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

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Dr. Evelyn Chang: Well, thanks so much for having me. I really appreciate it. My name is Evelyn Chang. I’m a Physician Investigator at the Greater Los Angeles and I’ve been working on the PACT Intensive Management National Evaluation for the last six years. And I’d love to be able to share a little bit more about it with you today. And invite any VA investigator to collaborate on the data, the vast amount of data that we have on high-risk, high-needs patients. So I’m going to go first to our poll question.

[Pause from 00:34 to 00:40]

Rob: And I will launch that poll now. And the poll is up. Question being where are you in your investigative career cycle? Answer options early-career or junior investigator, mid-career, late-career or senior investigator, not sure time flies, or not applicable, not a research staff. And Evelyn, we have about 50% of your viewing audience having made their choices so we’ll give people a few more moments. It usually levels off between 70 and 80%. And it looks like it’s just about leveled off now so I’m going to go ahead and close the poll and share out the results. And let you know that 29% of your viewing audience today are in their early-career, none are mid- or late-career, none say not sure, and 71% say they’re not research staff.

Dr. Evelyn Chang: Okay.

Rob: And I’m going to close the poll.

Dr. Evelyn Chang: Well, thanks. That’s really helpful actually. So thanks so much for that. I would say for me, I’m not sure. I think I’ve aged out of junior investigator unfortunately. So I’m somewhere, somewhere in there. But I’ve been at the VA for I think, ten years now. I started off originally as a VA Health Services Research fellow. I did a lot of work in Primary Care-Mental Health Integration and then after my fellowship, an opportunity came up to help lead an evaluation of a PACT Intensive Management initiative for the demonstration that I’m going to show you, that I’m going to share with you a little bit more about today and then I’ve been leading it ever since. So it’s kind of just has evolved into I think, a really productive and just very interesting questions that have come up. And we’ve learned a lot that I’m also going to be sharing with you today too.

So the objectives for today are to first to describe findings from a primary care-funded initiative on high-risk Veterans, which is called the PACT Intensive Management or PIM. And secondly, to invite VA investigators to collaborate with our research team on special topics. And these might include other high-risk patient topics like women Veterans and Veterans with chronic pain, using virtual modalities to care for these high-risk patients. We have datasets that are both qualitative and quantitative and furthermore, we have financial resources that are available to support investigators and analysts for this fiscal year and this fiscal year only, for now, to help to jumpstart investigations. And this might be helpful for further research funding or for even pilot funding.

So some potentials might be, how can virtual modalities be used by PACT teams to effectively care for high-risk patients at home. This is part of the Choose Home Initiative, a question that’s very pertinent to that initiative. How does understanding patient preferences and values impact outcomes of complex patients with chronic pain? And how does intensive case management impact outcomes of complex patients with substance use disorders? Another potential question might be, what additional needs do high-risk women Veterans have that may or may not be managed in women’s health PACT or general PACT? And if you have any questions, feel free to just put it in the chat window, and Robert will let us know the questions.

These are some of the products that we have had from the PACT Intensive Management in case you’re interested in doing further reading about it. As I was saying, we have a ton of data, and so it’s led to quite a few publications and a lot more in the pipeline. But there’s just still a lot more that we haven’t even delved into yet because of our latitude bandwidth and, you know, we would love to partner with others in your expertise in high-risk or high-needs, high-cost patients. So some of these include what protocol we used for a randomized quality improvement evaluation. Also, I’m using a survey to look at care coordination and provider stress in the management of high-risk patients. Also, looking at using minutes of meetings to look at the key elements of implementing intensive primary care. The fourth one is the impact of Primary Care Intensive Management on high-risk Veterans' cost and utilization. So using CDAW and MCA data. And then finally, effects of intensive primary care on high-need patient experiences. So this came from a patient survey.

So just to give a little background about high-need high-cost patients or high-risk patient populations in the VA. Most of these patients are actually cared for in general primary care. So this was a little surprising to us because we thought that there would actually be more patients in some of these other specialty primary care teams. But when you actually take a snapshot, a cross-section of high-risk patients it looks like 88% of them are actually managed in general or assigned to general primary care. Only 5% in women’s health, 2% in geriatrics, 1% in Homeless PACT, 2% in HBPC, and 3% in other specialized primary care teams.

