Predicting Risk of Hospitalization and Death

SD Fihn MD MPH

Clinical System Development and Evaluation
Veterans Health Administration

July 2016
POLL

What is your primary role in the VA?
A. PACT Physician
B. PACT Nurse
C. Other Clinical Staff
D. Other Administrative Staff
E. Other
Knowledge of a patient’s clinical characteristics and risk of adverse event can help target services.

- Providers can’t accurately predict patients at highest risk of deterioration.
- PACT RN Care Managers charged to coordinate care.
- No systematic way to identify Veterans who might benefit most → predictive analytics using data from EHR.
Initial Development of the Care Assessment Need (CAN) Score

• 4,505,501 veterans enrolled in primary care who had ≥1 visit
  – Validated models in literature → Benchmarking, Candidate covariates

• Standard and multinomial (polytomous) logistic regression
  – Conjoint modeling of hospitalization/death w/in 90d, 1-yr
  – 90 terms from 7 domains in CDW

• Probability of admission or death within a specified time period (90 days or 1 year) converted to percentile, (0 = lowest risk, 99 = highest risk) in relation to all other enrolled Veterans

## Input Variables – CAN 2.0

**Demographics**
- Age Group
- Air Force Flag
- Eligibility (1, [2-4], 5+)
- Rank Flag (Officer vs Enlisted)
- Marital Status
- Priority
- SES index
- Sex

**Vital Signs**
- BMI (≥40)
- Weight Variability
- HR (80-60)
- Resp Rate (≥20)
- Sys & Dias BP

**Utilization**
- No. Hospital/Bed Days
- No. Medical Providers
- No. Visit Type:
  - All
  - Inpatient
  - Emergency Care
  - Cardiology
  - CT
  - Mental Health
  - Other Non-Face
  - Primary Care (PC)
  - Phone Care
  - PC Phone Care
  - No. 11-20min Phone
  - No. 21-30min Phone
  - No. Est Office Visit

**Chronic Illness**
- Deyo-Charlson Score
- HCCs:
  - AFib and CHF
  - Dementia
  - Mental Health and PTSD
  - Metastatic Cancer
  - Alcohol
  - Chronic Airway Obstruction

**Lab/Radiology**
- No. Albumin
- No. Blood, Urine, Nitrogen
- Lymphocytes (Low)
- Red Blood Cells (Low)
- Sodium (Low)
- White Blood Cells (High)
- No. Troponin
- No. Chest X-Ray

**Pharmacy**
- Antipsychotic
- Beta-blocker
- Benzodiazepine
- Beta agonist nebulizer
- Furosemide
- Statin
- Metformin
- NSAID
- Furosemide Tablets
- No. of drugs filled

**Text Notes**
- No. Consent Notes
- No. Telephone Notes
Average Probabilities by CAN Score

<table>
<thead>
<tr>
<th>Model</th>
<th>C</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 Day Event</td>
<td>0.79</td>
<td>0.002</td>
</tr>
<tr>
<td>1 Year Event</td>
<td>0.81</td>
<td>0.004</td>
</tr>
<tr>
<td>90 Day Hospitalization</td>
<td>0.83</td>
<td>0.004</td>
</tr>
<tr>
<td>1 Year Hospitalization</td>
<td>0.81</td>
<td>0.002</td>
</tr>
<tr>
<td>90 Day Mortality</td>
<td>0.87</td>
<td>0.006</td>
</tr>
<tr>
<td>1 Year Mortality</td>
<td>0.86</td>
<td>0.003</td>
</tr>
</tbody>
</table>
Mean Bed Days

Average # of Bed Days by CAN Score

VETERANS HEALTH ADMINISTRATION
Mean Number of Providers by CAN Score
Mean Number of Distinct Drugs by CAN Score
<table>
<thead>
<tr>
<th>CAN Score</th>
<th>Patient Name</th>
<th>SSN</th>
<th>Probability of Event %</th>
<th>Diagnoses Count</th>
<th>PALLIATIVE CARE</th>
<th>Last Pal Care Visit</th>
<th>HBPC Visit</th>
<th>2yr ER/UC Visit Count</th>
<th>2yr Disch Count</th>
<th>Last Disch Date</th>
<th>2yr PC Visit Count</th>
<th>Last PC Visit Location</th>
<th>Last PC Visit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td></td>
<td></td>
<td>45%</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>97</td>
<td></td>
<td></td>
<td>18%</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96</td>
<td></td>
<td></td>
<td>15%</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
<td></td>
<td>15%</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Unique Users
By VISN all years
Current CAN Usage -- Most Use in Region 2 (VISN 8)

- **CAN Score Report Usage by Region and VHA for Past Twelve Months**

- **CAN Score Report User Count by Region and VHA for Past Twelve Months**

* This only reflects use of reports produced by the VSSC and will not include counts of when RDW or VDW have included the CAN Score index in a local or regional report.

