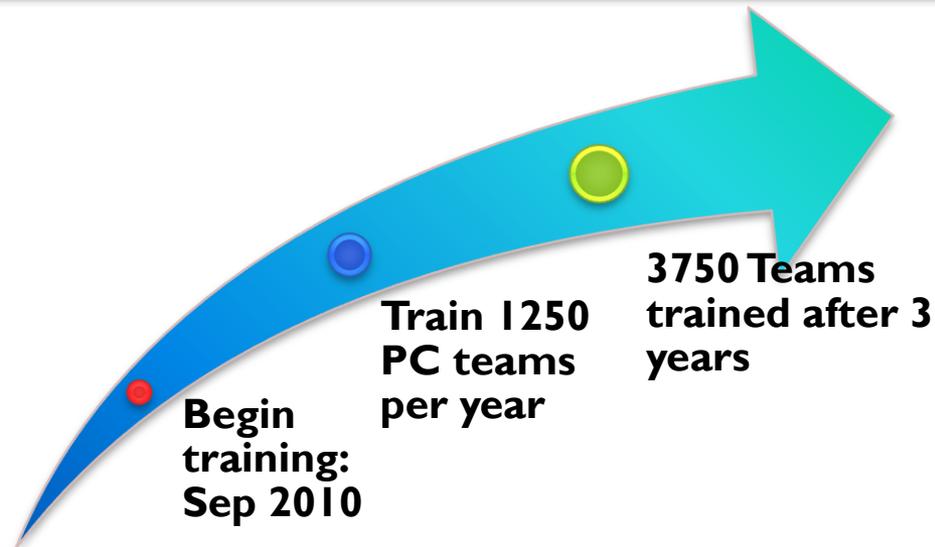
Education and Training

1 week intensive training in:

