



Care Assessment Need (CAN) Score and the Patient Care Assessment System (PCAS): Tools for Care Management

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June 27, 2013



VA's Health Care Delivery Model

- Personalized, Proactive and Patient-Driven
- Team Care
- Continuous Improvement
- Data-Driven, Evidence-Based
- Value
- Prevention / Population Health

⇒ **Coordinated Care**



Goal: Enhance Quality & Eliminate Unnecessary, Unplanned Care



Top 10 VHA Discharge Diagnoses 2008

- Affective psychoses
- Heart Failure
- Chronic ischemic heart disease
- Respiratory symptoms/other chest sx
- Pneumonia
- Cardiac dysrhythmias
- Schizophrenic disorders
- Chronic bronchitis
- Alcohol dependence
- General symptoms

(Maynard and Fihn, Internet Journal Epi 2010)

Knowledge of a patient's risk of adverse event can help target services

Broad range of clinical programs designed improve care for veterans with complex chronic illness

Home-based primary care

Case-management

Specialty clinics, e.g., heart failure

Telehealth

Palliative care

Providers can't accurately predict Veterans 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

Modeling Strategy

- Patient characteristics
 - Demographics – age, priority level
 - Coexisting conditions – Deyo/Charlson score, HCCs
 - Vital signs
 - Utilization – inpatient and outpatient
 - Pharmacy
 - Lab values
- Outcomes occurring in subsequent yr.
 - Readmissions, deaths, either at 30, 60, 90 days & 1 yr
- Conjoint modeling admission and death using polytomous (multinomial) logistic regression

Model Terms

1. Demographics

Age (≥ 65)

Sex

Marital status

Svc . Conn. $\geq 50\%$

2. Chronic Illness

Deyo-Charlson

HCCs

MI/UA/CABG

Valvular dis.

Resp. failure

HTN

Stroke

Renal Failure

COPD

Atrial fib.

ASPVD

Pneumonia

Diabetes

Liver disease

Malnutrition

Dementia

Functional disease

Metastatic Cancer

Trauma

Psych disease

PTSD

Depression

3. Utilization

Outpt visits (>4)

PC visits (>1)

Cardiology visits

Pulmonary visits

Mental health visits

ER visits (>1 1st yr)

Other visits (>3)

Recent Admission

BDOC (1-10 vs 0)

No. providers (>3)

4. Vital Signs

Sys & Dias BP

Heart rate (>85)

Resp. rate (≥ 20)

BMI (<25)

5. Pharmacy

Total # refills (>0)

