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Center for the Study of Healthcare Innovation, Implementation & Policy

# What Would Patient-Aligned Care Teams (PACT) Need To Better Care For High-Risk Patients?

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# Today's Presentation

- Describe a Primary Care-funded 5-site initiative on high-risk Veterans: PACT Intensive Management (PIM)
- Present findings from stakeholder perspectives (PIM leaders, PACT facility leaders, PACT clinicians, social workers)
  - Which PIM components could be incorporated into existing PACT workflow, to improve care for complex patients?
  - What would PACTs need to do this?
- Discuss intensive care management tasks PACTs can reasonably perform

# Poll Question #1

- What is your primary role in VA? (select one)
  - PACT teamlet member
  - PACT extended team member (e.g., social work, pharmacy)
  - Facility primary care leader
  - Researcher
  - Other

# Care For High-Need Patients Is A National Priority

VIEWPOINT

VITAL DIRECTIONS FROM THE NATIONAL ACADEMY OF MEDICINE

## Tailoring Complex Care Management for High-Need, High-Cost Patients

**David Blumenthal, MD**
The Commonwealth Fund, New York, New York.

**Melinda K. Abrams, MS**
The Commonwealth Fund, New York, New York.

The NEW ENGLAND JOURNAL of MEDICINE
Perspective
SEPTEMBER 8, 2016

## Caring for High-Need, High-Cost Patients — An Urgent Priority

David Blumenthal, M.D., M.P.P., Bruce Chernof, M.D., Terry Fulmer, Ph.D., R.N., John Lumpkin, M.D., M.P.H., and Jeffrey Selberg, M.H.A.

NATIONAL ACADEMY OF MEDICINE

**MODELS OF CARE FOR HIGH-NEED PATIENTS**

A National Academy of Medicine Workshop
*…funded by the Peterson Center on Healthcare*

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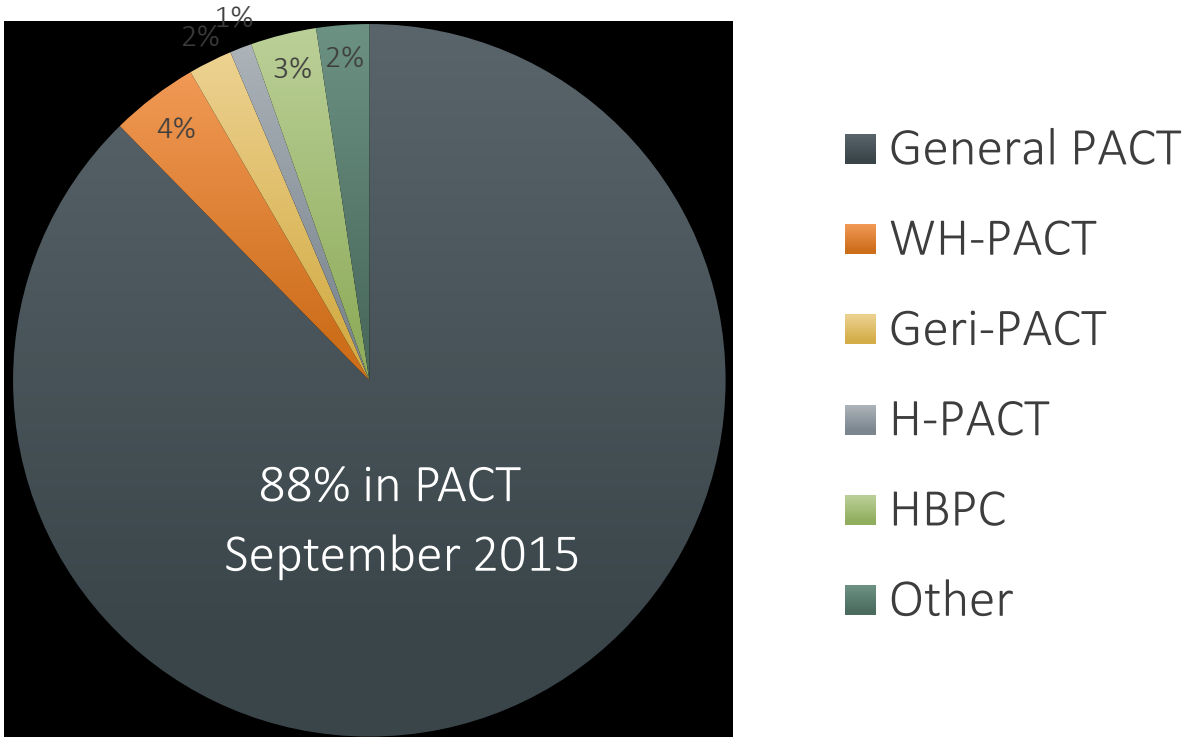
# Snapshot Of High-Risk Patient Population In VHA: PACT Assignment For High-Risk Patients