Team Function & Design

Care Management & Coordination

Patient Centered Care



Consultation Teams

5 Regional Teams

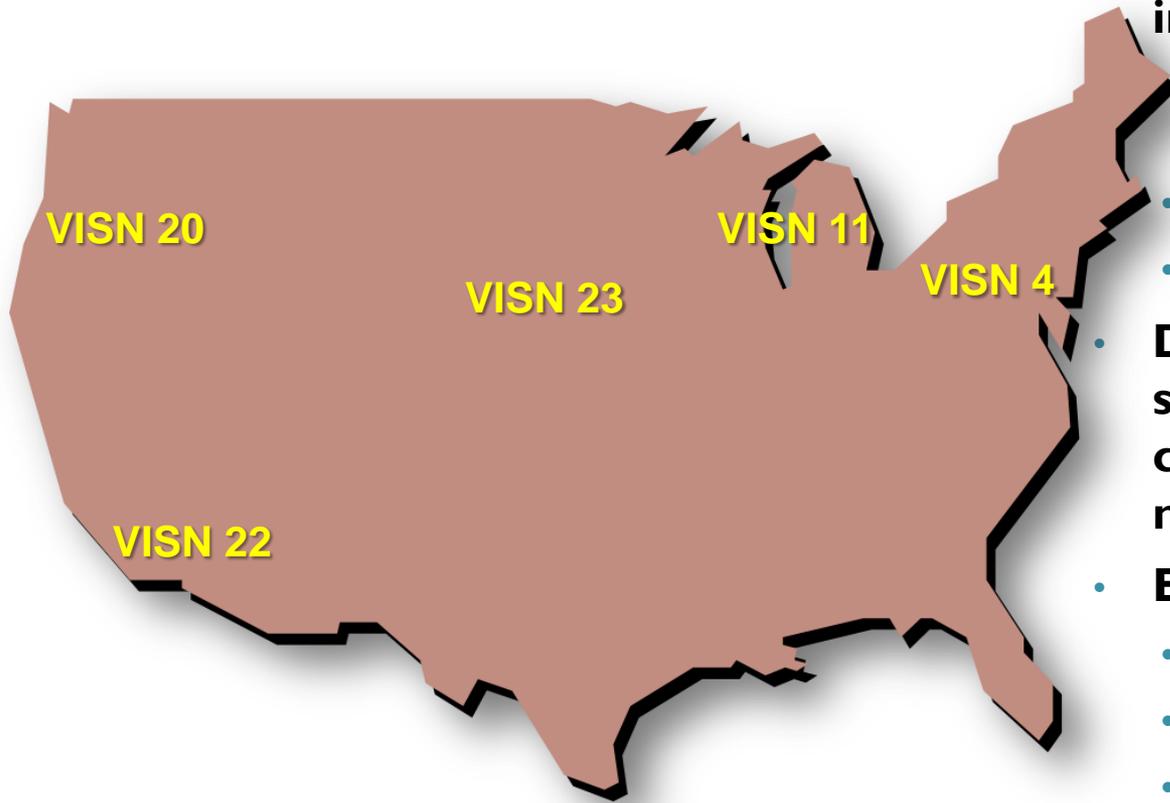
PCP, RN, Administrative lead

5-6 Site visits per region per year

Provides constructive feedback and on-site teaching at request of VISN

Begin site visits December 2010

Demonstration Laboratories



- Evaluate the effectiveness and impacts of VHA's PCMH model
 - Apply robust research designs and methods
 - Different practice settings
 - Different geographic locations
- Develop and test innovative solutions for the core components of the PCMH model
- Evaluate solutions for effects on
 - Costs
 - Clinical outcomes
 - Patient and provider experience

Centers of Excellence in Primary Care Education

Puget Sound

Boise

San Francisco

Cleveland

Connecticut

- **Develop and test innovative approaches to prepare for Primary Care practice in the 21st century**
 - Physician residents
 - Students
 - Advanced practice nurse
 - Undergraduate nursing students
 - Associated health trainees
- Utilize VA primary care settings

PACT Compass

Panel Management

- Panel size
- Panel capacity
- DCG
- Teamlet staff FTE
- Staffing ratio
- Revisit rate
- Number of new patients

Patient Engagement and Satisfaction

- All-Employee survey PC satisfaction scores
- SHEP scores (selected)
- Patient complaints (Patient Advocate)
- My HealtheVet enrollment
 - % IPA

Continuity

- *Provider*: % visits with assigned PCP
- ED visit rate
- *Team*: % visits with team

Access

- Desired Date appointments
 - Same day
 - Within 7 days
 - Within 14 days
- 3rd next available
- Group clinic encounters
- Telephone clinic encounters
- No-show rate
- Telephone access data
- Secure messaging data

Coordination

- Admission rate
- Pt contacted within 2 days of discharge
- Pt contacted within 7 days of discharge
- CCHT Enrollment
- Consult tracking
- Specialty referral rates

Clinical Improvement

- Admission rates
- ED visit rates
- Panel case mix
- Readmission rates
- Ambulatory Care Sensitive Admissions
- Mortality

Learning, Discovery, Continuous Improvement

Readiness Assessment Staffing Support

- ACP Medical Home Builder
- Primary Care Staffing

Training and Education

- PCMH Summit
- PACT Collaborative
- TILC (Transformation Initiative Learning Centers)
- Consultation Teams

Demonstration Labs

Measurement: PACT Compass

- Access
- Continuity
- Patient Engagement/Satisfaction
- Coordination
- Panel Management
- Clinical Improvement

IT Improvements

- PCMM enhancements
- CPRS enhancements
- Identify high risk patients
- Secure Messaging