So when you ask primary care staff about their experiences in caring for high-risk patients, half of them agree that, half of providers and nurses agree that caring for high-risk patients is one of the most stressful aspects of their job. You know, a lot of these patients have a lot of needs that may not be well managed in primary care and they may walk-in a lot. They may have a lot of acute care utilization, are hard to manage. And also very, have a lot of care coordination needs. And most agree that my job would be better if I had an interdisciplinary team to help care for my high-risk patients. And their barriers to optimal care for these patients include problems with coordination and communication with other providers and also problems with complex or difficult patients. And finally, problems with PACT function.

So the PACT Intensive Management demonstration was sponsored and funded by the Office of Primary Care. Its goal was to develop and to test approaches to manage high-risk patients and to identify best practices through an operations-evaluation partnership. So Office of Primary Care wanted to learn as much as they could from this demonstration, so they also funded our evaluation team to learn as much as they could about that. The PACT Intensive Management demonstration program began in fiscal year ’14 to pilot intensive outpatient management to assess their, the high-risk patient needs and to provide tailored services beyond primary care. And the outcomes included VA health care costs, utilization, provider satisfaction, and patient satisfaction.

Our five demonstration sites were selected in October 2013, and they include the ones that you see here on this map. San Francisco and they have two CBOCs. Milwaukee. Cleveland and they also included one CBOC. The Salisbury, and also Atlanta.

There are two major models of these PIM teams. Four of five were actually adjunct to primary care teams so they did not provide primary care but functioned alongside primary care. And then the fifth one Salisbury was its own separate primary care team, meaning that they actually transferred the patient to its own primary care team. Of the ones that were adjunct to primary care, it was loosely modeled after models in literature such as the GRACE model of the Geriatric Resources for I think Assessing and Caring for Elders. There was also the Camden Coalition model that some of you might be familiar with. And also, Eric Coleman’s transitions in care model.

There were some commonalities for these PIM teams. They all included weekly interdisciplinary care team meetings. They also included comprehensive interdisciplinary assessments. So these interdisciplinary care teams included usually, a provider, a nurse, a social worker, and a mental health provider. Sometimes they would also incur, include a peer support specialist. So each one of them would actually complete their own assessment and come together to figure out what the best treatment plan might be for the patients. They included nontraditional approaches such as co-attends and inpatient visits. So what this meant would be that a member of the team, such as the peer support specialist, might actually accompany the patient on a specialty visit to help with care coordination and to help to advocate for the patient and also help with treatment upon implementation. They would also visit the patient to help with discharge planning when they were in the hospital. Mostly it was in the VA, but very rarely in the non-VA hospitalization. Those are more particularly for [unintelligible 10:45] vulnerable patients. They would also perform care coordination activities, mostly with other VA and non-VA providers, also with patients and their family and caregiver. They would do a lot of medication management, this means helping to handle medication refills, doing education on medications, and also helping to fill pillboxes. Also, they would help with case management, meaning that they would help to arrange transportation, provide health coaching, to help with change in behaviors. And at least four of the sites also included home visits. These home visits were different from home health agencies or home-based primary care in that it was usually a diagnostic short-term limited home health. The first visit usually was an interdisciplinary visit with an assessment. A very thorough assessment of huge things that the patients might need and also their risk factors. At least four of the sites also included mental health and/or addiction support. Usually, a mental health provider, a psychologist, which included a connection to addiction treatments if necessary.

So for PACT Intensive Management, it was rather unique because it was an operation partnered evaluation. It was because this was something of interest to our funders and Office of Primary Care. Because of resource constraints, and because the answer was not known, there was still mixed data as of fiscal year ’14. I think it’s even a little bit more clear now. But then it was, the data was mixed on what to do about these patients, and if they benefited from additional resources. So it was actually set up as a randomized quality improvement evaluation. We randomly generated an invitation list for each PIM team and the inclusion criteria included CAN score, which is the Care Assessment Need score for greater than or equal to 90th percentile. They also had a recent six-month history of ER visits or hospitalizations in the VA setting. They had to have a primary care provider in general primary care or women’s health primary care or general geriatrics primary care. And we also included infectious disease PACT also as, just as a tracer or a special, an example of specialty PACT team. But we did not include those that were in already a more comprehensive care team such as Homeless PACT or HBPC or a nursing home. Also, we had a limited ability for primary care providers to refer their patients to PIM.