ACEI/ARB

Alpha-blocker

Nebulized drugs

Antiplatelet drugs

Anti-depressants

Antipsychotics

Benzodiazepine

Beta-blockers

Bumetanide/ Torsemide

Thiazides

CCB

Digoxin

Furosemide

Insulin

Metolazone

Metformin

Nitrate-long acting

Opioids

NSAIDS

Lipid lowering drugs

P-par-gamma-agonists

K+ sparing diuretic

Oral steroids

Warfarin

6. Interactions

18 interaction terms

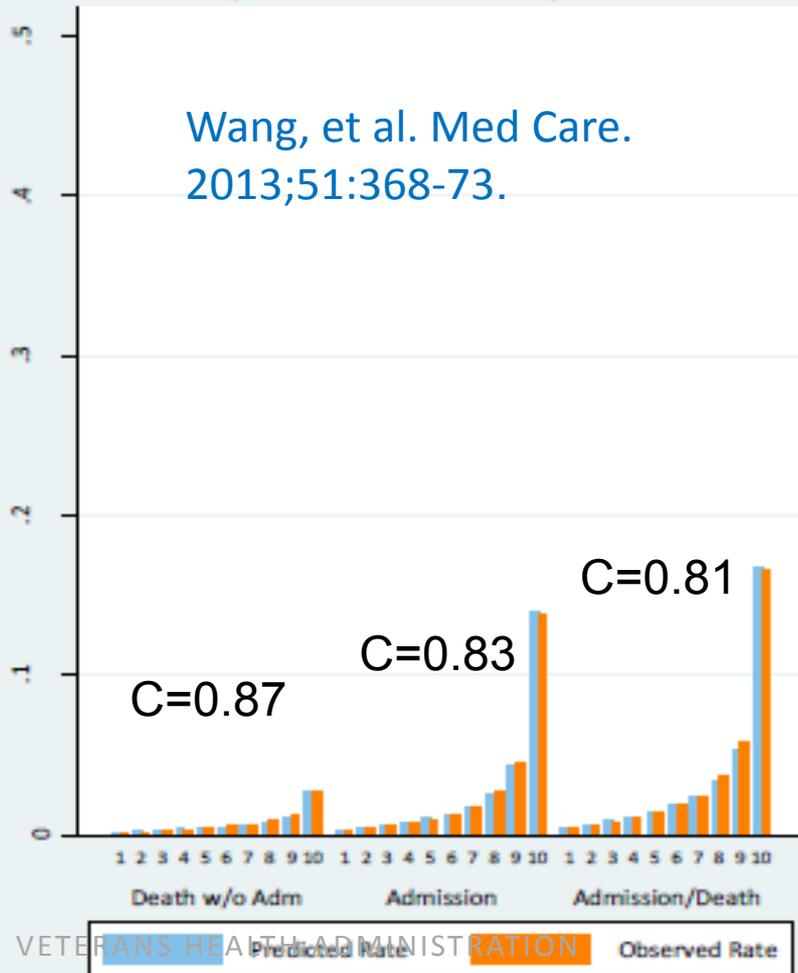
$RRR \leq 0.8$ or $RRR \geq 1.5$ (adm); $RRR \leq 0.8$ or $RRR \geq 1.5$ (death); $RRR \leq 0.8$ or $RRR \geq 1.5$ (both)

Care Assessment Need (CAN) Score

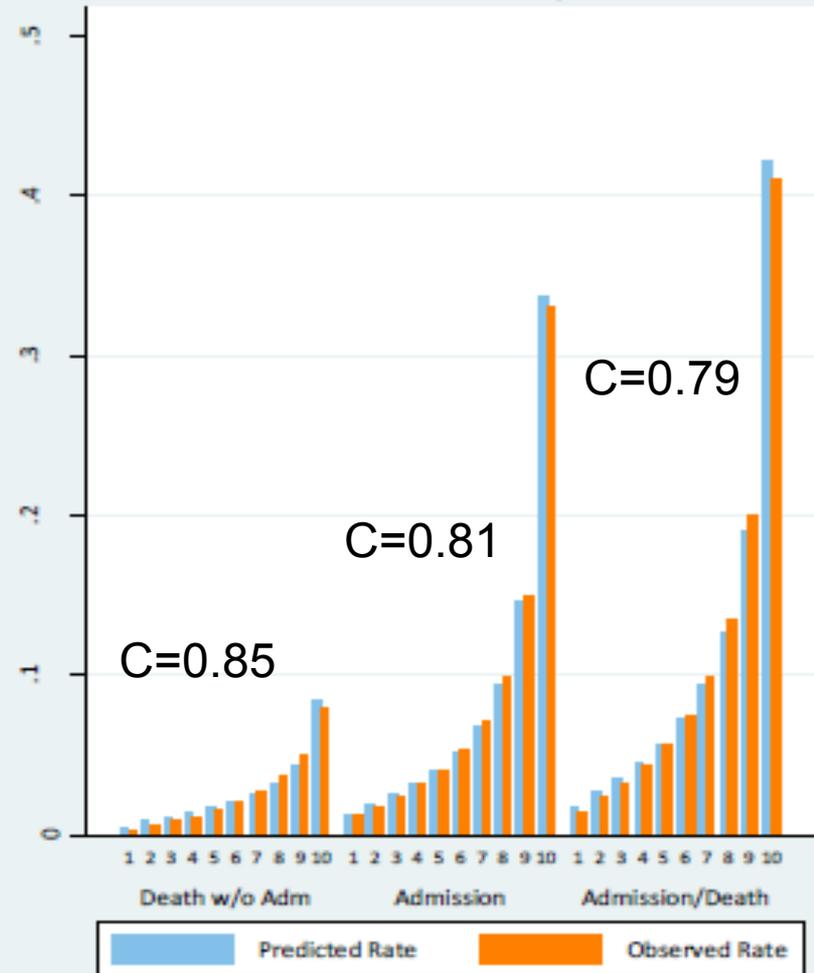
- Reflects estimated probability of admission or death within a specified time period (90 days or 1 year)
- Expressed as a percentile, ranging from 0 (lowest risk) to 99 (highest risk)
- Indicates how a given Veteran compares with other individuals in terms of likelihood of hospitalization or death