** Drill to detail by selecting a Region column.**
Few Patients with High Scores Referred to Coordination Programs Telehealth, HBPC, Palliative Care, and Hospice

**Palliative Care**
Score ≥ 95 -- 5,000 of 268,833 total patients (1.9%)

**Hospice**
Score ≥ 95 -- 775 of 268,833 total patients (0.2%)
Issues

• Nonspecificity
  – About 1/3 of patients with very high score deemed appropriate for intensive primary care management.
  – Score does not link to specific action
  – Out of work-flow

• Depends mainly on VA data
  – May not perform as well for care in the community.

• Special Populations
## Clinical Subgroups of High-Risk Patients (IRT)

### Diagnoses by Subgroup

<table>
<thead>
<tr>
<th>Substance Abuse</th>
<th>Liver</th>
<th>General Cancer</th>
<th>Cancer + Cardiac</th>
<th>Complex Diabetes</th>
<th>Complex Mental Hlth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse</td>
<td>77%</td>
<td>27%</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>84%</td>
<td>31%</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicotine Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>33%</td>
<td>16%</td>
<td>28%</td>
<td></td>
<td>35%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>48%</td>
<td>20%</td>
<td>35%</td>
<td></td>
<td>52%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>18%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAD</td>
<td>17%</td>
<td>18%</td>
<td>38%</td>
<td>46%</td>
<td>19%</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>17%</td>
<td>41%</td>
<td>29%</td>
<td>46%</td>
<td>58%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>41%</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>16%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>23%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### High Risk Comorb: Hepatitis Liver Dis
Inpatient Services of High Risk Patients

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>N patients</th>
<th>All VA Hospitalizations Per Pt/Per Year Mean (SD)</th>
<th>Psychiatric Hospitalizations Per Pt/Per Year Mean (SD)</th>
<th>Readmissions within 30 days Per Pt/Per Year Mean (SD)</th>
<th>Length of Stay 8+ days (% of All Hospitalizations)</th>
<th>ED Visits Per Pt/Per Year Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Substance Abuse”</td>
<td>10,579</td>
<td>1.06 (1.68)</td>
<td>0.24 (0.69)</td>
<td>0.55 (1.02)</td>
<td>65.6</td>
<td>2.72 (3.81)</td>
</tr>
<tr>
<td>“Liver”</td>
<td>5,826</td>
<td>1.14 (1.67)</td>
<td>0.05 (0.30)</td>
<td>0.55 (1.03)</td>
<td>53.2</td>
<td>2.28 (2.99)</td>
</tr>
<tr>
<td>“General Cancer”</td>
<td>5,026</td>
<td>0.83 (1.35)</td>
<td>0.05 (0.28)</td>
<td>0.63 (1.26)</td>
<td>49.4</td>
<td>1.95 (2.84)</td>
</tr>
<tr>
<td>“Cancer + Cardiac”</td>
<td>8,628</td>
<td>1.09 (1.54)</td>
<td>0.01 (0.09)</td>
<td>0.58 (1.11)</td>
<td>52.6</td>
<td>2.00 (2.50)</td>
</tr>
<tr>
<td>“Complex Diabetes”</td>
<td>23,691</td>
<td>0.86 (0.57)</td>
<td>0.01 (0.15)</td>
<td>0.58 (1.07)</td>
<td>45.7</td>
<td>1.95 (2.55)</td>
</tr>
<tr>
<td>“Complex Mental Hth”</td>
<td>14,649</td>
<td>0.57 (1.02)</td>
<td>0.09 (0.40)</td>
<td>0.55 (1.09)</td>
<td>40.2</td>
<td>2.08 (2.70)</td>
</tr>
</tbody>
</table>
### Outpatient Services of High Risk Patients

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>N patients</th>
<th>PC PCP visits in person</th>
<th>PC phone visits (all providers)</th>
<th>Outpatient specialty visits (any non-PC encounters)</th>
<th>Mental health clinic outpatient encounters</th>
<th>PCMH in person &amp; phone encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Substance Abuse”</td>
<td>10,579</td>
<td>4.65 (4.74)</td>
<td>0.25 (0.52)</td>
<td>4.70 (7.47)</td>
<td>29.18 (34.58)</td>
<td>0.71 (2.44)</td>
</tr>
<tr>
<td>“Liver”</td>
<td>5,826</td>
<td>5.17 (4.33)</td>
<td>0.48 (0.68)</td>
<td>10.59 (12.76)</td>
<td>10.16 (23.08)</td>
<td>0.43 (2.05)</td>
</tr>
<tr>
<td>“General Cancer”</td>
<td>5,026</td>
<td>4.94 (4.33)</td>
<td>0.48 (0.68)</td>
<td>11.15 (14.25)</td>
<td>8.85 (18.08)</td>
<td>0.62 (2.53)</td>
</tr>
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<td>8,628</td>
<td>4.98 (4.54)</td>
<td>0.55 (0.72)</td>
<td>14.40 (17.18)</td>
<td>0.94 (4.47)</td>
<td>0.11 (0.79)</td>
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<td>9.54 (12.10)</td>
<td>2.27 (9.65)</td>
<td>0.20 (1.34)</td>
</tr>
<tr>
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<td>14,649</td>
<td>5.51 (4.74)</td>
<td>0.38 (0.64)</td>
<td>6.70 (8.84)</td>
<td>12.13 (19.27)</td>
<td>0.73 (2.78)</td>
</tr>
</tbody>
</table>
A Point-of-Care Clinical Application for Team-Based Primary Care