So again, this was designed as a randomized quality improvement evaluation and we randomized 1,105 to the PIM outpatient management and then 1,105 to usual primary care. And then from that point, the patients were all, were able to opt-in or opt-out of the program. And also, the PIM team, when they did their triage, they were able to opt-in patients to the program.

So I’m going to turn over to the next poll question about what types of datasets you might be most interested in using just in general in your career or even right now.

[Pause from 14:17 to 14:20]

Rob: And that poll is up and running. Question being, what types of datasets are you most interested in using? And this is a select all that apply. And we have almost 40% of your viewing audience having made their choices so it’s going to take a little bit longer. But I’ll read the question, the answer options. Administrative data, specifically CDW or MCA, health factors embedded in CPRS templates and reminder dialogs, qualitative interviews, and survey. And Dr. Chang, we have about 70, over 70% of your audience having made their choices. So I’m going to go ahead and close the poll and read the results out. And since this is a select all that apply we will have more than 100%. However, for administrative data CDW MCA, 64% is the number we got back for that, 27% for health factors embedded in CPRS templates and reminder dialogs, 45% in qualitative interviews, and 45% survey. And now I'm closing the poll \_

Dr. Evelyn Chang: Okay, thanks.

Rob: \_ and we’re back on your slides.

Dr. Evelyn Chang: Thanks. So thanks, that’s really helpful. I’m actually really impressed with how many are actually working with health factors. Health factors are not a type of dataset that I was very familiar with before I started this project. And so just in case, any audience members aren’t aware of what health factors are, in regular routine clinical care we often, providers often use reminder dialogs and CPRS templates. And we can actually embed almost like surveys. Poll even some kind of free text questions, so that it’s just so much faster to get more descriptive data that’s not available in the CDW. So, for instance, if we wanted to learn more about social support, and the PIM team members asked about social support, we were able to embed that as a question in their interdisciplinary assessment. So we actually have a lot of data on caregivers, social support, financial sufficiency, housing sufficiency, things like that. So it’s been, it’s very helpful to use that data because it helps to prevent doing chart reviews, which can be very time-intensive.

So in terms of the data sources, we have all of those. We used a lot of administrative data including inpatient and outpatient utilization from our CDW Medical SAS Files. We have demographics, medical comorbidities, health factors. Like I was mentioning, our VA Managerial Cost Accounting for the MCA data. And also, we used Fee Basis data, which we included in our cost analyses. This little bit is different now I believe with MISSION and, or Choice and MISSION. So the rules are a little bit different, but we still have, we still use that. In terms of interviews, we interviewed a very comprehensive, we interviewed PIM team members, patients who received PIM services, PACT team members who also were a recipient of these services, and also facility-level leaders to see what they thought about it. We have surveys of PACT providers and nurses about their experiences with high-risk patients, we have three waves of that. We also have surveys of high-risk patients under their experience in VA. And this was led by Dr. Donna Zulman, who was also a CDA recipient, and this was done under research funding.

In terms of our findings, we actually found that not all high-risk patients received intensive management. So our PIM teams evaluated medical records for most patients who fit the eligibility criteria. Again, CANs greater than or equal to 90 and if they have a recent ER visit or hospitalization. But they actually found that most, that many, were a low priority for PIM. And only half of high-risk patients identified were actually enrolled. So some of this was due to, they were already engaged in primary care mental health. So they didn’t, the PIM teams didn’t feel like they could actually do any, offer anything more to help the patients to benefit. Some of them, they also found that you know, they also were doing fine in a non-VA setting and they were just coming to the VA for medications. So they didn’t feel like they could add much more there. And in very few instances, it might have been because they might not have been a good fit, for instance, if they were actively using substance use, substances, or they had severe mental health issues that might prevent or present as a barrier to engaging with the PIM team, they might not engage those patients or enroll those patients.