Predicted and Observed Likelihood of Death/Admission 4,505,501 primary care patients

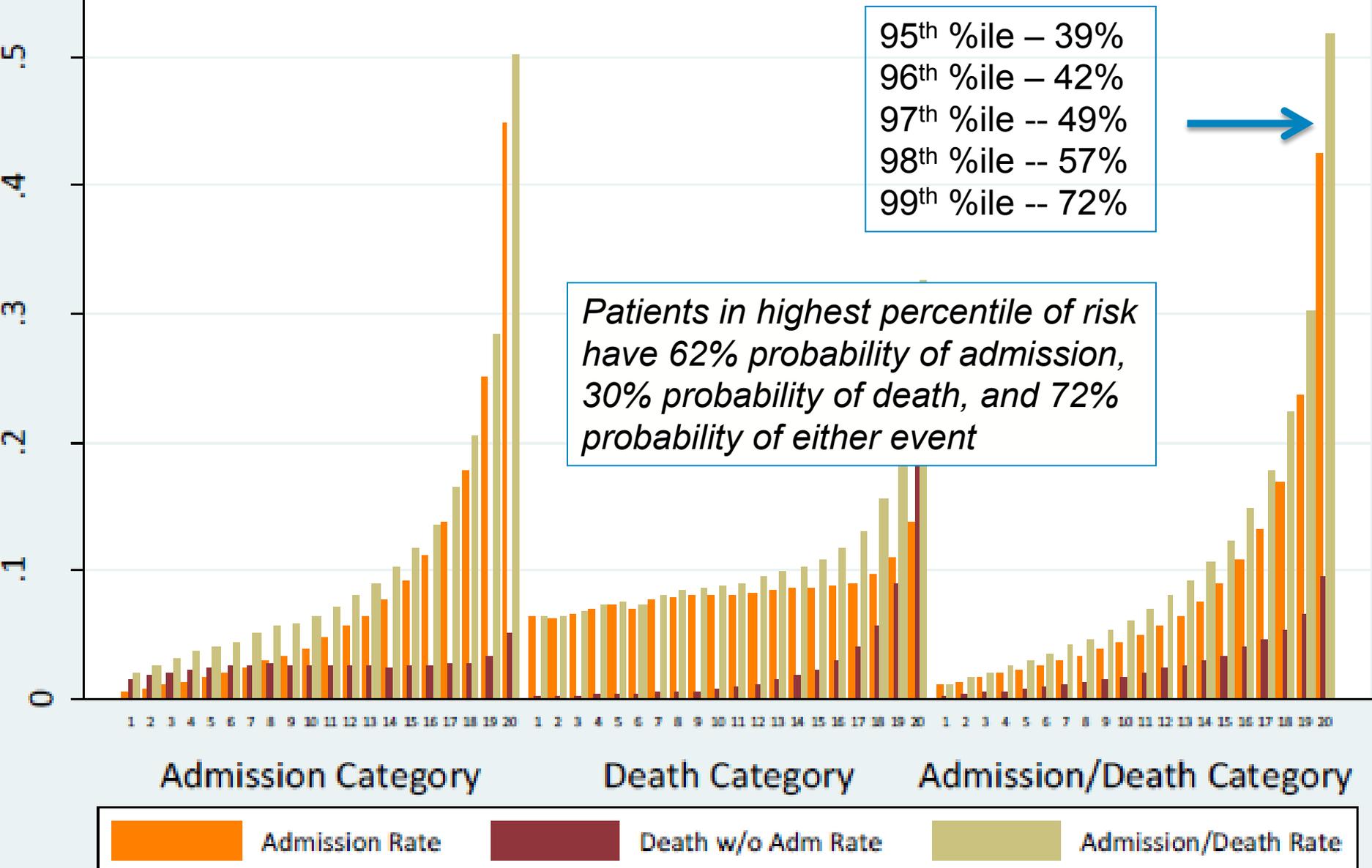
90-Day Model Calibration by Risk Deciles