Chang, et al. “Who Provides Care for Patients at High Risk of Hospitalization?” (in preparation)

# 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

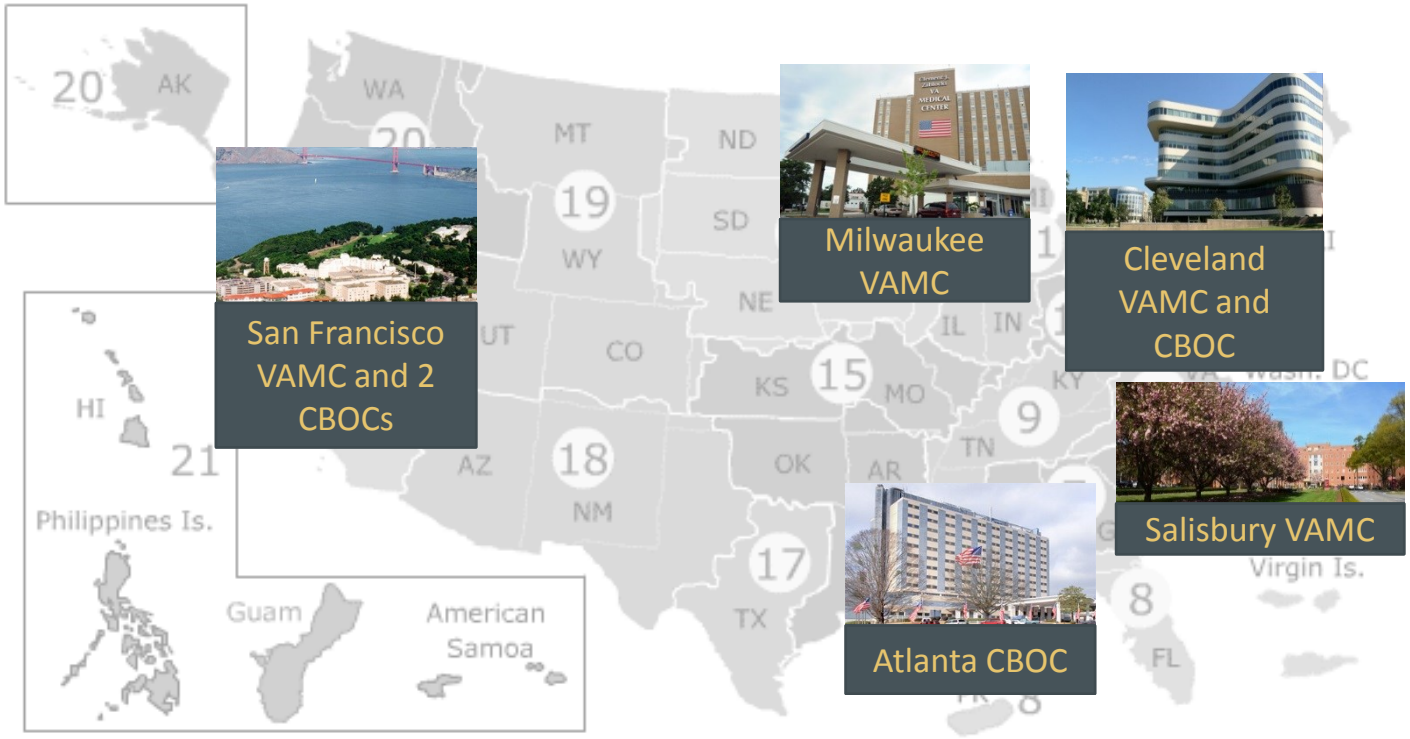


PACT survey 2014."Experiences in Caring for High-Risk Patients"

