An Invitation to Collaborate on the VHA PACT Intensive Management (PIM) National Evaluation

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On behalf of the

PIM National Evaluation Center (NEC)

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Poll Question

- Where are you in your investigative career cycle? (select one)
  - Early career (junior investigator)
  - Mid-career
  - Late career (senior investigator)
  - Not sure. Time flies!
  - N/A – Not a research staff

Objectives

- To describe findings from a Primary Care-funded initiative on high-risk Veterans: PACT Intensive Management (PIM)
- To invite VHA investigators to collaborate with PIM research team on special topics
  - Special high-risk patient topics (e.g., Women, Veterans with chronic pain, Virtual modalities, etc)
  - Dataset is qualitative and quantitative
  - Financial resources available to support investigators and analysts for FY20 to jumpstart investigations, especially for further research funding

Potential questions

- How can virtual modalities be used by PACT teams to effectively care for high-risk patients at home? (Choose Home initiative)
- How does understanding patient preferences and values impact outcomes of complex patients with chronic pain?
- How does intensive case management impact outcomes of complex patients with substance use disorder(s)?
- What additional needs do high-risk Women veterans have that may or may not be managed in WH-PACT or PACT?

References related to PIM

- Chang, et al. 2018. *Clinical Trials*. "An operations-partnered evaluation of care redesign for high-risk patients in the Veterans Health Administration (VHA): Study protocol for the PACT Intensive Management (PIM) randomized quality improvement evaluation."


PIM protocol

- Okunogbe, et al. 2017. *J Gen Intern Med*. "Care Coordination and provider stress in primary care management of high-risk patients."


Okunogbe, et al. 2017. JGIM

- Chang, et al. 2017. *Healthcare*. "What are the key elements for implementing intensive primary care? A multisite Veterans Health Administration case study."


Chang, et al. 2017. Healthcare.

- Yoon, et al. 2018. *Annals of Internal Medicine*. "Impact of Primary Care Intensive Management on High-Risk Veterans' Cost and Utilization."