Communication

- Staff
- Patients
- Stakeholders

Centers of Excellence in Primary Care Education

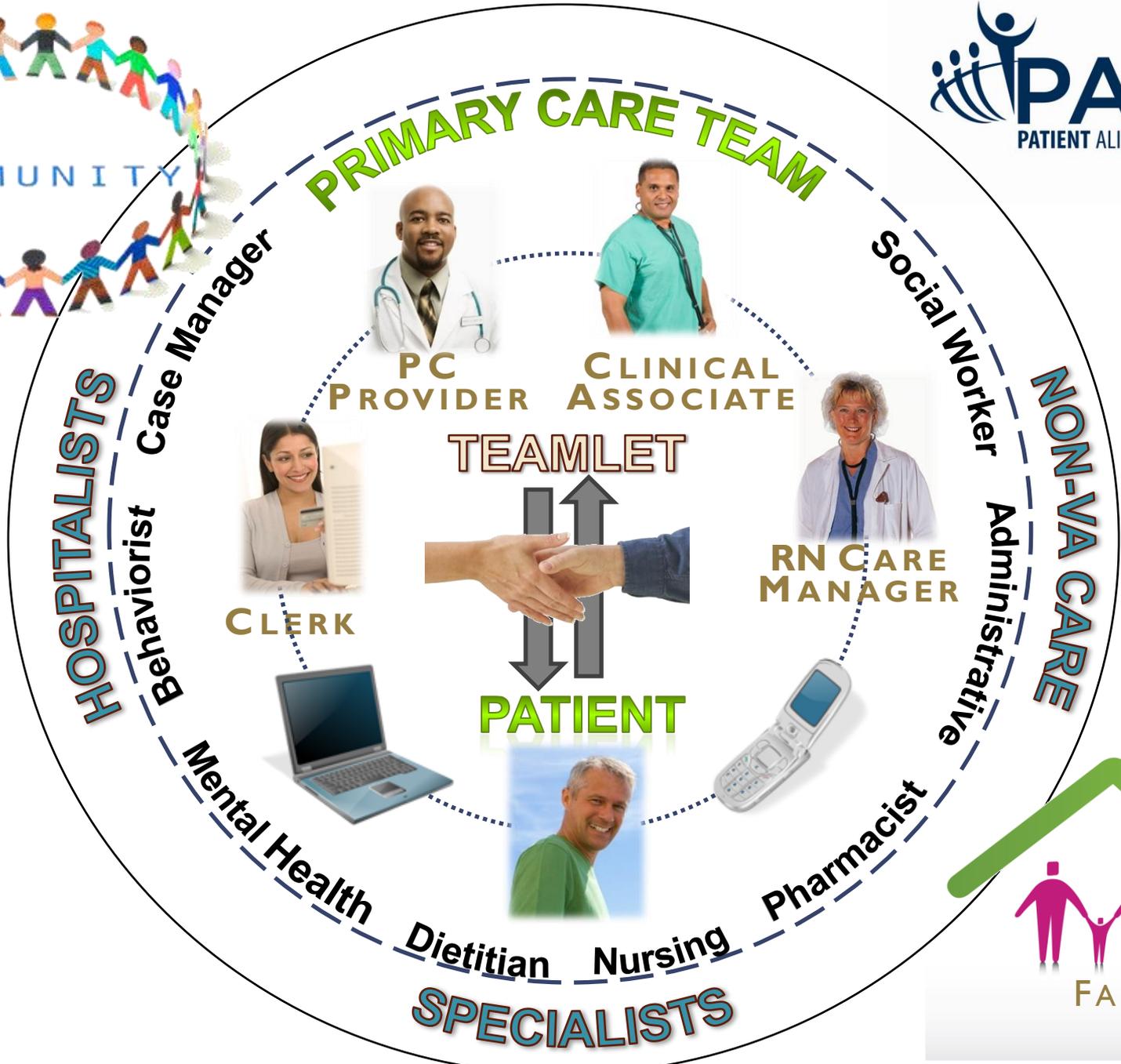
Implementation Guidance and Support

- PACT Handbook
- Workload capture
- Protocols

PACT Certification Specialty Integration



COMMUNITY



HOSPITALISTS

PRIMARY CARE TEAM

NON-VA CARE

SPECIALISTS



FAMILY

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Ishani, A., et.al, Effect of Nurse Case Management Compared to Usual Care on Controlling Cardiovascular Risk Factors in Patients with Diabetes: A Randomized Controlled Trial. (In submission).

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PACT Demo Lab Coordinating Center Overview

Stephan D. Fihn, MD, MPH



Demo Lab Coordinating Center Mission

Support and evaluate the VA transition to PACT through effective clinical-research partnerships developed by the PACT Demo Lab Coordinating Center and the PACT Demo Labs

- Oversight & coordination of PACT Demo Labs
- National Evaluation of PACT Implementation



Specific Objectives/Goals

- Define core measures of clinical and organizational processes and outcomes
- Extract and analyze data from VA national databases to evaluate PACT implementation and report results to VA leadership
- Develop lab-specific metrics, to support implementation and evaluation of lab-initiated organizational and clinical programs
- Timely reporting of lab activities and findings

Collaborators (VA)

Funding: Patient Care Services/Office of Primary Care

Sponsors: Richard Stark, Gordon Schectman

- PCS – Paul Nichol, Rachel Wiebe, Kathy Frisbee
- OQP – Joe Francis, Jim Shaffer, Steve Wright, Michelle Lucatorto
- NCOD – Scott Moore, Chris Orszak
- HSR&D – David Atkins
- ORD/ORO/VA Central IRB – Lynn Cates, Tom Puglisi
- OI&T/Corporate Data Warehouse – Steve Anderson
- Systems Redesign – Mike Davies



Collaborators/Consultants (Non-VA)

