Patient Aligned Care Teams (PACT) Demonstration Lab Initiative

Research-Clinical Partnerships to Evaluate and Enhance VA PACT Implementation

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Stephan Fihn, MD, MPH (Demo Lab Coordinating Center)
Judith Long, MD, MPH (VISN 4 Demo Lab)
Eve Kerr, MD, MPH (VISN 11 Demo Lab)
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David Katz, MD, MSc (VISN 23 Demo Lab)

VA HSR&D Meeting   Washington DC   February 17, 2011
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

Million patients

Age

<25 25-34 35-44 45-54 55-64 65-74 75-84 85-up

6.1% Female

21% had encounter in Mental Health

44%

25%

Female Male
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

| 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

THE PRIMARY CARE TEAM

- Takes collective responsibility for patient care
- Is responsible for providing all the patient’s health care needs
- Arranges for appropriate care with other specialties
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
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%)
Patient-Aligned Care Team

- Patient Centered
- Team Work
- Prevention and Population Based
- Provides Value
- Data Driven, Evidence Based
- Continuous Improvement

Provides Value
Prevention and Population Based
Continuous Improvement
Data Driven, Evidence Based
Team Work
Patient Centered
First Step: October 2009
American College of Physicians  Medical Home Builder

N= 850 VHA Primary Care Practices
Overall Average Score: 69%
Total Score

VHA ACP Medical Home Builder Scores, October 2009

Primary Care Practice
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

**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

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

**Monitored via Primary Care Staffing and Room Utilization Data**

**Panel size adjusted (modeled) for rooms and staffing**

*The Patient’s Primary Care Team*
Funding Guidance

- **Priority 1: Teamlet Staff**
  - 3 Teamlet members + Provider
  - RN, LPN/HT, Clerk
  - New hires or reassignment

- **Priority 2: Team Staff**
  - Additional Team staffing:
    - PharmD, social work, dietetics, behavioral health, Women’s Health, etc.
    - HPDP Prog. Mgr., Health Behavior Coord., MHV Coord.*

- **Priority 3: Readiness**
  - Training and/or Travel Support
  - VISN PCMH Lead and/or Coordinator
  - PCMH support projects
  - Health Promotion Disease Prevention

- **Priority 4: Space**
  - Redesign/expand PC exam rooms
  - Group rooms
  - Furniture for primary care space
  - Improve appearance of PC space

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**Funding Breakdown**

- Staffing: $227.7
- Prevention: $75.0
- MHV: $20.7
- Program Support: $25.6

*(Millions)*
Primary Care (PCMM)
National Staffing Ratio

Support Staff/PC FTE

Mar-10  Apr-10  May-10  Jun-10  Jul-10  Aug-10  Sep-10  Oct-10  Nov-10  Dec-10
PC Support Staff Mix

- **January 2010**
  - Pharm
  - Clerk
  - LPN/MA
  - RN
- **September 2010**
  - Pharm
  - Clerk
  - LPN/MA
  - RN
- **December 2010**
  - Pharm
  - Clerk
  - LPN/MA
  - RN
Collaborative

- 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

Begin training: Sep 2010
Train 1250 PC teams per year
3750 Teams trained after 3 years
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

VISN 4
VISN 11
VISN 20
VISN 22
VISN 23
Centers of Excellence in Primary Care Education

- 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 HealthVet 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
References


Health Partners uses “BestCare” practices to improve care and outcomes, reduce costs. Institute for Health Care Improvement. Available at: http://www.ihi.org/NR/rdonlyres/7150DBEF-3853-4390-BAF30ACDCA648F5/0/IHITripleAimHealthPartnersSummaryofSuccessJul09.pdf


Geisenger Health System, presentation at White House roundtable on Advanced Models of Primary Care, August 10, 2009.


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).

Dwan, NA., et.al, Economic Evaluation of a Disease Management Program for Chronic Obstructive Pulmonary Disease, (In submission).
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 Genevro 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