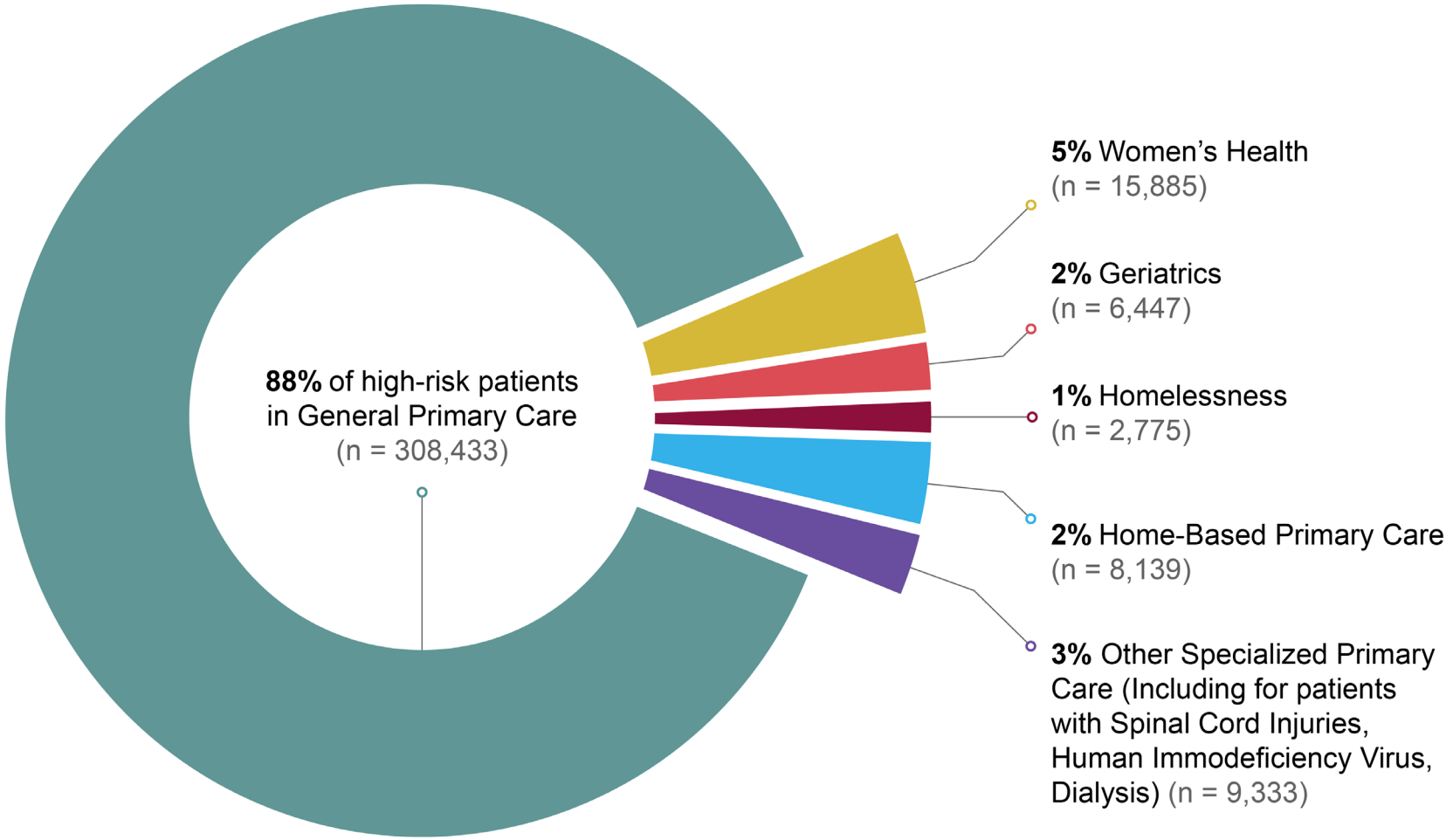

Yoon, et al. PIM 12m Outcomes

- Zulman, et al. 2019. *J Gen Intern Med*. "Effects of intensive primary care on high-need patient experiences: Survey findings from a Veterans Affairs randomized quality improvement trial."


Zulman, et al. JGIM

Snapshot of High-Risk Patient Population in VHA: PACT assignment for high-risk patients

during September 2015 (last 4 weeks of FY15)



Chang, et al. "Who Provides Care for Patients at High Risk of Hospitalization?" (submitted)