The PIM teams were able to, of the patients that they did enroll, increase patient engagement in outpatient care, and increase their trust in the VA. And they were able to potentially do this at, also potentially alleviate PACT burden at no greater cost to the VA Health Care System. They actually were able to decrease ER visits and hospitalizations. There was a trend for that. It was not significant, but there was enough of a decrease that it offset the significant increase in outpatient visits and this also included the PIM team visit. So in counting for the program cost itself, most of these costs were in primary care, mental health, CCHT, geriatric, and care and case management [unintelligible 20:29] code.

In terms of other lessons learned, we learned that some key features of these PIM teams or Intensive Care Management programs should include a social worker and a mental health provider. Usually, it’s a psychologist for our teams. We just found that there were a lot of social needs that are not being met in primary care and also a lot of mental health needs. Where these patients may not be engaging in VA mental health. Also, teams should meet at least weekly to discuss high-risk patients and their treatment plans. A comprehensive assessment should include the assessment of patient goals and also physical, psychological, and social needs. So our PIM teams are actually all trained in whole health. So whole health looked very different back then from what it is now. Whole health was, there was training as an interdisciplinary team, and most the teams actually undertook that training. So they had a foundation in patient-centered care in motivational interviewing. And they were able to really engage patients by first understanding their needs and their goals. Another key feature was that many patients actually had trajectories that may not be able to change even despite their best efforts. So advanced care planning was actually very important. And lastly, providing caregiver education and support was important for behavior change because often, you know, caregivers are really there to support the patient but if caregivers are not included in the treatment planning, then they may not know how best to implement the treatment plan that a health care team has developed.

So based on what we learned for those key lessons, we actually took them in true learning health care system fashion to actually develop a standardized model for PIM 2.0. So in this new model, we actually changed it from a randomized quality improvement evaluation to a referral model. Because the question here was, would patient identification of high-risk patients by referral actual increase the fit with PIM? So we switched it to a referral model where any provider could actually refer the patient to a PIM. And also, the model consisted of an interdisciplinary team with a physician, nurse, social worker, and mental health provider. Before, not all of them had a social worker, you know, believe it or not. That was something that we just learned about. So they all had to have a social worker or a mental health provider. And also, rather than having a standalone PACT, they were all adjunct to a primary care team. The idea behind this was because these PIM teams were set up to be an expert resource to facility and PACT teams. So, in order to have some turn or to have some turnover of the primary care, these high-risk patients, they felt like we needed to be able to discharge them after three or six months. Otherwise, it would be something more like a MHICM or APPIC where you know there’s a role for those type of programs. But for PIM, rather than being launched to a primary care team, they wanted to be able to touch as many patients as possible.

So in terms of some of their perceptions, factors related to preventable ER visits, they found that an adequate engagement with ambulatory care, such as primary care, mental health, specialty, and CCHT or TeleHealth, was probably the number one factor related to preventable ER visits. Number two was medication nonadherence. As you can imagine, a lot of these patients have health literacy issues and also don’t trust the VA or trust the VA providers. May not want to take their medications and also, they have polypharmacy. Most of them are on many, many medications and it’s very hard for them to even stick to their regimen that they’ve been prescribed. Third, they have, often have treatment noncompliance in terms of maybe not kind of adhering to their diet or even coming to appointments, so we found high no show rates. Also, many of them had active alcohol and substance use. And finally, many of them had poor health literacy or insufficient education on health issues, or inappropriate use of the ER.

In terms of other patient problems that the PIM teams identified as being potentially reversible with intensive management. I found these to be very interesting. So these are the patients who they felt like they could actually discharge more quickly, more in the three to six-month timeframe. So if patients had social needs like social isolation or need for geriatric resources like Adult Day Health Care or in-home support services or other social work resources like transportation, housing, or if they had food insecurity or if they have health literacy issues or caregiver burnout. Then they felt like that was something that they could easily arrange for the patient and discharge from their services rather quickly. Also, some patients with mental health or behavioral needs such as medication nonadherence or a diagnosis of noncompliance, usually the teams took assessments of these to figure out what might be underlying nonadherence and were usually able to find modifiable factors. Also, depression or PTSD, very common and also very modifiable with treatment. Usually just connecting them to PC-MHI or doing some limited treatment in their own team or connecting them onto specialty care if needed. And also, patients with barriers to in-person visits. And thankfully now with, I think VVC and virtual home visits this is actually much less of a barrier for primary care.