- American College of Physicians – Michael Barr
- Group Health Coop. – Rob Reid, Katie Coleman
- Commonwealth Foundation – Melinda Abrams
- National Committee for Quality Assurance – Sarah Scholle
- University of Washington/Dept. of Health Services – Dan Lessler, David Grembowski, Doug Conrad, Chuck Maynard
- AHRQ - Janice Geneviro and David Meyers

Progress to Date

- Matrix of candidate measures & data sources
- Pilot testing care mgmnt/predictive modeling
- Cohort definitions
- Coordination with learning collaboratives
- Full integration with PACT IT planning
- Exploring new measures for key domains
 - Pt. Experience – new CAHPS/SHEP measures
 - Team function

Overarching Questions

- Does implementing PACT improve care?
 - Processes, outcomes
 - Variation by type of site, type of patient?
 - Patient experience
 - Provider/clinical team satisfaction
- What is the most effective way(s) to implement PACT?
- What are costs and savings associated with PACT?
- How does VA respond to new questions that arise during rollout?

Sample Measures

Domain	Construct	Measure	Data Source
DISEASE MANAGEMENT	Health status	Current patient Survey of health status	SF-12 (SHEP)
	Blood pressure control	% of adults age 18-85 years with a diagnosis of hypertension and blood pressure adequately controlled (<140/90 mm Hg)	CDW
	LDL-C control	percentage of adults age 18-75 years with acute myocardial infarction, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, or ischemic vascular disease diagnosis and good LDL-C control (<100 mg/dL)	CDW
	Blood sugar control	% of adults age 18-75 years with diabetes (type 1 and type 2) with good A1C control (<9.0%)	CDW
UTILIZATION/COSTS	VA Utilization	Encounters per person-year by visit type (PC, specialty, ED, telephone, etc.); High cost procedures; Admissions/Readmissions	DSS, NPCD
	Medicare utilization	For dually eligible veterans: No. visits/ admissions paid by Medicare; proportion total primary/specialty care visits (VA+Medicare) paid by Medicare	Medicare claims, OPC

Sample Measures – cont.

Domain	Construct	Measure	Data Source
ACCESS/ CONTINUITY	Appointment wait times	% of patients seen on same day (within 1 day, within 14 days) as desired appointment date	VSSC
	Telephone consults	% of calls successfully answered within 30 seconds	IPT, Dayton
	Email contacts	% of pt.generated emails responded to w/in 24 hrs.	
	Group visits	% of PCP time scheduled for any group visits	VSSC
	Continuity	% of encounters with assigned PCP, teamlet (non-provider clinical staff)	PCMM
PROCESS OF CARE	Staffing ratios for effective teams	Staffing Ratio; Staffing mix by provider type; # of unfilled vacancies.	PCMM
	Members working to top of competency	Survey of team members compared to typical team tasks by position type	Survey, LC data
PT. EX- PERIENCE	Patient perceptions of continuity and coordination of care, quality of care, self-management support	Add PCMH-related CAHPS questions to OQP SHEP survey; possibly oversample Demonstration Labs and/or specific sub-populations. Meta-analysis of intensive qualitative work with patients at Demonstration Labs	SHEP, qualitative work

Evaluation

- Qualitative Process/Implementation Evaluation of the VISN
 - Structured interviews of PCMH implementers (complete)
 - Structured interviews of providers and staff (ongoing)
 - Observation of PACT events (ongoing)
 - Patient survey and focus groups (planned)
- Quantitative Outcome Evaluations
 - Provider survey assessing organizational climate (complete)
 - Evaluation of primary care provider booking density and ED use (ongoing)
 - Quantitative measures of implementation using VISN 4 VDW (ongoing)



Interventions

- Clinical Innovation Pilot Projects (ongoing)
 - Pain Care Management for the Medical Home
 - Telehealth in the PADRECC
 - Targeting Specific Needs of OEF/OIF veteran with PTSD in Primary Care
 - Engaging Caregivers in the Care of Veterans with Dementia
- Provider Activity Study
 - Phase 1: Tool development (ongoing)
 - Phase 2: Evaluation of relationship between provider activity, process measures, and health outcomes (planned)
 - Phase 3: Intervention to improve provider time management (planned)



VISN4
CEPACT



Questions We Are Addressing

- How are elements of PACT being defined and implemented differently at each site? Why? What is the result?
 - Noted differences: nurse care manager role, pilot teamlets vs. all of primary care, chronic care protocols ...
- What facilitates/impedes implementation of PACT in different settings?
 - Early findings: leadership, access to/understanding of performance data
- What are meaningful measures of PACT implementation and how do they influence care and outcomes?
- How do we improve best practices through PACTs?