Primary Care Staff Experiences of Caring for High-Risk Patients

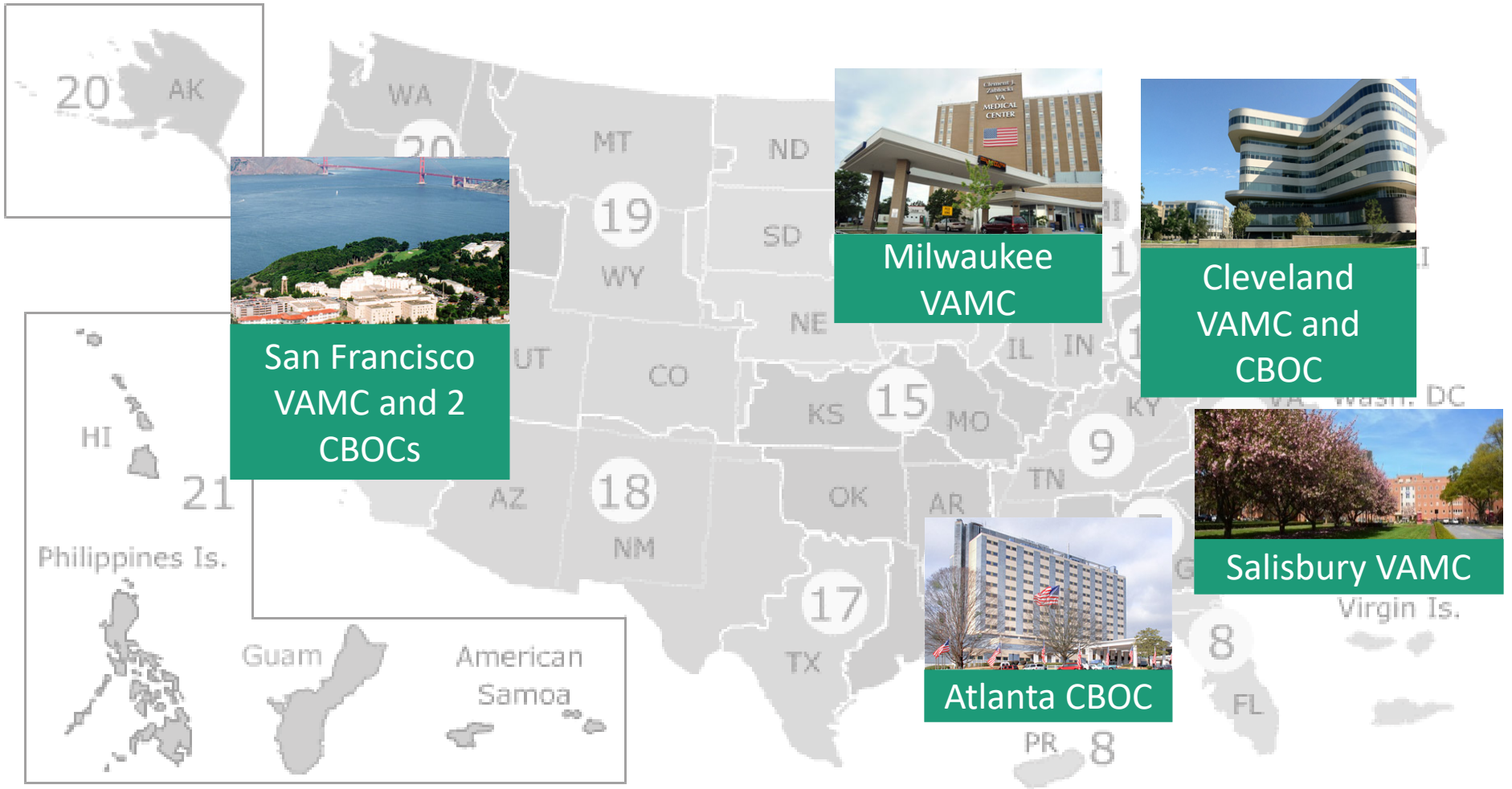
- Half of PACT providers & nurses agreed that “caring for high-risk patients is one of the most stressful aspects of my job” (49%)
- Most agreed that “my job would be better if I had an interdisciplinary team to help care for my high-risk patients” (78%)
- Barriers to optimal care for these patients include:
  - Problems with coordination and communication with other providers
  - Problems with complex or difficult patients
  - Problems with PACT function

PACT survey 2014. “Experiences in Caring for High-Risk Patients”