So there were some patients that were not easily helped even by PIM teams. Those with severe personality disorder. Those with severe substance use disorder except for opioid use disorder. So interestingly enough, because opioid use disorder is treated well with actually medication-assisted treatment options like methadone, [unintelligible 26:41], and Vivitrol, they actually thought this was actually modifiable. Patients with chronic suicidality with, not only easily helped those with caregiver impairment, with no caregiver, was fairly challenging. Also, those with too many competing life demands. Those patients were fairly difficult to engage into primary care or into, I’m sorry; to PIM teams.

In terms of PIM team perspective on what patients thought and what they thought was the most valuable service that they offered were really things that helped to build patients’ trust in the health care system. So a lot of what they did was to help to connect patients to other existing services. First engaging the patient, helping them to trust them in order to trust the VA Health Care System at large. These PIM features included interdisciplinary treatment planning, PIM knowledge of VA resources and relationships. Also, that first initial or diagnostic home visit they found was extremely valuable to help patients gain trust in the VAs Health Care System. Here they usually did a thorough medication reconciliation and helped, and also met family and caregivers. Also assessing the patient’s availability of social support was very valuable. Engaging the patient in health care and self-care like we talked about. Being responsive and accessible to patients, this was also very key because patients sometimes, you know, when they get lost in a phone tree and trying to find a VA provider, they just feel like the VA’s given up, you know, they don’t care about them. But when they actually are able to find somebody who answers the line very quickly, they tended to really appreciate that. Also having frequent communications with the patients and PACT providers to coordinate was very valuable and also medication management. And again, the co-attends like we had mentioned before.

So those are some of the lessons that we’ve learned so far. And we’d be happy to partner with any investigators on special topics. Again, we have funding available only for fiscal year ’20, available to investigators and analysists on special topics. Or if you have any other things, feel free to email me. So some topics might include again, virtual care, chronic pain. This was half of the sample. So we intentionally oversampled women Veterans at 10% because we knew it’s the fastest growing subpopulation. And also, geriatric patients and also peer support specialists.

If you’re interested in potentially partnering, this is a brief outline of the process where you might develop a brief proposal and analysis plan. We actually have a very short template of things that we might be looking for in your proposal. We review this first among our evaluation team, and then we’ll bring it forward to the Office of Primary Care for operational approval. We’d be able to invite you guys to our Friday calls twice a month as a Co-I. And analysts would be invited to weekly calls for coordination and data sharing. We actually have a VINCI folder and we also have an MOU for data sharing. We have these kind of calls for qual and for the quanta team. And also, we would ask to consider the PIM demonstration site members as potential co-authors. You know, they were, that we really consider them as our subject matter experts and we try to include them in our, on our manuscripts as much as possible because they have, they offer a lot of insight for patients and also for what worked.

And just to summarize, PIM has represented an opportunity for the VA to learn about how to best manage high-risk patients. And primary care is interested in learning more about the management of certain populations of high-risk patients. And we have a lot of datasets focused on high-risk patients that might be useful to any VA investigator. Furthermore, we have funding and data to help to jumpstart investigations, particularly if you want to use it for further research funding.

So if you have any questions, feel free to contact me. I’d be happy to answer anything or set up any meetings and also provide any documentation.

I’d like to, also, acknowledge the members of our PIM Initiative, our demonstration leads, our executive committee, and also National Evaluation Committee who are listed here. I want to give a shoutout to those in Palo Alto who have been really instrumental, and they were the ones who have invited me to give the talk today, Steve Asch and Donna Zulman. Also, Jean Yoon out there and also Michael Ong, Susan Stockdale, and Marian Katz in Los Angeles.

So I’m going to actually end here to see if there’s any questions.