Tamara L. Box, PhD
Stephan D. Fihn, MD MPH
MAR 2017

VHA OFFICE OF CLINICAL SYSTEMS DEVELOPMENT AND EVALUATION
POLL

Have you ever used CAN or PCAS?
A. No, I have not used them.
B. I have only used CAN.
C. I have only used PCAS.
D. I use both of them regularly.
The **Patient Care Assessment System** is a **web-based application** to provide **Patient Aligned Care Teams (PACT)** with tools to **identify, manage, and coordinate care** for their paneled patients.

➡️ Special emphasis is given to high risk patients and sub-populations.
PROVIDING DATA IN ONE VIEW

CDW

VISTA

ADMIN

CAN

NON-VA

MODELS
PROVIDING DATA IN ONE VIEW
HOW DO I GET TO PCAS?

• **NO local installation needed**

• **Linked through Primary Care Almanac (Tools Menu) (coming soon!)**
  – Direct URL
  – Through CPRS

• **No Special Login Required**
  – If you are a member of a PACT team, the application will recognize you!
  – *If you are not part of a team in PCMM, we are working on enhanced access in early 2017 – stay tuned!*

• **Available nationwide; 4000+ users from every VISN and used nearly 30,000 times so far in FY17**
**Manage Patients**

Use the fields below to filter your panel to find a specific patient or group of patients. Or, use the risk-based panel filters on the right to quickly locate a group of patients. Each underlined column is sortable. Once you have found your patient, simply click on their name to navigate to their PCAS record.

<table>
<thead>
<tr>
<th>Filter Panel By Patient(s) or Appointment:</th>
<th>Or Filter Panel Based on Risk Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search By Name:</td>
<td>Manual High Risk Flag</td>
</tr>
<tr>
<td>Search By Last 4 SSN:</td>
<td>Top CAN Scores (1yr. death or admission model)</td>
</tr>
<tr>
<td>Search By Next Appointment Date:</td>
<td>Top Clinical Priority OR Select</td>
</tr>
<tr>
<td>Search by Gender:</td>
<td>Received Homeless Services (last 12 Months)</td>
</tr>
<tr>
<td></td>
<td>Suicide Risk</td>
</tr>
<tr>
<td></td>
<td>Home-Based Primary Care</td>
</tr>
<tr>
<td></td>
<td>Home Telehealth Participants</td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
</tr>
<tr>
<td></td>
<td>Hospice Care</td>
</tr>
<tr>
<td></td>
<td>Heart Failure Patients with an Admission in Last 30 Days</td>
</tr>
<tr>
<td></td>
<td>Bed Days of Care (BDOC)</td>
</tr>
<tr>
<td></td>
<td>MCA Cost (Formerly DSS Cost)</td>
</tr>
<tr>
<td></td>
<td>Goals of Care Conversation for Life-Sustaining Treatment (GOC2)</td>
</tr>
</tbody>
</table>

[Clear Filter]
### Filter Panel By Patient(s) or Appointment:

<table>
<thead>
<tr>
<th>Search By Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Search By Last 4 SSN:</td>
<td></td>
</tr>
<tr>
<td>Search By Next Appointment Date:</td>
<td>Start Date:</td>
</tr>
<tr>
<td>Search by Gender:</td>
<td>-- Choose</td>
</tr>
</tbody>
</table>

### Or Filter Panel Based on Risk Characteristics:

- Manual High Risk Flag
- Top CAN Scores (1yr, death or admission model)
- Top Clinical Priority
- Received Homeless Services (last 12 Months)
- Suicide Risk
- Home-Based Primary Care
- Home Telehealth Participants
- Palliative Care
- Hospice Care
- Heart Failure Patients with an Admission in Last 30 Days
- Bed Days of Care (BDOC)
- MCA Cost (Formerly DSS Cost)
- Goals of Care Conversation for Life-Sustaining Treatment (GOCC)
## Manage Patients

Use the fields below to filter your panel to find a specific patient or group of patients. Or, use the risk-based panel filters on the right to quickly locate a group of patients. Each underlined column is sortable. Once you have found your patient, simply click on their name to navigate to their PCAS record.