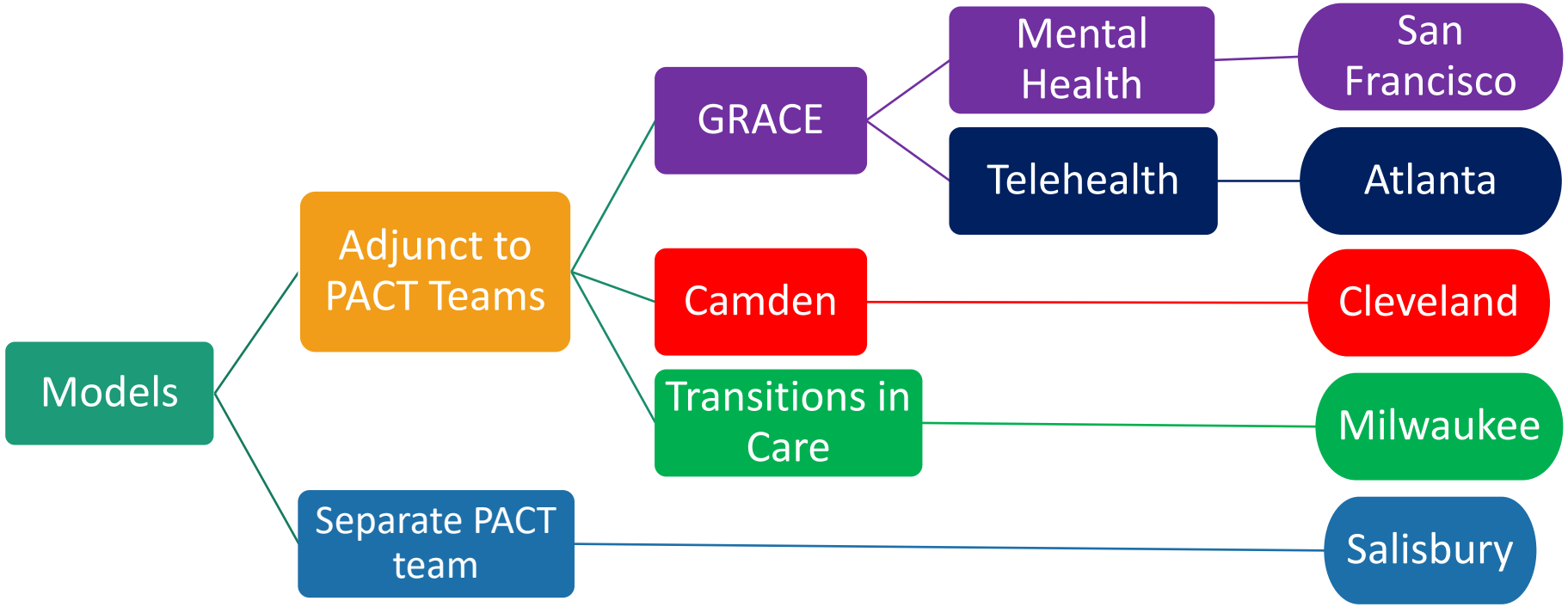
PACT Intensive Management (PIM) Demonstration

- Goal to develop and test approaches to manage high-risk patients and identify best practices through operations-evaluation partnership.
- Patient Aligned Care Team Intensive Management (PIM) demonstration program began FY14 to pilot intensive outpatient management to assess high-risk patients' needs and provide tailored services beyond PACT.
- Outcomes included VA health care costs, utilization, provider satisfaction, patient satisfaction.