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DISEASE MANAGEMENT</strong></td>
<td>Health status</td>
<td>Current patient Survey of health status</td>
<td>SF-12 (SHEP)</td>
</tr>
<tr>
<td></td>
<td>Blood pressure control</td>
<td>% of adults age 18-85 years with a diagnosis of hypertension and blood pressure adequately controlled (&lt;140/90 mm Hg)</td>
<td>CDW</td>
</tr>
<tr>
<td></td>
<td>LDL-C control</td>
<td>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 (&lt;100 mg/dL)</td>
<td>CDW</td>
</tr>
<tr>
<td></td>
<td>Blood sugar control</td>
<td>% of adults age 18-75 years with diabetes (type 1 and type 2) with good A1C control (&lt;9.0%)</td>
<td>CDW</td>
</tr>
<tr>
<td><strong>UTILIZATION/COST</strong></td>
<td>VA Utilization</td>
<td>Encounters per person-year by visit type (PC, specialty, ED, telephone, etc.); High cost procedures; Admissions/Readmissions</td>
<td>DSS, NPCD</td>
</tr>
<tr>
<td></td>
<td>Medicare utilization</td>
<td>For dually eligible veterans: No. visits/admissions paid by Medicare; proportion total primary/specialty care visits (VA+Medicare) paid by Medicare</td>
<td>Medicare claims, OPC</td>
</tr>
</tbody>
</table>
# Sample Measures – cont.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS/CONTINUITY</td>
<td>Appointment wait times</td>
<td>% of patients seen on same day (within 1 day, within 14 days) as desired appointment date</td>
<td>VSSC</td>
</tr>
<tr>
<td></td>
<td>Telephone consults</td>
<td>% of calls successfully answered within 30 seconds</td>
<td>IPT, Dayton</td>
</tr>
<tr>
<td></td>
<td>Email contacts</td>
<td>% of pt.generated emails responded to w/in 24 hrs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group visits</td>
<td>% of PCP time scheduled for any group visits</td>
<td>VSSC</td>
</tr>
<tr>
<td></td>
<td>Continuity</td>
<td>% of encounters with assigned PCP, teamlet (non-provider clinical staff)</td>
<td>PCMM</td>
</tr>
<tr>
<td>PROCESS OF CARE</td>
<td>Staffing ratios for effective teams</td>
<td>Staffing Ratio; Staffing mix by provider type; # of unfilled vacancies.</td>
<td>PCMM</td>
</tr>
<tr>
<td></td>
<td>Members working to top of competency</td>
<td>Survey of team members compared to typical team tasks by position type</td>
<td>Survey, LC data</td>
</tr>
<tr>
<td>PT. EXPERIENCE</td>
<td>Patient perceptions of continuity and coordination of care, quality of care, self-management support</td>
<td>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</td>
<td>SHEP, qualitative work</td>
</tr>
</tbody>
</table>
Leadership: Rachel Werner MD PhD, Judith Long MD, David Asch MD
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)
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
VISN 11 Demo Lab

Eve Kerr, MD, MPH
Patient Registries: Identifying High Risk Patients
- Targeted Chronic
  - Diabetes
  - Heart failure
  - Depression
  - Co-Morbidities
  - Chronic Pain
- Transitional
  - ED
  - Hospital
  - Nursing home
- Socially Complex

IDENTIFIED PATIENTS
Navigator System: Patient-driven care choices
- Systematic assessment
- Menu of care programs
- Program recommendations driven by patient goals/needs

Facilitated Self-Mgmt Support
Care Partners
Peer to Peer
Transitional Care Program

Enhanced Management
- Interdisciplinary pain clinic
- Primary care mental health
- Short term intensive case management
  - MOVE/Tele-MOVE
  - Palliative care
  - Tele-health (CCHT)

Health Care Delivery Teams
- Primary Care
- Specialty Care
- Home-based Primary Care

VAAAHS PATIENT-ALIGNED CARE TEAM INNOVATIONS

VISN 11 Demo Lab
Ann Arbor, MI
**VISN 11 Demo Lab**

**Major innovations being studied**

**The Navigator System**

<table>
<thead>
<tr>
<th>SSN: 66661043</th>
<th>Adams</th>
<th>George</th>
<th>Patient Notes</th>
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</thead>
<tbody>
<tr>
<td><strong>Short term assessment</strong></td>
<td>should be done at 2 weeks, 3 months and 9 mo.</td>
<td>Long term assessment at 6 and 12 months</td>
<td></td>
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<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Initial Assessment</th>
<th>Referrals</th>
<th>Short Term Assessments</th>
<th>Long Term Assessments</th>
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<tr>
<td><strong>Gender</strong></td>
<td>MALE</td>
<td></td>
<td></td>
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<tr>
<td><strong>Date of Birth</strong></td>
<td>6/10/1939</td>
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<td></td>
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<tr>
<td><strong>Patient Number</strong></td>
<td>66661043</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Team</strong></td>
<td>RED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Site</strong></td>
<td>ANN ARBOR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PCP</strong></td>
<td>TAYLOR, CAROLINE MD</td>
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<td></td>
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<tr>
<td><strong>Eligible Date</strong></td>
<td>12/1/2010</td>
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**Navigator Activity History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
<th>Disposition</th>
<th>Notes</th>
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<table>
<thead>
<tr>
<th>CHF</th>
<th>Diabetes</th>
<th>Pain</th>
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<tr>
<td></td>
<td>X</td>
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<tr>
<td></td>
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</table>
VISN 11 Demo Lab
Key research-clinical partnerships
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.
VISN 11 Demo Lab
Progress Highlights

- 1<sup>st</sup> 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
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
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 My Heal the Vet 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
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.