<table>
<thead>
<tr>
<th>Last 4 SSN</th>
<th>Patient Name</th>
<th>CAN</th>
<th>Clinical Priority</th>
<th>Clinical Priority Reason</th>
<th>High Risk Flag</th>
<th>High Risk Flag Reason</th>
<th>VA Last Appointment</th>
<th>VA Next Appointment</th>
<th>Care Plan Reevaluation Date</th>
<th>Care Plan</th>
<th>Tasks</th>
<th>GOCC</th>
<th>Team</th>
<th>Active or Pending Consults</th>
<th>BDOC</th>
<th>MCA Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>Test, Patient</td>
<td>99</td>
<td>9</td>
<td>Esophageal cancer s/P surgery</td>
<td>Y</td>
<td>Homeless, Cancer</td>
<td>DD MMM YYYY</td>
<td>DD MMM YYYY</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td>TEAM A</td>
<td>1</td>
<td>1</td>
<td>$23,927.15</td>
<td></td>
</tr>
<tr>
<td>1001</td>
<td>Test2, Patient</td>
<td>98</td>
<td>9</td>
<td>CAD, Diabetes, Obesity, Sleep apnea, Pain, anxiety, Dysthymic Disorder</td>
<td>Y</td>
<td>Clinical Priority, Statistical High Risk (CAN)</td>
<td>DD MMM YYYY</td>
<td>DD MMM YYYY</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td>TEAM B</td>
<td>3</td>
<td>10</td>
<td>$40,160.62</td>
<td></td>
</tr>
<tr>
<td>1002</td>
<td>Test3, Patient</td>
<td>98</td>
<td>10</td>
<td>PVD, CAD, Carotid Artery D2, COPD, Tobacco Use, Bipolar Disease</td>
<td>Y</td>
<td></td>
<td>DD MMM YYYY</td>
<td>DD MMM YYYY</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td>TEAM B</td>
<td>1</td>
<td>0</td>
<td>$16,065.27</td>
<td></td>
</tr>
<tr>
<td>1003</td>
<td>Test4, Patient</td>
<td>98</td>
<td>7</td>
<td>Hemodialysis</td>
<td>Y</td>
<td>Dialysis</td>
<td>DD MMM YYYY</td>
<td>DD MMM YYYY</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td>TEAM A</td>
<td>1</td>
<td>7</td>
<td>$229,689.76</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BDOC</th>
<th>CSS</th>
<th>Clear Filter</th>
</tr>
</thead>
</table>
### Assign Clinical Priority & High Risk Flag

#### CARE ASSESSMENT NEEDS SCORES [?]

<table>
<thead>
<tr>
<th>(CAN) Scores (1-99):</th>
<th>Admission</th>
<th>Combined Event (Death or Admission)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 day Score:</td>
<td>97 (19%)</td>
<td>97 (20%)</td>
</tr>
<tr>
<td>1 year Score:</td>
<td>97 (42%)</td>
<td>97 (53%)</td>
</tr>
<tr>
<td>Clinical Priority (1-10) [?]</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Manual High-Risk Flag [?]</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Risk Flag Reason [?]</td>
<td>Mild dementia</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Patient Information

- National BDOC: 3
- Polypharmacy Count: 16
- Pain Scale: 0
- OEF/OIF/OND: No
- Suicide Risk: No
- Received Homeless Services (last 12 months): NULL
- Home-Based Primary Care: No
- Home Telehealth Participant: No
- Palliative Care: No
- Hospice Care: No
- Spinal Cord Injury: NOT APPLICABLE
- Agent Orange Exposure Documented: No
- Heart Failure Re-Admission 30-day Watch: No
Risk Characteristics

Patient Name: Test Veteran

1 Year Admission or Death Over Time

Risk Date
- 06-19-15
- 07-24-15
- 08-28-15
- 10-02-15
- 11-06-15
- 12-11-15

- 100
- 80
- 60
- 40
- 20
- 0

- Yes
- No

Polypharmacy Count [7]: 0
Pain Scale [7]: 6
OEF/OIF/OND? [7]: No
Suicide Risk [7]: No
Received Homeless Services (last 12 months) [7]: Yes
Home-Based Primary Care [7]: No
Palliative Care [7]: No
Home Telehealth Participant [7]: No
Heart Failure Dx with Admission In Last 30 Days [7]: No Admissions Last 30 Days
Northeast Cancer Registry Records [7]: No records found
**Assign Clinical Priority & High Risk Flag**

**CARE ASSESSMENT NEEDS SCORES [?]**

<table>
<thead>
<tr>
<th>(CAN) Scores (1-99)</th>
<th>Admission</th>
<th>Combined Event (Death or Admission)</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>1 year Score:</td>
<td>97 (42%)</td>
<td>97 (53%)</td>
</tr>
</tbody>
</table>

**Clinical Priority (1-10) [?]**: 7

**Manual High-Risk Flag [?]**: Yes

**Risk Flag Reason [?]**: Mild dementia
This field indicates if a patient has received any VA homeless services in the last 12 months. Source: PCP Panel Cube. Updated: Nightly.
### Risk Characteristics

Risk Characteristics overview and page directions will be pulled from database.