# PACT Intensive Management (PIM) Demonstration

- Goal: 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
# Oct 2013

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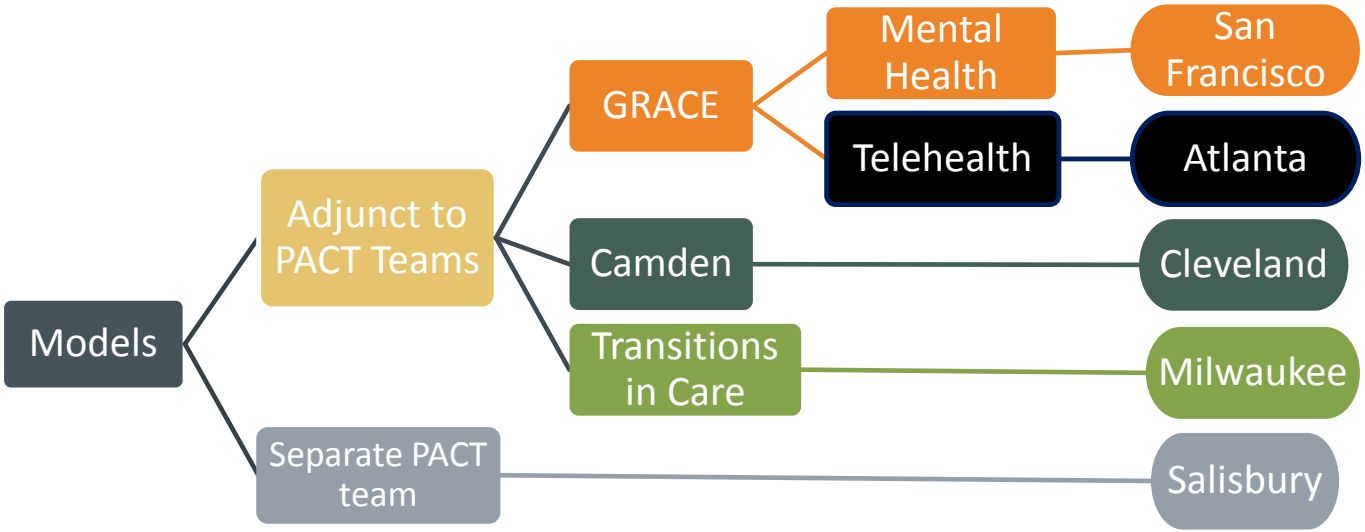
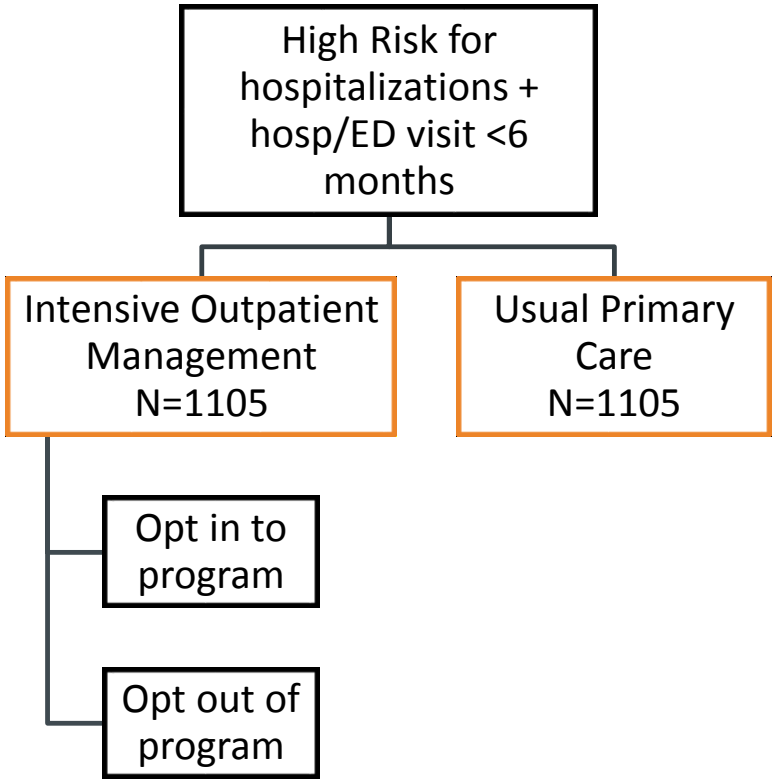
# PIM 1.0 Demonstration Site Models



# Common Features Across PIM Teams

- Met regularly as an interdisciplinary care team
- Screened 20-25 high CAN patients per month, triaged patients, notified PACT providers, assessed, and finally engaged Veterans identified as appropriate
- Nontraditional approaches (e.g., “co-attends,” inpatient visits)
- Performed care coordination activities
  - Health coaching
  - Communicating/coordinating with other providers
  - Arranging transportation for appointments
- Assisted with medications (e.g., refills, education, adherence)
- At least four sites included:
  - Home visits to gain patient’s trust and assess environment
  - Mental health and/or addiction assessment and support

# Randomized Quality Improvement Evaluation (Operations)



# Findings From Year 1

- Not all high-risk patients received intensive management.
  - Teams evaluated medical records for most patients, but found many to be low priority for PIM
  - Half of high-risk patients identified for PIM team were enrolled.
- For patients they 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)

# 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 That Might Be Reversible With Case 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



From PIM Focus Group

# 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



From PIM Focus Group

# Lessons Learned: Key PIM Features What Can Be Done In PACT?

- [x] 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.
- [ ] Advance care planning is important; many high risk patients have worsening health conditions that are unlikely to improve.
- [ ] Providing caregiver education and support important for behavior change and to ensure continued involvement.