Key Products

- ▶ Tools
 - ▶ To assess patient flow and provider productivity
 - ▶ Validated assessments of patients with dementia for care givers
- ▶ Advances in Clinical Practice
 - ▶ Using home telehealth
 - ▶ Improving pain care management and disease specific care
 - ▶ Enhancing provider productivity
- ▶ Continuous Feedback
 - ▶ Research briefs for VISN leadership, Newsletters, Website
- ▶ Scientific Publications and Presentations



Key Partnerships

- VISN 4 Leadership
 - David Macpherson (CMO), Michael Moreland (VISN 4 Director)
- Key Implementers at VISN 4 Sites
- Center for Health Equity Research and Promotion (CHERP)
- Mental Illness Research, Education and Clinical Centers (MIRECC)
- Performance Reporting and Outcomes Measurement to Improve the Standard of care at End-of-life (PROMISE) Center
- PACT Demo Lab Coordinating Center
- University of Pennsylvania





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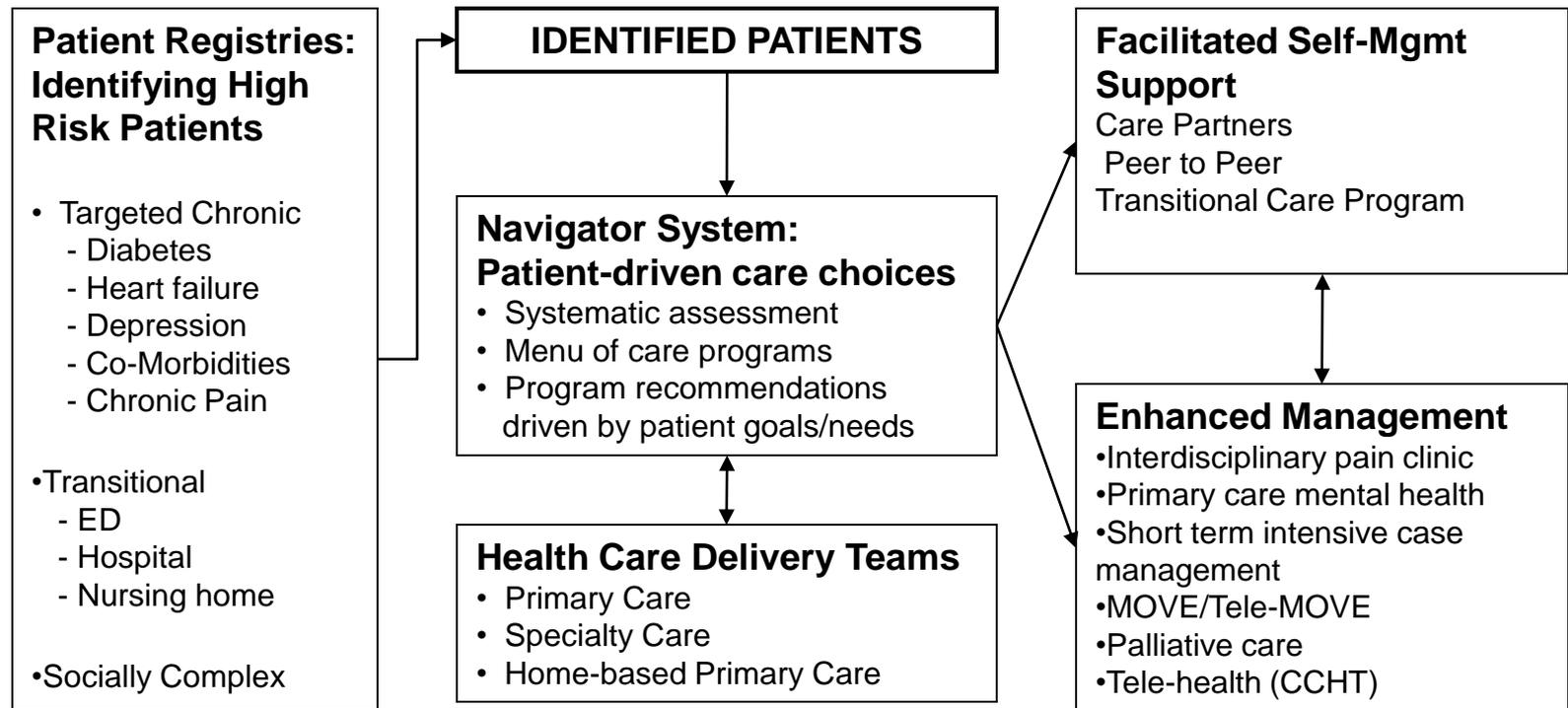
Eve Kerr, MD, MPH