#### Key Cost Risk Factors (for the past 12 months)

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA Cost</td>
<td>$13,077.97</td>
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<tr>
<td>Beneficiary Travel Costs</td>
<td>$0.00</td>
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<tr>
<td>FEE Costs (Disbursed Amount)</td>
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</tr>
<tr>
<td>FEE Costs (Payment Amount)</td>
<td>No Records Found</td>
</tr>
<tr>
<td>VERA Classification Last Fiscal Year</td>
<td>5: Multiple Problem</td>
</tr>
<tr>
<td>VERA Classification Current Fiscal Year</td>
<td>2: Basic Medical/Ht, Lung, GI</td>
</tr>
<tr>
<td>Number of Hospital Discharges (last 12 months)</td>
<td>1</td>
</tr>
<tr>
<td>National BOOC</td>
<td>4</td>
</tr>
<tr>
<td>Polypharmacy Count</td>
<td>0</td>
</tr>
<tr>
<td>Pain Scale</td>
<td>6</td>
</tr>
<tr>
<td>OEF/IOF/OND</td>
<td>No</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>No</td>
</tr>
<tr>
<td>Received Homeless Services (last 12 months)</td>
<td>Yes</td>
</tr>
<tr>
<td>Home-Based Primary Care</td>
<td>No</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>No</td>
</tr>
<tr>
<td>Home Telehealth Participant</td>
<td>No</td>
</tr>
<tr>
<td>Heart Failure Dx with Admission in Last 30 Days</td>
<td>No Admissions Last 30 Days</td>
</tr>
<tr>
<td>Northeast Cancer Registry Records</td>
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</table>
### Team Information

Team Information Overview Text will go here, no need to add directly to database or page just use this front end and all will populate correctly.

---

### PACT Team

<table>
<thead>
<tr>
<th>Team Name</th>
<th>Team Member Name</th>
<th>Position</th>
<th>Role</th>
<th>Location</th>
<th>Date Assigned</th>
<th>Office Phone</th>
<th>Digital Pager</th>
<th>Email Address</th>
<th>Receive PCAS Notifications</th>
</tr>
</thead>
<tbody>
<tr>
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<td>MEMBER NAME</td>
<td>MEDICAL SUPPORT ASSISTANT</td>
<td>PC ASSIGNMENT</td>
<td>689GC</td>
<td>07/12/2012</td>
<td>860-450-</td>
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<td></td>
<td>Yes</td>
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<tr>
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<td>MEMBER NAME</td>
<td>REGISTERED NURSE</td>
<td>PC ASSIGNMENT</td>
<td>689GC</td>
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<td>860-450-</td>
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<td></td>
<td>No (01/03/2015)</td>
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<tr>
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<td>MEMBER NAME</td>
<td>PHYSICIAN</td>
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<td>850450</td>
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<td>REGISTERED NURSE</td>
<td>PC ASSIGNMENT</td>
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<td>2140</td>
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<td>07/12/2012</td>
<td>860-450-</td>
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**Home/Community Provider Information**

No Home/Community Provider Information Found

[Add Home/Community Provider]
### Outpatient Encounters (Last 12 Months)

#### FILTER

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Diagnosis (keyword or ICD)</th>
<th>Type</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>MEDICAL</th>
<th>HOSPITAL</th>
<th>Brammer</th>
<th>HEM ONC INFUSION CHAIR 2 WHAV</th>
<th>161.9: MALIGNANT NEOPLASM OF LARYNX, UNSPECIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/21/2014</td>
<td>Name</td>
<td>Specialty Care</td>
<td>CONNECTICUT HCS</td>
<td>330</td>
<td>VHA</td>
</tr>
<tr>
<td>01/24/2014</td>
<td>Name</td>
<td>Diagnostic</td>
<td>CONNECTICUT HCS</td>
<td>108</td>
<td>LAB DIV 609 OOS ID 108</td>
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<tr>
<td>01/28/2014</td>
<td>Name</td>
<td>Specialty Care</td>
<td>CONNECTICUT HCS</td>
<td>330</td>
<td>LAB DIV 609 OOS ID 108</td>
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<tr>
<td>01/28/2014</td>
<td>Name</td>
<td>Ancillary</td>
<td>CONNECTICUT HCS</td>
<td>160</td>
<td>INPT PHARM ADMISSION WHAV-X</td>
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<td>Name</td>
<td>Diagnostic</td>
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<td>108</td>
<td>LAB DIV 609 OOS ID 108</td>
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## Inpatient Discharges (Last 12 Months)

<table>
<thead>
<tr>
<th>Discharge Date</th>
<th>Facility Location</th>
<th>Discharge Diagnosis</th>
<th>Discharge Case Manager/Nurse</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/05/2015</td>
<td>WEST HAVEN</td>
<td>188.4: MALIGNANT NEOPLASM OF POSTERIOR WALL OF URINARY BLADDER</td>
<td>PROVIDER NAME</td>
<td>VA</td>
</tr>
<tr>
<td>12/12/2014</td>
<td>SMITH HOSPITAL</td>
<td>458.0: ORTHOSTATIC HYPOTENSION</td>
<td>FEE</td>
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<tr>
<td>08/01/2014</td>
<td>WEST HAVEN</td>
<td>997.5: URINARY COMPLICATIONS, NOT ELSEWHERE CLASSIFIED</td>
<td>PROVIDER NAME</td>
<td>VA</td>
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<tr>
<td></td>
<td></td>
<td>188.4: MALIGNANT NEOPLASM OF POSTERIOR WALL OF URINARY BLADDER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Health Factors (Last 12 Months)

Team Information Overview Text will go here, no need to add directly to database or page just use this front end and all will populate correctly.