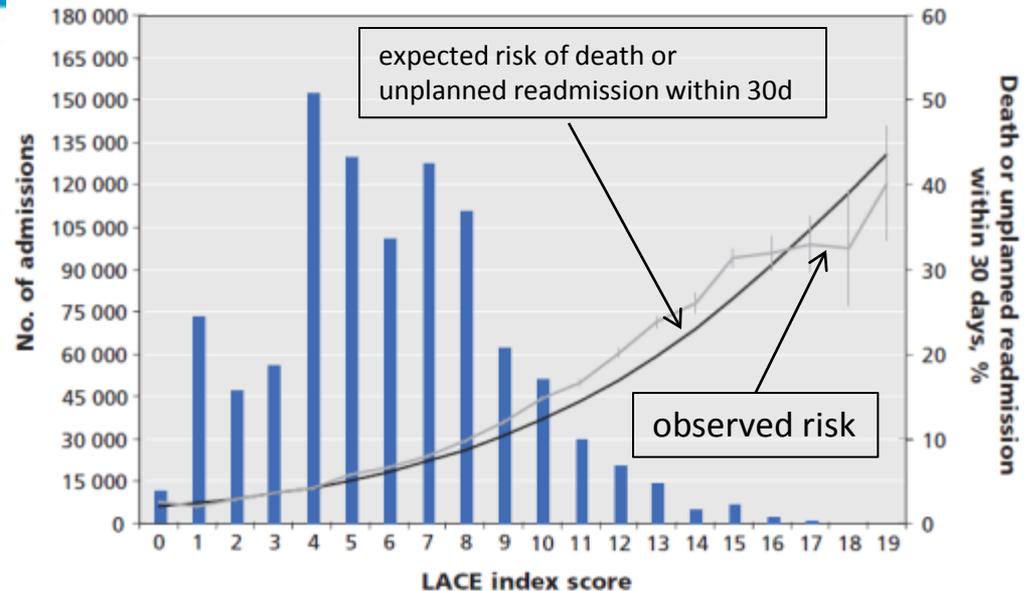
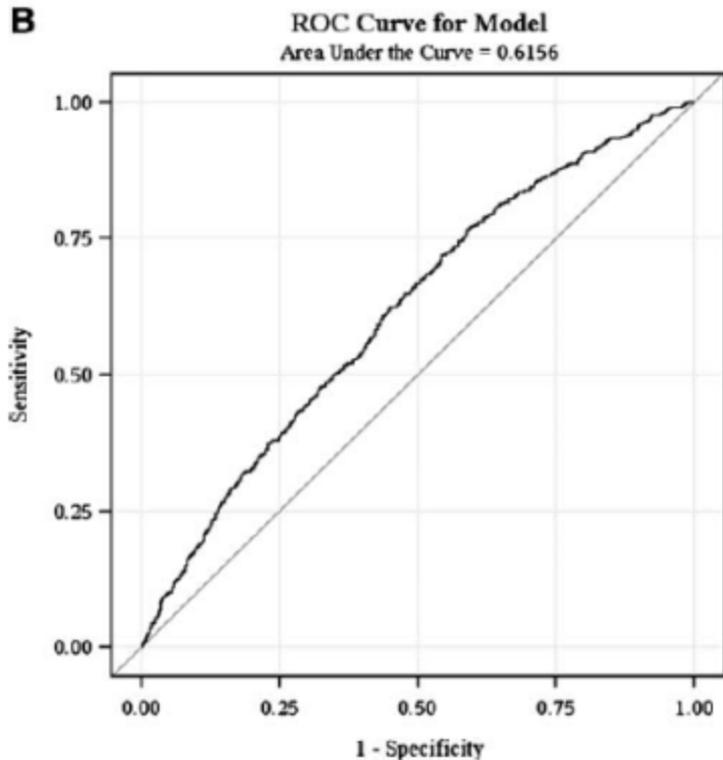
1-Year Model Calibration by Risk Deciles