# WHAT CAN PACTS DO TO BETTER CARE FOR THEIR MOST COMPLEX PATIENTS?

SUSAN STOCKDALE, PHD

# Poll Question #2

- How interested would you be in implementing intensive management practices for complex patients in your clinical setting? (select one)
  - NA, I don't do patient care
  - Very interested
  - Somewhat interested
  - Not interested, just trying to survive

# PACT Perspectives On Managing High-Risk Patients: Data Sources And Analytic Method

- Semi-structured, qualitative interviews with:
  - PACT PCPs, RNs, social workers (Fall 2017 - Winter 2018, 3-6 per PIM site)
  - PACT facility leaders (Spring/Summer 2018, 2-4 per PIM site)
  - PIM team/program leaders (Summer 2018, n = 6)
- Created interview summaries of main domains
- Compiled information into respondent by domain matrix for rapid analysis
- Formative summary of results provided to leadership for process improvement, decision making about program sustainability
- Formal thematic coding/analysis now in progress

# Disclaimer

- Structure and functioning of PACTs varies widely across VA, which would impact the capacity of PACTs to perform some intensive care management tasks/activities
- Our results may not be representative of all VA facilities
  - Qualitative interviews
  - Limited to 5 sites with PIM programs

# PACT Clinicians' Perceptions Of PIM Components PACTs Could Do

- Variation in perceptions of what PACTs could do:
  - PACTs already doing most of what PIM does, except home visit. PACT cannot provide same level of intensity or clinician availability
  - PACTs could provide more frequent calls/visits with patients, patient/care giver education and psychosocial support, referrals to community services, and manage care transitions
  - PACTs could not do what PIM does because of patients' high psychosocial needs, low-functioning PACTs, inability to perform home visits, and constraints of clinic schedules

*"I already do many of these things with my patients, but it's difficult to apply to someone in their home since I can't see them in their home.* ***Presence in the home is one thing can't do.*** *We do engagement, advocacy, etc., but there's a limit with someone who is very needy.* ***I can't always be the navigator for someone who needs this level of intensity****." (PACT RN)*

# PIM Team Leads' Perceptions Of PIM Components that can be Incorporated Into PACT

- Intensive case management with a subset of patients (PACT RNCMs, social workers)
- Better use of PCMHI
- Virtual in-home care (iPad)
- Home visits
  - Feasible?
  - RNCM, SW would need dedicated time, supervision by HBPC

*"the **home visits** are so helpful but I just can't imagine a way that the [PACT] social worker could be gone the whole day, or the [PACT] RN. **I just don't know how that would happen.**" (PACT social worker)*

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# Key Stakeholders' Perceptions On What PACTs Need To Do What PIM Does

- All KS groups agreed that PACTs would need dedicated time for in-depth chart review and assessments, collaboration/coordination through IDT meetings (e.g., SW, PCMHI, pharm D), more frequent follow-up with patients

- Staffing mentioned by one or more key stakeholder groups:
  - Fully staffed PACTs, all roles (PIM team leads, PACT clinicians)
  - Additional PACT staffing (PACT clinicians, facility leaders)
  - Potentially new PACT roles (Discharge coordinator; Nurse dedicated to walk-ins, who could also do home visits; RN/SW "crash" team that can do home visits; Staff for co-attends; Case manager to follow patients closely)
  - Separate PACT for complex patients (PACT clinicians)

# What Would PACTs Need To Do What PIM Does?

- PACT clinicians stressed importance of personnel willing to do intensive case management, flexible about role boundaries

*"We would need **PACT team members that were willing to go above and beyond**. So, I just happen to have PACT team members that will do anything, and so they can get close to doing some of the tasks the PIM team did. But what would we need? You know, if we were going to do more intensive management, **we probably would need willing participants to do this kind of more intensive management.**" (PACT PCP)*