**Patient Name:**  
**SSN:**  
**DOB:**

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Health Factor Type</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/7/2014 8:30</td>
<td>HIV TEST - DECLINED</td>
<td></td>
</tr>
<tr>
<td>11/7/2014 9:30</td>
<td>NOT REGISTERED FOR MHV</td>
<td></td>
</tr>
<tr>
<td>11/14/2014 11:10</td>
<td>V1 - ADVANCE DIRECTIVE NOT AT VAMC</td>
<td>patient will bring in a copy at next visit</td>
</tr>
<tr>
<td>1/15/2015 15:25</td>
<td>NEGATIVE - HAS STABLE HOUSING</td>
<td></td>
</tr>
</tbody>
</table>
### VA and Non-VA Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Med Start Date</th>
<th>Status</th>
<th>Expiration Date</th>
<th>Refill Date</th>
<th>Renewal Date</th>
<th>Prescribing Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZOLPIDEM</td>
<td>10 MG</td>
<td>10/1/2014 10:22:00 AM</td>
<td>ACTIVE</td>
<td>9/29/2014 12:00:00 AM</td>
<td>7/24/2014 12:00:00 AM</td>
<td>VACT-NEWINGTON,CT</td>
<td></td>
</tr>
<tr>
<td>FERROUS SULFATE</td>
<td>325 MG</td>
<td>9/26/2014 12:02:20 PM</td>
<td>EXPIRED</td>
<td>10/30/2016 12:00:00 AM</td>
<td>9/15/2014 12:00:00 AM</td>
<td>10/8/2013 12:00:00 AM</td>
<td>VACT-WEST HAVEN,CT</td>
</tr>
<tr>
<td>GABAPENTIN</td>
<td>300 MG</td>
<td>2/25/2013 1:13:41 PM</td>
<td>EXPIRED</td>
<td>9/30/2014 12:00:00 AM</td>
<td>2/22/2013 12:00:00 AM</td>
<td>2/22/2013 12:00:00 AM</td>
<td>VACT-WEST HAVEN,CT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Med Start Date</th>
<th>Status</th>
<th>Expiration Date</th>
<th>Refill Date</th>
<th>Renewal Date</th>
<th>Prescribing Location</th>
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</thead>
<tbody>
<tr>
<td>TRAMADOL</td>
<td>50 MG</td>
<td>10:26:14 AM</td>
<td>PROVIDER</td>
<td>12:00:00 AM</td>
<td>12:00:00 AM</td>
<td>12:00:00 AM</td>
<td>HAVEN,CT</td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>1 MG</td>
<td>2/25/2013 1:12:42 PM</td>
<td>EXPIRED</td>
<td>9/30/2014 12:00:00 AM</td>
<td>2/22/2013 12:00:00 AM</td>
<td>2/22/2013 12:00:00 AM</td>
<td>VACT-WEST HAVEN,CT</td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>1 MG</td>
<td>11/12/2014 12:05:00 PM</td>
<td>DISCONTINUED</td>
<td>11/10/2014 12:00:00 AM</td>
<td>5/29/2014 12:00:00 AM</td>
<td>VACT-NEWINGTON,CT</td>
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</tr>
</tbody>
</table>
Patient Consults

Hide Page Overview...  

Consults for patient, select consult for more details.

Patient Name: Test Veteran  
SSN: XXXX  
DOB: 00/00/0000  

Filter:
Filter By CPRS Status: -- Choose --  
Filter By Request Date: Start Date:  
End Date:  

Clear Filter

<table>
<thead>
<tr>
<th>To Request Service Name</th>
<th>Request Date</th>
<th>Urgency</th>
<th>CPRS Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>O/RHEUMATOLOGY OPT</td>
<td>02/06/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>O/GASTRO COLONOSCOPY</td>
<td>02/06/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>EYEGlass REQUEST - OMAHA</td>
<td>02/19/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>PROSTHESICS REQUEST - OMAHA</td>
<td>03/26/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>O/OCCUPATIONAL THERAPY</td>
<td>03/26/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>O/PHYSICAL THERAPY OUTPATIENT</td>
<td>03/26/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>CANCELLED</td>
</tr>
<tr>
<td>PROSTHESICS REQUEST - OMAHA</td>
<td>04/05/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>PROSTHESICS REQUEST - OMAHA</td>
<td>04/05/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>O/GASTRO COLONOSCOPY</td>
<td>05/07/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>GENERAL SURGERY HEMORRHoids</td>
<td>05/07/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>O/ENT OTHER</td>
<td>05/07/2013</td>
<td>GMRCURGENCY - WITHIN 1 MONTH</td>
<td>COMPLETE</td>
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<tr>
<td>O/OPHTHALMOLOGY OPT OTHER</td>
<td>06/25/2013</td>
<td>GMRCURGENCY - ROUTINE</td>
<td>CANCELLED</td>
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<tr>
<td>O/urology HEMATURIA</td>
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<td>GMRCURGENCY - ROUTINE</td>
<td>SCHEDULED</td>
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</tbody>
</table>
## Consults