PIM Demonstration Sites Selected Oct 2013



PACT Intensive Management 1.0 (PIM) Demonstration Site Models



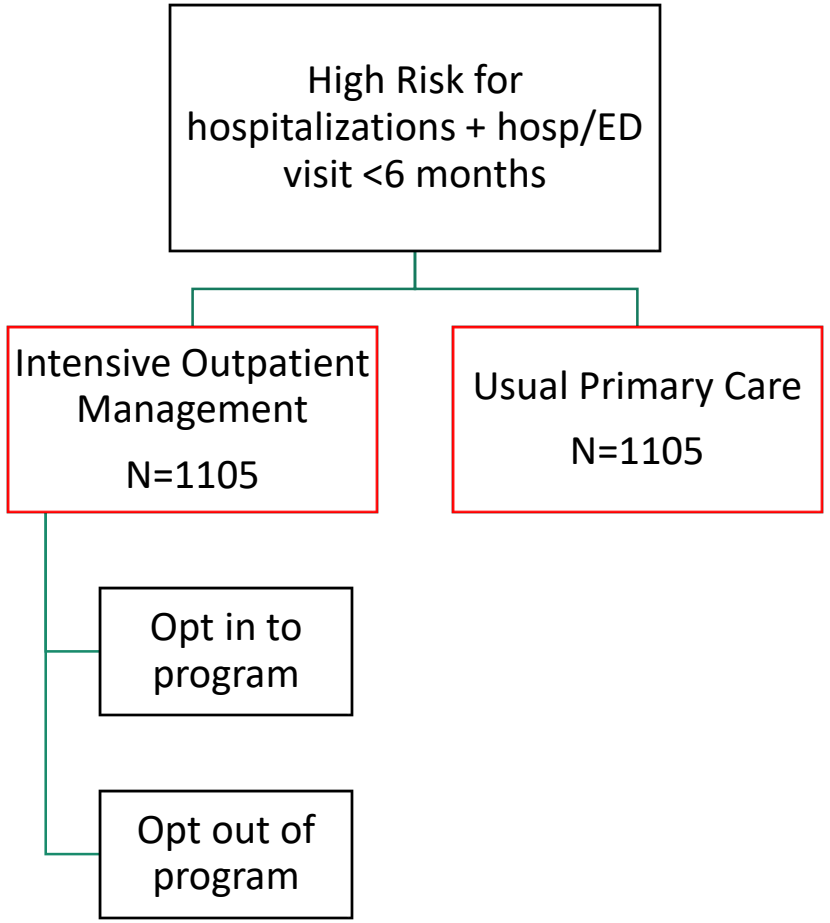
PIM Team Activities

- Weekly interdisciplinary care team meetings
- Comprehensive interdisciplinary assessments
- Nontraditional approaches (e.g., “co-attends,” inpatient visits)
- Care coordination activities
- Medication management
- Case management (e.g., transportation, health coaching)
- At least four sites included:
  - Home visits
  - Mental health and/or addiction support

PACT Intensive Management (PIM)
Target patient population

- Inclusion criteria:
  - CAN ≥ 90th percentile
  - 6-month history of ED visit or hospitalization in VA setting
  - With a PCP in PACT, WH-PACT, Geri-PACT
  - Will test ID-PACT (as an example of specialty PACT)
  - Not in a comprehensive care program (H-PACT, HBPC, nursing home) in the past 2 months
- Randomly generated invitation lists for each PIM team
- PACT providers may refer patients to PIM

Design: Randomized Quality Improvement Evaluation (Operations)



Poll Question

- What types of datasets are you most interested in using? (select all that apply)
  - Administrative data (CDW, MCA)
  - Health factors embedded in CPRS templates and reminder dialogs
  - Qualitative (interviews)
  - Survey

Data Sources

- Administrative data
  - VA Inpatient and outpatient utilization from CDW Medical SAS Files
  - Demographics
  - Medical comorbidities
  - Health factors (standardized templates)
  - VA Managerial Cost Accounting (MCA)
  - Costs of VA-sponsored care from Fee Basis data
- Interviews with PIM team members, patients who received PIM services, PACT team members, facility-level leaders
- Surveys of PACT providers and nurses about their experiences with high-risk patients
- Surveys of high-risk patients about their experience in VA (under Research)

Findings

- Not all high-risk patients received intensive management.
  - Teams evaluated medical records for most patients who fit eligibility criteria (CAN >= 90, recent ER visit/hosp), but found many to be low priority for PIM
  - Half of high-risk patients identified for PIM team were enrolled.
- PIM teams were able to:
  - Increase patient engagement in outpatient care and trust in the VA (Zulman, et al)
  - Potentially alleviate PACT burden (Okungobe, et al)
  - At no greater cost to VA healthcare system (Yoon, et al)

Lessons learned: Key Features

- Teams should include both a social worker and a mental health provider (e.g., psychologist).
- Teams should meet at least weekly to discuss high-risk patients and their treatment plans.
- Comprehensive assessment should include assessment of patient goals and physical, psychological, social needs.
- Many patients with trajectories that may not change, so advanced care planning important
- Providing caregiver education and support important for behavior change.