Rob: Dr. Chang, we do have a few questions queued up. But I’ll take the opportunity to let your audience know that if you have a question you’d like to ask, there is a section in that GoToWebinar dashboard or control panel on the right-hand side of your screen. You can pull it out if you want to, make it bigger, type your questions in, and I’ll ask them. First up, it looks like this is a two-parter. This person writes, does the PIM evaluation count as operations or research? And then they wrote in pretty soon after that, would we need to submit an IRB modification to work with PIM data?

Dr. Evelyn Chang: Yeah, that’s a good question. So we’ve actually been operating under operation. We had originally, this was even before QUERI had established their beautiful protocols that they have now, but we were able to obtain a determination of non-research through central bodies, and so everything we do is under operations. We do not have to submit for IRB; however, in order for any investigator to actually do, conduct work under operations, we do have to get it approved under operations meaning, that’s why we have that proposal and template. So that we can ensure that the question is something that is of interest to the Office of Primary Care and as long as we have their approval, then we’ll be able to consider it as operations. Anything else if you’re interested in pursuing, so, for instance, we have another investigator who is interested in machine learning to understand these high-risk patient populations. That would be very interesting too, but it would not be practical for VA operations or primary care. So for those instances, we would route those to IRB for research.

Rob: Thank you. We have a couple more questions. For inclusion criteria, based on CAN 90%, greater than 90 percentile does that translate to a CAN score of 90 or above? And is that for 90-day or one-year events?

Dr. Evelyn Chang: That sounds like somebody who really knows their CAN score. So, this is a, we used the CAN score for 90-day history of, or a 90-day probability of hospitalization. The reason for that was, we wanted to have, we wanted to be able to provide PIM teams with a near-future high-risk for hospitalization. We wanted again to get them people who would potentially have modifiable risk factors. So we just, we also chose hospitalization rather than combined event or for that only. I hope that answers your question. [Pause from 35:00 to 35:05] Yeah, 90 or greater than or equal to 90th percentile.

Rob: Next question. How does percent of women Veterans, in total, compare with the 5% shown on your pie chart?

Dr. Evelyn Chang: So for the PIM enrollment or actually for when we did the, when we use our inclusion criteria to randomly assign, or randomly select patients, we actually oversampled 10% women. So of the 1,105 here that were assigned for PIM, 110 of them were women. So we actually have a sample of 110 versus 110. For the pie chart, this is any patient with a high CAN score. This, we actually use a CAN score of greater than or equal to 95 on the national sample. And of that entire cohort of high-risk patients in the VA nationally, 88% of them were actually managed or assigned to primary care and 5% of them were assigned to women’s health. So hopefully, that helps to distinguish a little bit more about where the 5% and 10% comes from. It turns out, I would say that women are complex for a lot of different issues that we’ve been finding. Usually, they have more mental, we’ve done a quick comparison to see what are some differences between men and women who are at high-risk, and it turns out they just have more mental health complexities than men do; they tend to have more mental health utilization. So that’s something that we’re potentially taking, interested in taking a look at. And as you know, they also have greater MST, military sexual trauma. So all these have been spawned just even more interesting questions.

Rob: Those are all the questions that we have at this time. If nobody writes in, in the meantime, perhaps now is a good time to make closing comments Dr. Chang. Do you have any?

Dr. Evelyn Chang: Okay. Sure. Thank you guys again for having me. I really appreciate that. I appreciate the opportunity to share more about the demonstration and many of our data sources. We’d be really delighted to work with anybody who’s interested in partnering with us on an operationally relevant question or on something that you think would be helpful for learning more about how to better manage high-risk patients in general. Feel free to contact me with any questions. I’m always interested in talking with enthusiastic investigators about this topic, so feel free to email me.

Rob: Thank you, Dr. Chang. Thank you, attendees, for spending the time with us today. And Dr. Chang, thank you for your work in general for the VA but especially for preparing and presenting today. Audience members, when I close the Cyberseminar momentarily, you’ll be presented with a short survey. Please do take a few moments and provide some answers. We count on those and we do pay attention and use them to continue to bring you high-quality Cyberseminars such as this one. Once again, Dr. Chang, thank you. And with that, I’ll wish everybody a good day.

[ END OF AUDIO 38:53]