VISN 11 Demo Lab Ann Arbor, MI



VAAHHS PATIENT-ALIGNED CARE TEAM INNOVATIONS



VISN 11 Demo Lab

Major innovations being studied

The Navigator System



SSN: Patient Notes [Schedule Activity or Call Back](#)

Short term assessment should be done at 2 weeks, 3 months and 9 mo.
 Long term assessment at 6 and 12 months

Patient Information | Initial Assessment | Referrals | Short Term Assessments | Long Term Assessments

Patient Information

George	Adams	Gender	MALE	Team	RED
Home Phone	734-555-1212	Date of Birth	6/10/1939	Site	ANN ARBOR
Other Phone		Patient Number	66661043	PCP	TAYLOR, CAROLINE MD
? Is it OK with patient to leave phone message with health information? <input checked="" type="radio"/> Yes <input checked="" type="radio"/> No <input checked="" type="radio"/> Unknown			Eligible Date	12/1/2010	
			CHF	<input type="checkbox"/>	
			Diabetes	<input checked="" type="checkbox"/>	
			Pain	<input type="checkbox"/>	

Navigator Activity History

Date	Time	Activity	Disposition	Notes	<input type="button" value="Jump to First Activity"/>

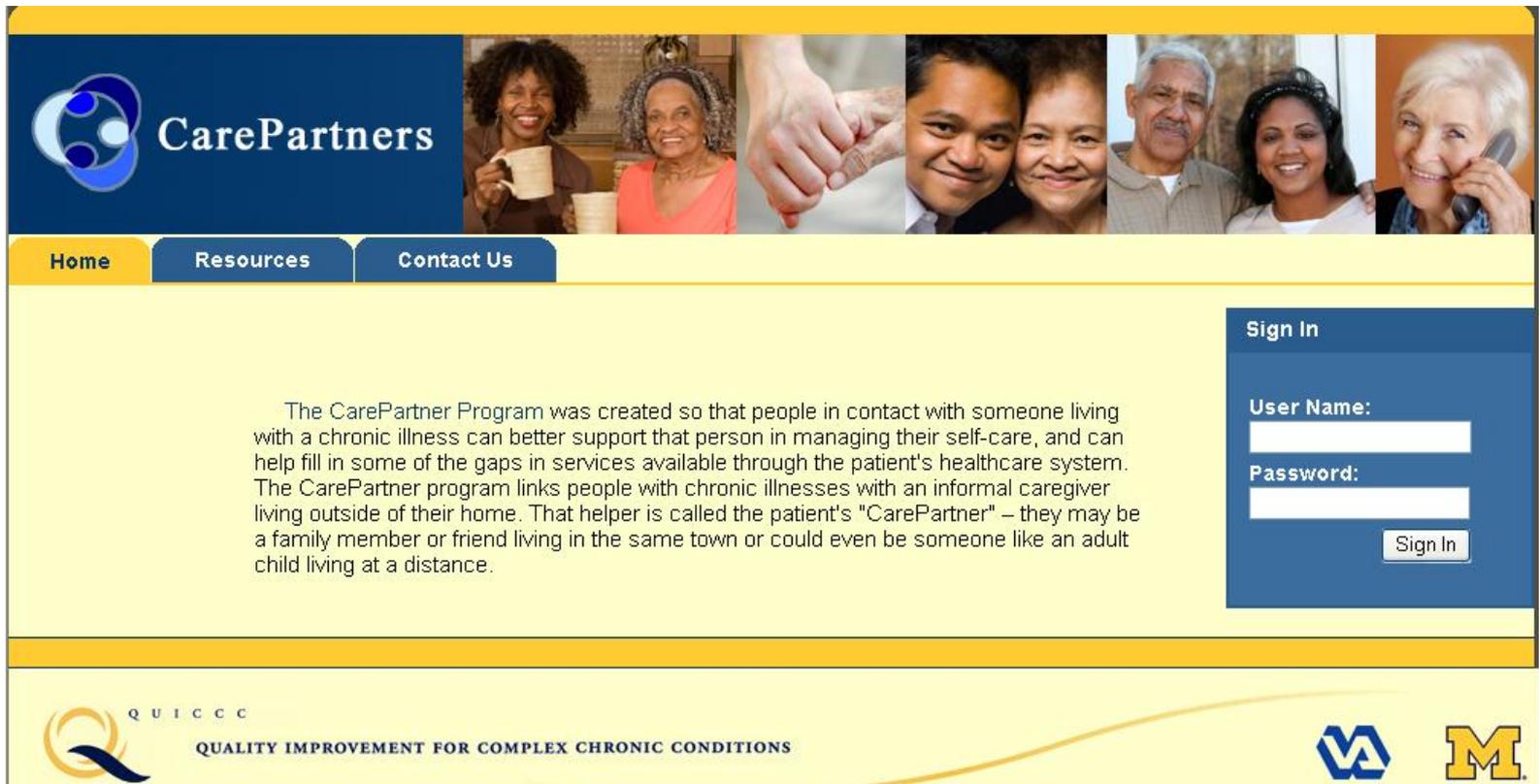
VISN II Demo Lab

Key research-clinical partnerships



VISN 11 Demo Lab

Key products/contributions



The screenshot shows the CarePartners website interface. At the top left is the CarePartners logo, which consists of a stylized blue and white circular icon followed by the text "CarePartners". To the right of the logo is a horizontal strip of six small images: two women smiling, two hands shaking, a man and woman smiling, a man and woman smiling, and an older woman talking on a mobile phone. Below the logo and images is a navigation bar with three buttons: "Home", "Resources", and "Contact Us". The main content area is yellow and contains a paragraph of text on the left and a sign-in form on the right. The sign-in form has a blue background and contains the text "Sign In", "User Name:", a text input field, "Password:", another text input field, and a "Sign In" button. At the bottom of the page is a footer with the QUICCC logo (a stylized 'Q' with a blue swoosh) and the text "QUICCC QUALITY IMPROVEMENT FOR COMPLEX CHRONIC CONDITIONS". To the right of the QUICCC logo are two logos: a blue and white "W" logo and a yellow "M" logo.

CarePartners

[Home](#) [Resources](#) [Contact Us](#)