1-Year Adverse Event Rates by Risk Categories



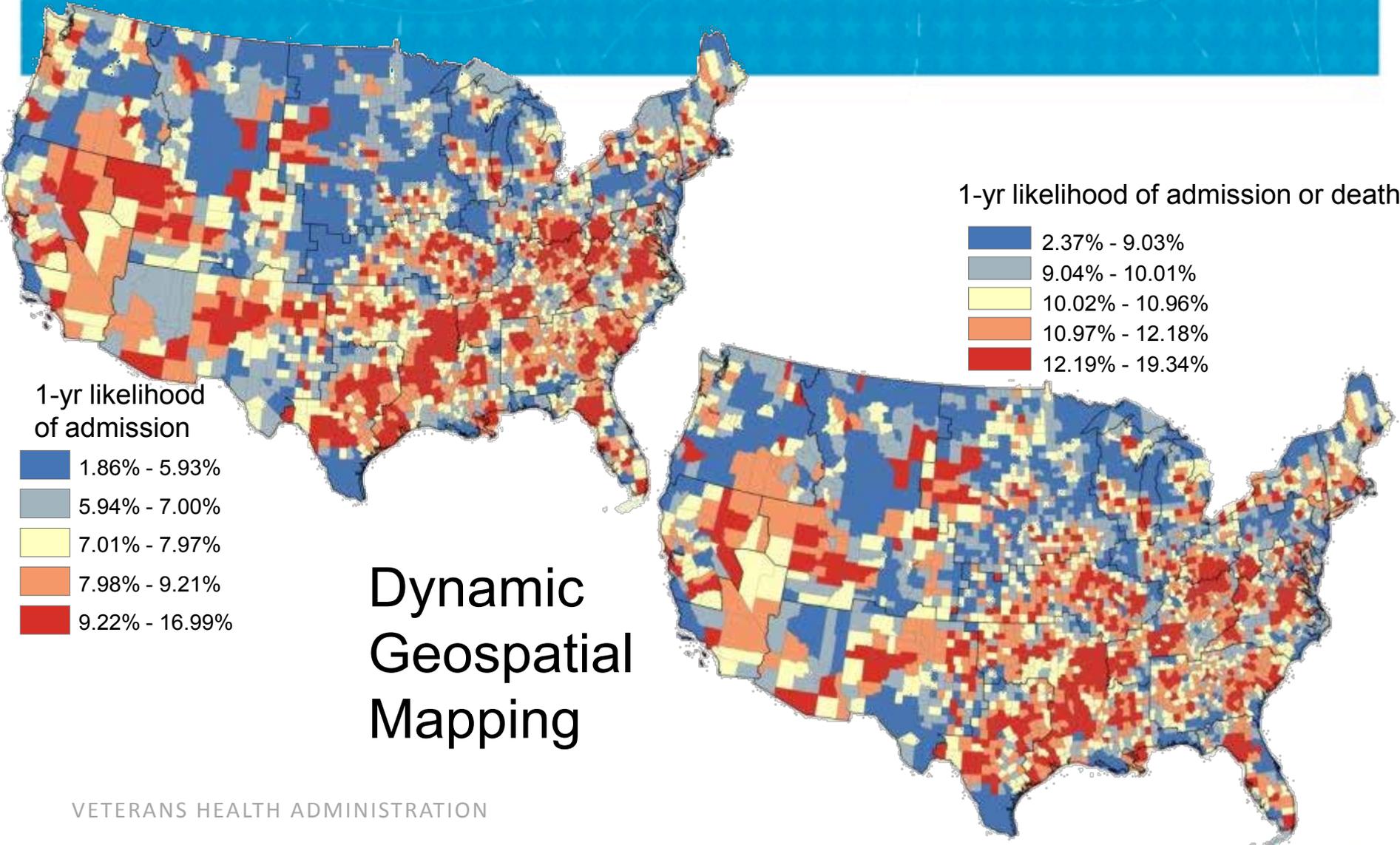
Comparison with other models



Readmission model for 10,946 pts disch home from general medicine svcs at 6 AMCs. *Hason, et al. JGIM Dec 2009 (epub ahead of print)*