- Facility leaders emphasized
  - Better use of existing skills/resources (eg, whole health coaching, MHICM, H-PACT)
  - Boundary setting with patients
  - Smaller panels for RNCMs

# Tools Or Resources That PACTs Might Need To Manage High-Risk Patients

- Tools to organize information for patients (e.g., goals, provider names and contact info, medications/therapies)
- Tools to identify high-risk patients and construct a panel for intensive follow-up
- Checklists for nurses to track tests, treatments, and follow-up
- A reminder system to help RNCMs follow-up on consults and other care management tasks
- SOPs for disease-specific intensive care management (CHF, COPD, DM)



From PIM Team Leader Interviews

# Tools Or Resources That PACTs Might Need To Manage High-Risk Patients

- Ability to do a home visit
- System for routing calls from specific patients directly to providers
- Offer same-day appointments

*"We have some neat tools. **I can't keep up with all the tools**, to tell you the truth." (PACT physician leader)*



From PACT Clinician Interviews

# Tools Or Resources That PACTs Might Need To Manage High-Risk Patients

- Better use of existing tools for panel management, community resources, space
- Increased access to telehealth, expanded telehealth capacity (telehealth RN panels with max 90 patients)
- Tools/resources to increase efficiency
- Trainer/facilitator to work with teams on how to manage high-risk patients

*". . . to get the tools disseminated to everybody and to teach everybody how to use it.* ***I need a facilitator*** *that will work with all of the teams and* ***help each team with [data].*** *" (PACT physician leader)*

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From PACT Facility Leader Interviews

# Summary Of Tools For High-Risk Patients Under Development For PACT

| 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<br>○ Checklist for Home Visits (Virtual Home Visit version available)<br>○ Medication Adherence Assessment<br>○ Healthcare Behavioral Contract<br>○ 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 |

# Other Tools/Toolkits

- QUERI Care Coordination Program Toolkit: https://vaww.visn10.portal.va.gov/sites/Toolkits/toolkit/Pages/Home.aspx
- PACT and specialty care toolkits: https://vaww.srkms.portal.va.gov/Pages/Toolkits.aspx#pact
- VISN 4 Patient engagement toolkit: https://www.visn4.va.gov/VISN4/CEPACT/PE_Practices/pe-toolkit.asp
- PCAS – available through Primary Care Almanac: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fAlmanac%2fMainMenu&rs%3aCommand=Render
- Hudson Valley Intelligent Preventive Care Web App – available for some VISNs:
  James Marquez (developer)

# Trainings PACTs Might Find Useful To Better Manage High-Risk Patients

- PACT clinicians, PIM team leads both thought PACTs are already capable of doing most of what PIM does, already have the skills, knowledge
- PIM team/program said PACTs could use additional training in:
  - Social determinants of health
  - How to conduct interdisciplinary team meetings
  - Additional training in motivational interviewing

# Trainings PACTs Might Find Useful To Better Manage High-Risk Patients

- Primary care facility leaders said more training needed for:
  - Using panel management tools, data, performance metrics
  - Available resources for managing high-risk patients
  - PACT roles/responsibilities
  - Intensive care management training (for RNs)
  - Engaging high-risk patients, motivational interviewing
  - Boundary-setting with patients

# Summary: Can PACTs Provide Intensive Primary Care?

- PACTs may already have most of the skills/trainings they would need to provide intensive primary care
- To provide these services, PACTs may need:
  - Optimal **staffing ratios** (fully staffed teams, possibly additional staffing, or decreased panel sizes)
  - Training on relevant **resources** for complex patients and how to use them
  - Ability to perform **home visits** or collaborating/coordinating better with other VA or community services that could do home visits and assessments
  - PACTs, however, may not able to provide the intensity and availability to patients that PIM teams offer

# Next Steps

- Formal coding and analysis to see if patterns emerge from the data by key stakeholder group, site, etc.
- Explore whether PACT structure and functioning may have shaped our key stakeholders' perceptions of PACTs' ability to provide intensive primary care.

# Poll Question #3

What activities for high-risk patients could feasibly be performed by PACT teams? (select all that apply)

- Weekly superhuddle with extended PACT team
- Virtual home visit (iPad)
- Frequent phone calls with high-risk patients
- Assessment of social determinants of health
- Caregiver support and education

# Discussion Questions

- What activities for high-risk patients could feasibly be performed by PACT teams?
- What resources, trainings, or tools do you think are needed to better care for high-risk patients in your panel?
- How might PACT structure and/or functioning at your facility impact ability to provide intensive primary care?

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# QUESTIONS?
# COMMENTS?

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