The CarePartner Program was created so that people in contact with someone living with a chronic illness can better support that person in managing their self-care, and can help fill in some of the gaps in services available through the patient's healthcare system. The CarePartner program links people with chronic illnesses with an informal caregiver living outside of their home. That helper is called the patient's "CarePartner" – they may be a family member or friend living in the same town or could even be someone like an adult child living at a distance.

Sign In

User Name:

Password:

QUICCC
QUALITY IMPROVEMENT FOR COMPLEX CHRONIC CONDITIONS

W M

VISN 11 Demo Lab

Progress Highlights

- 1st version of Navigator System built and tested
- CarePartners (IVR) program developed for diabetes and CHF
- Transitional Care Program in development
- Focus Group Guides, Interview Guides, and Surveys developed for rigorous evaluation of both Veterans and staff



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VISN 20 Demo Lab

David Hickam, MD, MPH

Michael Alperin, MD



VISN20 Demo Lab

Project Setting

- Collaborative project among:
 - Portland VA Medical Center (lead site)
 - VA Roseburg Healthcare System
 - Southern Oregon Rehabilitation Center and Clinics (White City VAMC)
- Evaluating implementation of PACT model in 16 VA primary care clinics serving 85,000 veterans in 3 states.
 - 10 urban/suburban clinics
 - 6 rural clinics
 - More than 50 teamlets



VISN20 Demo Lab

Major innovations being studied

- Primary care transformation
 - Effective team functioning
 - Patient centered care
 - Population management
- Care conduits
 - Cohorts with specific chronic diseases (CHF)
 - Integration of primary and specialty care
 - Care management tools
 - Patient stratification by severity
 - Staff competencies

VISN20 Demo Lab

Key research-clinical partnerships

- Close affiliation between research staff and primary care leadership
 - Portland primary care operations group
- Key participation by top-level managers
 - Portland Director of Primary Care Division
 - White City Chief of Staff
 - Roseburg ACOS/Primary Care

VISN20 Demo Lab

Key products/contributions

- To clinical care improvement
 - Unified care plan for CHF
 - Scripts and templates for use by teamlets
 - Registry tool
 - Built on successful model of diabetes registry
 - Adaptable to multiple diseases
- To research/implementation science
 - Needs assessment
 - Define variation across clinics about facilitators/barriers
 - Insight into change management