“LACE” model tested on 1M randomly selected pts discharged from Ontario hospitals 2004-08 (C statistic =0.6935). *Walraven et al CMAJ March 2010 (epub ahead of print)*

Use of High Level Analytic Data for Population Management and Resource Planning



Dynamic Geospatial Mapping

How to Access the CAN Score Report

Primary Care Almanac
CPRS Providers' Menu
Data updated through: 03/31/2013

VSSC Help Desk

Care Assessment Need Score - CAN Score

[Diabetic Cohort Reports Menu](#)

[Hypertension Cohort Reports Menu](#)

[Ischemic Heart Disease Reports](#)

[Primary Care Panel Overview Menu](#)

**** Patient level reports require an account for real SSN access.**

[Click here for instructions for establishing an account for real SSN access](#)

[Diabetic Patient List by Metric Choice](#)

[Provider Panel Overview](#)

[ER / Urgent Care Visit Count by Provider](#)

[Primary Care Hypertension Patients Provider Level Summary](#)

[Hypertension Medication Possession Ratio Outlier Report](#)

[Hypertension Greater Than 140/90 report](#)

[Ischemic Heart Disease Reports work in progress](#)

[IHD Patients Report for LDL >= 100 or LDL not done](#)



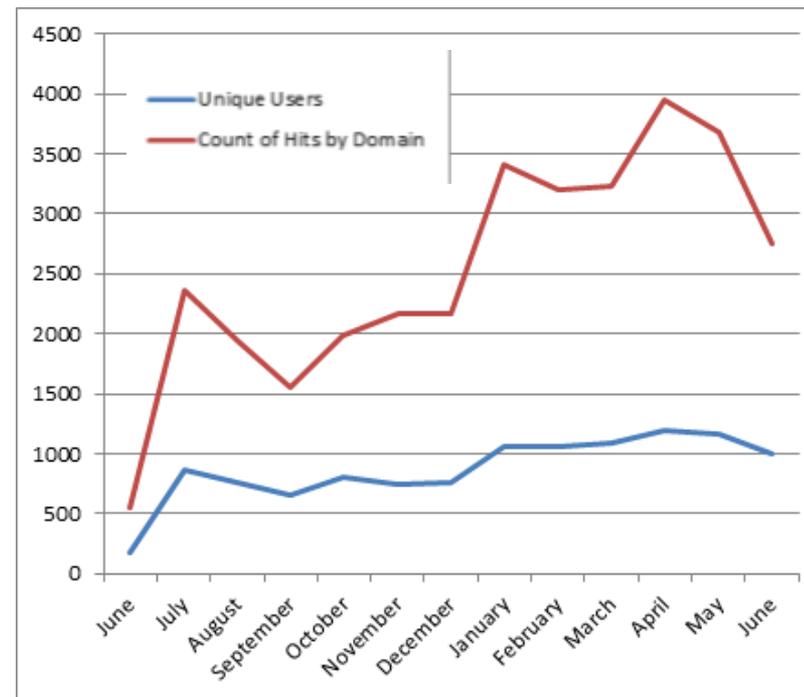
[Pact Compass Provider Level Summary](#)

[Discharged Patients for 2Day Follow Up by Team](#)



Marketing the CAN Score

- Available to all PCPs from EHR in Dec 2011 – “soft roll-out”
- Active roll-out in two VISNs
 - VISN 4 – PC Collaborative
 - VISN 17 – Live Broadcast (champion model)
- Broadcasts with live Q&A: primary care, nursing, VeHU
- Feedback to date – uniformly positive (some concerns about data overload)