PIM 2.0 Standardized Model

- Would patient identification of high risk patients by referral increase the fit with PIM?
- PIM 2.0 model consists of:
  - Referral program at the 5 demonstration sites
  - Interdisciplinary team with MD, RN, SW, MH provider
  - Adjunct to PACT rather then stand-alone PACT
    - Able to discharge patients after 3-6 months
- Designed to serve as an expert resource to facility and PACT teams

PIM Team Perceptions of Top 5 Factors Related to Preventable ER visits

- Inadequate engagement with ambulatory care (PACT, MH, specialty, CCHT) (n=48)
- Medication nonadherence (n=45)
- Treatment noncompliance (diet, appointments) (n=31)
- Alcohol, substance use (n=29)
- Poor health literacy or insufficient education on health issues/appropriate use of ER (n=26)

From CDW PIM 2.0 Health Factors among patients referred to PIM (n=262)

Patient Problems PIM Teams Identified as Often Reversible with Intensive Management

- Patients with social needs:
  - Social isolation
  - Need for geriatric resources (Adult Day Health Care, In-Home Supportive Services, etc)
  - Need for social work resources (transportation, housing, food insecurity)
  - Health literacy issues
  - Caregiver burnout
- Patients with mental and/or behavioral needs:
  - Medication non-adherence or diagnosis of non-compliance
  - Depression and/or PTSD
- Patients with barriers to in-person visits

Patients not easily helped, even by PIM teams

- Severe Personality Disorder
- Severe Substance Use Disorder (except for Opioid Use Disorder)
- Chronic suicidality
- Cognitive impairment with no caregiver
- Those with too many competing life demands

PIM Perspectives on Most Valuable PIM Service:

Help with building patient trust in healthcare

- Interdisciplinary treatment planning
- Knowledge of VA resources and relationships
- Initial (diagnostic) home visit – Rx, family
- Assessment of patient's availability of social support
- Engaging patient in healthcare and self-care
- Being responsive and accessible to patient
- Frequent communication with patients and PACT providers
- Medication management
- Co-attends

Looking to Partner with Investigators on Special Topics

- Funding available for FY20 only to investigators and analysts on special topics:
  - Virtual care
  - Chronic pain (at least half of sample)
  - Women Veterans (oversampled at 10%)
  - Geriatric patients
  - Peer support specialists
  - Other topics? Discuss with Evelyn.Chang@va.gov

Process

- Investigators develop brief proposal and analysis plan, reviewed by Office of Primary Care and National Evaluation Center for operations questions
- Investigators invited to Friday morning calls twice per month
- Analysts invited to weekly calls for coordination and data sharing (VINCI folder, MOU for data sharing)
- Consider PIM demonstration site members as potential co-authors

Summary

- PIM has represented an opportunity for VA to learn about how to best manage high-risk patients
- Primary Care interested in learning more about management of certain populations of high-risk patients
- PIM has many datasets focused on high-risk patients that may be useful to VA investigators
- Funding/data available to jumpstart investigations, especially for further research funding

Questions?

Contact Evelyn.Chang@va.gov

Acknowledgements:
Members of PIM Initiative

PIM Demonstration sites leads: Parag Dalsania, Jessica Eng, Nate Ewigman, Deborah Henry, Jeff Jackson, Neha Pathak, Brook Watts

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Summary of PIM Tools Developed for PACT That Can be used by greater PACT team

Domain	Tools Currently Available
Explore the Veteran's Clinical History and Goals (PACT- level)	○ High-Risk Patient Assessment Note
Create, Communicate, Implement a Plan of Care (PACT- level)	○ PACT Super Huddle Note ○ Checklist for Home Visits (Virtual Home Visit version available) ○ Medication Adherence Assessment ○ Healthcare Behavioral Contract ○ PACT Resource Guide of Community and VA Resources
Establish a Shared Vision and Charge for Action (Leadership level)	○ Facility-wide Committee for High-Risk Patients