Filter List By Patient:

Filter By Name: [TextBox]

Or By Risk Score:

Manual High Risk Flag

Search By Last 4 SSN:

Go

Filter By CPRS Status:

ACTIVE

Filter By Request Date:

Start Date: [TextBox]  End Date: [TextBox]

Go

Clear Filter

<table>
<thead>
<tr>
<th>Last 4 SSN</th>
<th>Patient Name</th>
<th>High Risk Flag</th>
<th>Request Date Time</th>
<th>Request Service Name</th>
<th>CPRS Status</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select</td>
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<td></td>
<td>04 Dec 2013</td>
<td>O/NON VA CARE PAIN REFERRAL</td>
<td>ACTIVE</td>
<td>OMA PACT 003 (636)</td>
</tr>
<tr>
<td>Select</td>
<td>1234</td>
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<td>20 Nov 2013</td>
<td>O/NON VA CARE PAIN REFERRAL</td>
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<td>Select</td>
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<td>O/NON VA CARE PAIN REFERRAL</td>
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<td>OMA PACT 003 (636)</td>
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<td>Select</td>
<td>1234</td>
<td></td>
<td>18 Nov 2013</td>
<td>O/NON VA CARE PAIN REFERRAL</td>
<td>ACTIVE</td>
<td>OMA PACT 003 (636)</td>
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<td>O/NON VA CARE PAIN REFERRAL</td>
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### Manage Patients

Hide Page Overview...  
This will be a description/overview of the Manage Patients page. This is database driven so any changes will be on the database side, no need to update the application. Neat! Test

<table>
<thead>
<tr>
<th>Filter Panel By Patient(s) or Appointment:</th>
<th>Or Filter Panel Based on Risk Characteristics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search By Name:</td>
<td>Manual High Risk Flag</td>
</tr>
<tr>
<td>Search By Last 4 SSN:</td>
<td>Top CAN Scores (1yr. death or admission model)</td>
</tr>
<tr>
<td>Search By Next Appointment Date:</td>
<td>Top Clinical Priority</td>
</tr>
<tr>
<td></td>
<td>Received Homeless Services (last 12 Months)</td>
</tr>
<tr>
<td></td>
<td>Suicide Risk</td>
</tr>
<tr>
<td></td>
<td>Home-Based Primary Care</td>
</tr>
<tr>
<td></td>
<td>Home Telehealth Participants</td>
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</table>

<table>
<thead>
<tr>
<th>Last 4 SSN</th>
<th>Patient Name</th>
<th>CAN</th>
<th>Clinical Priority</th>
<th>High Risk</th>
<th>Risk Type</th>
<th>Last Appointment</th>
<th>Next Appointment</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>01 Jul 2014</td>
<td>28 Sep</td>
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</table>

Clear Filter
### Tasks

Filter Tasks By:

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<tr>
<th>Status</th>
<th>Assigned To</th>
<th>Task Due Date</th>
<th>Task Type</th>
<th>Task Requested Date</th>
<th>Last Follow-Up Date</th>
<th>Task Priority</th>
<th>Status</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select</td>
<td>JANE DOE</td>
<td>03/25/2015</td>
<td>Call Patient</td>
<td>03/19/2015</td>
<td>03/20/2015</td>
<td>URGENT</td>
<td>Complete</td>
<td>Delete</td>
</tr>
<tr>
<td>Select</td>
<td>JOHN DOE</td>
<td>03/24/2015</td>
<td>Check Lab Results</td>
<td>03/19/2015</td>
<td></td>
<td>Medium</td>
<td>On Hold</td>
<td>Delete</td>
</tr>
<tr>
<td>Select</td>
<td>JANE DOE</td>
<td>03/25/2015</td>
<td>Letter to Patient</td>
<td>03/19/2015</td>
<td></td>
<td>HIGH</td>
<td>Pending</td>
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<tr>
<td>Select</td>
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<td>03/23/2015</td>
<td>Check Screening Results</td>
<td>03/19/2015</td>
<td></td>
<td>Low</td>
<td>On Hold</td>
<td>Delete</td>
</tr>
</tbody>
</table>
This is a notification from the Patient Care Assessment System that you have TASKS DUE in the next three days.