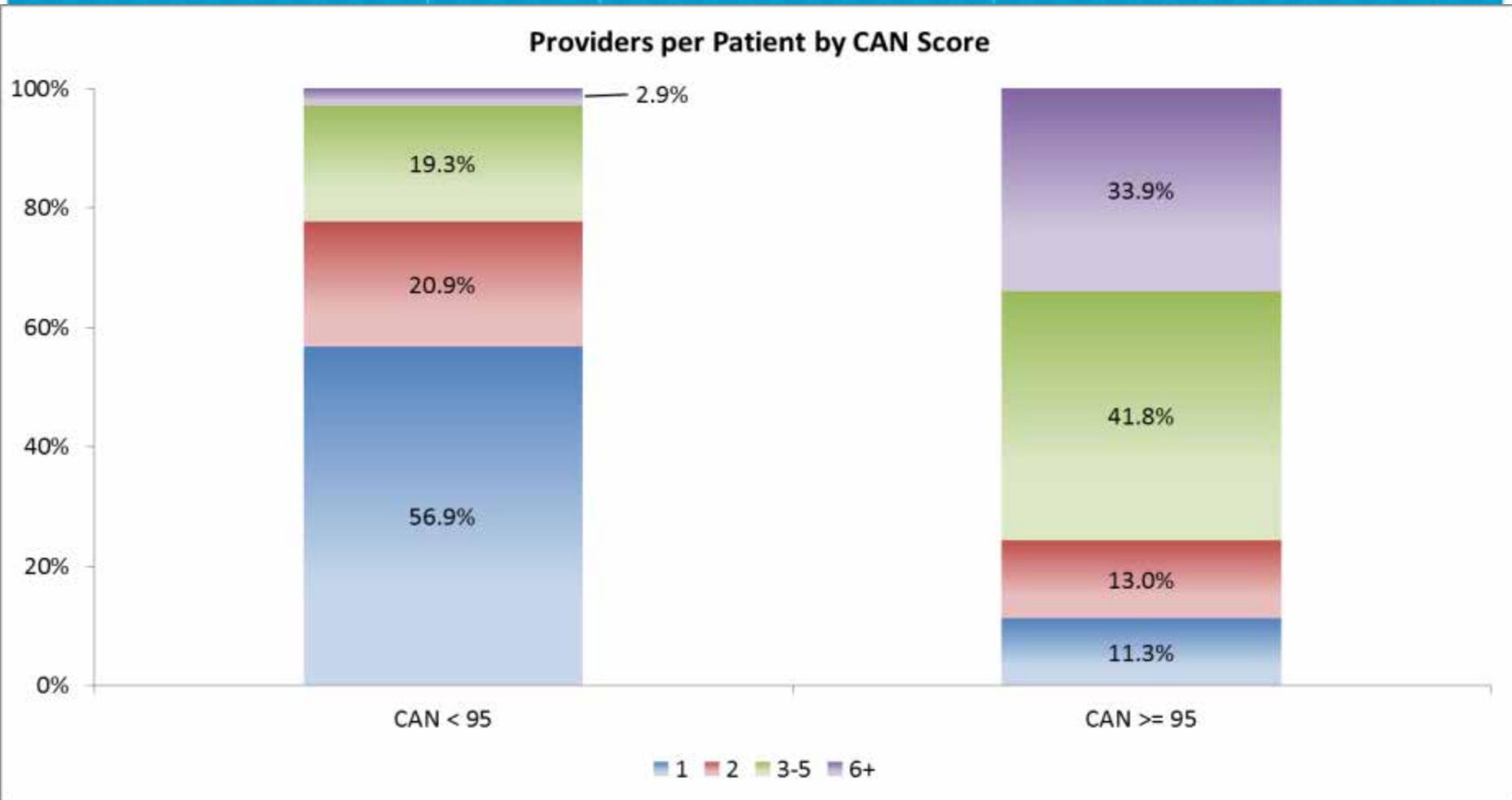
Marketing the CAN Score

- Encouraging Care Coordination
 - all participants in the delivery of health services work cooperatively
 - facilitating access to care
 - right care in the right place at the right time
 - shared responsibility
- Encouraging Care Management
 - Linking patients with needed services, resources, and opportunities
- Discouraging “misuse” of the score
 - The score is not a performance measure to try to “improve”
 - A high score does not indicate a pt is not receiving high quality of care
 - A low score is not an indication to ignore a pt