VISN20 Demo Lab

Progress Highlights

- High level of integration of Demo Lab staff in planning activities for primary care.
- High rates of participation by primary care staff in focus groups and interviews.
- Care management tools successfully prototyped.
- Full specification of registry tool.
- Construction of longitudinal database.
 - Time series analyses for disease-specific measures
 - 5 years of baseline data for all clinics



VISN 22 Demo Lab

Lisa V. Rubenstein, MD, MSPH



VAIL Overarching Goal

- Stimulate, prioritize, structure and support PACT-related innovation development in demonstration sites
 - Organized local innovation development using QI science tools & VAIL technical support
 - Evidence introduced at multiple points
 - Spread successful innovations regionally and nationally

Innovation: PACT +

- Can a QI research/clinical partnership enhance PACT success?
- Uses evidence-based quality improvement (EBQI)
 - VISN 22 Interdisciplinary Steering Committee
 - Interdisciplinary quality councils at each demonstration practice
 - Cross-medical center technical workgroups

Partnerships

- VISN 22 interdisciplinary leadership
- Loma Linda, San Diego, and VA Greater Los Angeles Health Systems
 - One demo practice per system this year, two next year, and ad lib the following year
- Coordinating Center
- Health services researchers/clinicians in VISNs 2, 6, 17 and 18 participating in pilot testing VAIL evaluation instruments

Expected Clinical Products/Contributions

- Toolkits, verified/validated in two to three sites, incorporates/builds on national tools
 - Basic PACT implementation tool kit
 - Successful Innovations tool kits (e.g., potentially MyHealtheVet enrollment, detecting medication adherence, teamlet report cards)
- Integration of existing V22 registry into routine PACT care
- Interdisciplinary leadership & QI cultural change methods

Key Expected Knowledge Products/Contributions

- Does ongoing research/clinical partnership enhance PACT implementation?
 - Qualitative investigation of teamlets
 - Healthcare provider and staff survey
 - Economic evaluation (with HERC)
 - Electronic quality measures, including mental health
 - Implementation/process evaluation



VA
HEALTH
CARE

Defining
EXCELLENCE
in the 21st Century

VISN 23 Demo Lab

David Katz, MD, MSc



VISN 23 Demo Lab

- Evaluation includes 5 states in VISN 23
 - 30 PACT Teams in VAMCs and CBOCs
 - 22 PACT Teams in VISN 23 Learning Collaborative
 - 8 PACT Teams in Central Region Learning Collaborative
- Demo Lab activities organized around 5 cores
 - Secondary Analysis and Biostatistics
 - Formative and Team Evaluation
 - Behavioral Health
 - Survey Development & Administration
 - Evidence Synthesis

VISN 23 Demo Lab

Major innovations being studied

- How does implementation of PACT affects the work roles of team members?
- Can a “Community of Practice” collaborative support PACT nurses during role transitions?
- How to improve information exchange between PACT and private providers for co-managed veterans?
- What is the relationship between key attributes of PACT model and quality of care?
- What are the preferences of PACT patients regarding self management of chronic disease?



VISN 23 Demo Lab

Key research-clinical partnerships

- Midwest Rural Health Resource Center
 - Collaboration on issues related to PACT implementation in rural settings
- VISN 23 Primary Care Service Line
 - Direct implementation efforts related to PACT
- VISN 23 and Central Region PACT Learning Collaboratives
 - Provide access to PACT teams and materials
 - Feedback from the Demo lab will be provided to the PACT teams



VISN 23 Demo Lab

Key products/contributions

- Patient care
 - Tailoring self-management of chronic disease based on patient preferences
 - Improving co-management of veterans
 - Optimizing PACT model in rural settings
- Implementation science
 - Understanding of the impact of PACT implementation on providers' roles
 - Exploring relationships between different team function measures and outcomes
 - Identifying best practices for implementing the PACT model in a variety of primary care settings



VISN 23 Demo Lab

Progress Highlights

- Completed an in-depth formative evaluation of the Grand Island, NE PACT (started in 2008)
- Collected baseline measurement of PACT provider perceptions of their work environment
- Conducting telephone interviews with PACT providers and piloting of telephone-based diary program
- Conducting systematic reviews of PCMH-related literature to inform implementation
- Developing a registry of VISN 23 PACT teams and tracking patient outcomes during follow-up
- Conducting an analysis of VISN 23 patient survey data during PACT implementation.