- **2 URGENT TASKS** (please click here to address these)
- **3 Medium Priority Tasks**

Of these,

- **2 is Call Patient**
- **1 is Service F/U**
- **1 is Letter to Patient**

Please use the direct links above, or [CLICK HERE TO ACCESS PCAS](mailto:). (Please note: you must be on the VA network)

Sincerely,

Patient Care Assessment System

**NOTICE:** THIS EMAIL IS INTENDED ONLY FOR THE ORIGINAL RECIPIENT AND SHOULD NOT BE COPIED OR FORWARDED.
CASE MANAGEMENT FLAGS
(Past 12 months)

E.g.,

– Visits related to Hospice,
– Purchased Skilled Home Care,
– Non VA Care Coordination,
– Caregiver Program,
– Mental Health Case Management, etc...
PATIENT INFORMATION

Risk Characteristics
Patient Demographics
Secondary Contacts
Team Information

CLINICAL DISPOSITION

Upcoming Appointments
Outpatient Encounters
Inpatient Discharges
Labs and Immunizations
Health Factors
Vital Signs
Medications
Patient Consults

CARE PLANNING

Patient Notes
Learning Preferences
Patient Health Inventory
Assessment and Goals

TASKS and REMINDERS

CARE PLAN NOTE
Please select the situation or background that applies to this note:

- Functional Status Concerns
- Social Issues
- Exacerbation of chronic disease state
- Development of new chronic illness
- Hospitalization
- Emergency of urgent care visit
- Newly Homeless
- Other (please include in the text box)

View Previous Notes:

- 22 Feb 2017 Functional Status Concerns
- 27 Feb 2017 New Chronic Illness Hospitalization
- 03 Mar 2017 Functional Status Concerns

Note Comments:

SITUATION / BACKGROUND UPDATE CONcerning:
Functional Status Concerns
Social Issues

... (Add manual note text)...

[Save] [Cancel] [VIEW]
Learning Preferences

Vision/Hearing/Literacy

Communication Preferences

Educational Assessment

Style of Learning and Barriers

Patient, Spouse, Significant Other is ready to learn:

- Yes
- No

Requires Special Aids to Comprehend:

- Yes
- No

If "Yes" describe special aids required:

Patient/Caregiver is Able to Read and Write:

- Yes
- No

Styles of Learning Preferred:

- Reading
- Discussion
- Lecture
THE COMPONENTS OF PROACTIVE HEALTH AND WELL-BEING

Patient Health Inventory
From: Office of Patient Centered Care

Personal Health Inventory
Professional Care
Reflections
ASSESSMENT & GOALS

Problem Identification

Functional Status Assessment
ADLs, IADLs, Pain, Mental Health, Mobility
Care Plan Goals

Functional Status Assessment

Fall Risk:  
- [ ] No-Risk  
- [ ] Low-Risk  
- [ ] High-Risk  

View Morse Scale
CARE PLAN NOTE

Patient Name: Test Veteran
SSN: XXX
DOB: 00/00/000

Please select the information to include in this note:
- [x] Most recent CAN scores
- [x] PCAS Clinical Priority score and description
- [ ] Next 3 appointments
- [ ] Pending or active consults
- [ ] Most recent Patient Note
- [ ] Learning Preferences
- [ ] Patient Health Inventory
- [ ] Assessment
- [ ] Goals
- [x] Current tasks associated with this patient’s care

Note Text:

PCAS Care Plan Note

**Most Recent CAN Scores**
90-day Admission 85 (5%)
1 yr Admission 80 (15%)
90-day Admission or Death 85 (7%)
1 yr Admission or Death 90 (24%)

**PCAS Clinical Priority Score**
10; Statistical High Risk, Dialysis, Cancer

... (Add manual note text)...

View Previous CARE PLAN Notes:
- 22 Feb 2017 01:22A
- 27 Feb 2017 04:36P
- 03 Mar 2017 12:11P

[Save] [Cancel]

[SEND TO CPRS] [VIEW]
Non-VA Community Care Collaboration

- NVCC Team Access to PCAS (VA Providers)
- Care Planning Tasks enhancements
- Linking Consults to Appointments and Tasks
QUERY and REPORT FUNCTIONALITY

COMBINE things like:

• Appointment Date Range
• Diagnosis Lookup
• Risk Characteristics or Group-Level Risk
• Combine Clinical Criteria – beyond page filters
POLL

What PCAS function is most important to you?
A. Viewing VA and Non-VA data in one summary location
B. Quickly locating patients in a panel based on various risk characteristics
C. Team-based tasking
D. Creating a patient-centered plan and writing to CPRS
E. Something else
TEAM

- Steve Krysiak
- Sophie Lo
- Will Green
- Craig Kreisler
- SP Thakur
- Stephan Fihn, MD MPH
- ABI Colleagues and Collaborators
- PACT Nurse and Provider Members of Requirements Team
- ONS and PCS Implementation Leadership Team
- PCAS Champions
THANK YOU

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PCAS URL: https://secure.vssc.med.va.gov/PCAS