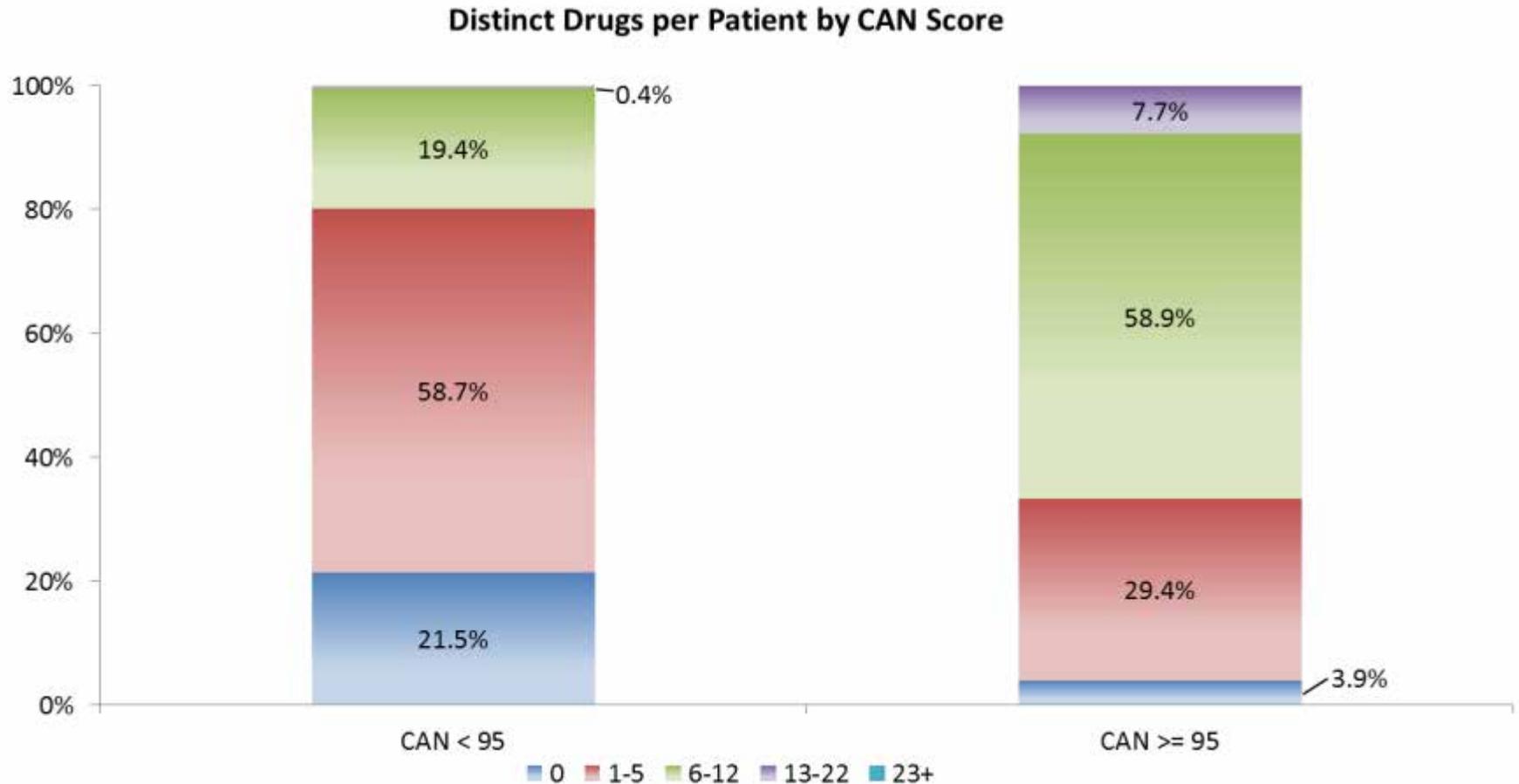
Can CAN scores help?

After adjusting for age, sex, comorbidity, and mental health diagnoses, patients with CAN scores in the highest 10% who saw their assigned PCP for >60% of visits, were 10% less likely to die or be hospitalized than similar risk patients who did not see their PCP during the year before PACT implementation. Similar, but less pronounced association for high risk patients who saw their assigned PCP up to 60% of the time.

High Number of Health Care Providers per Patient by CAN Score

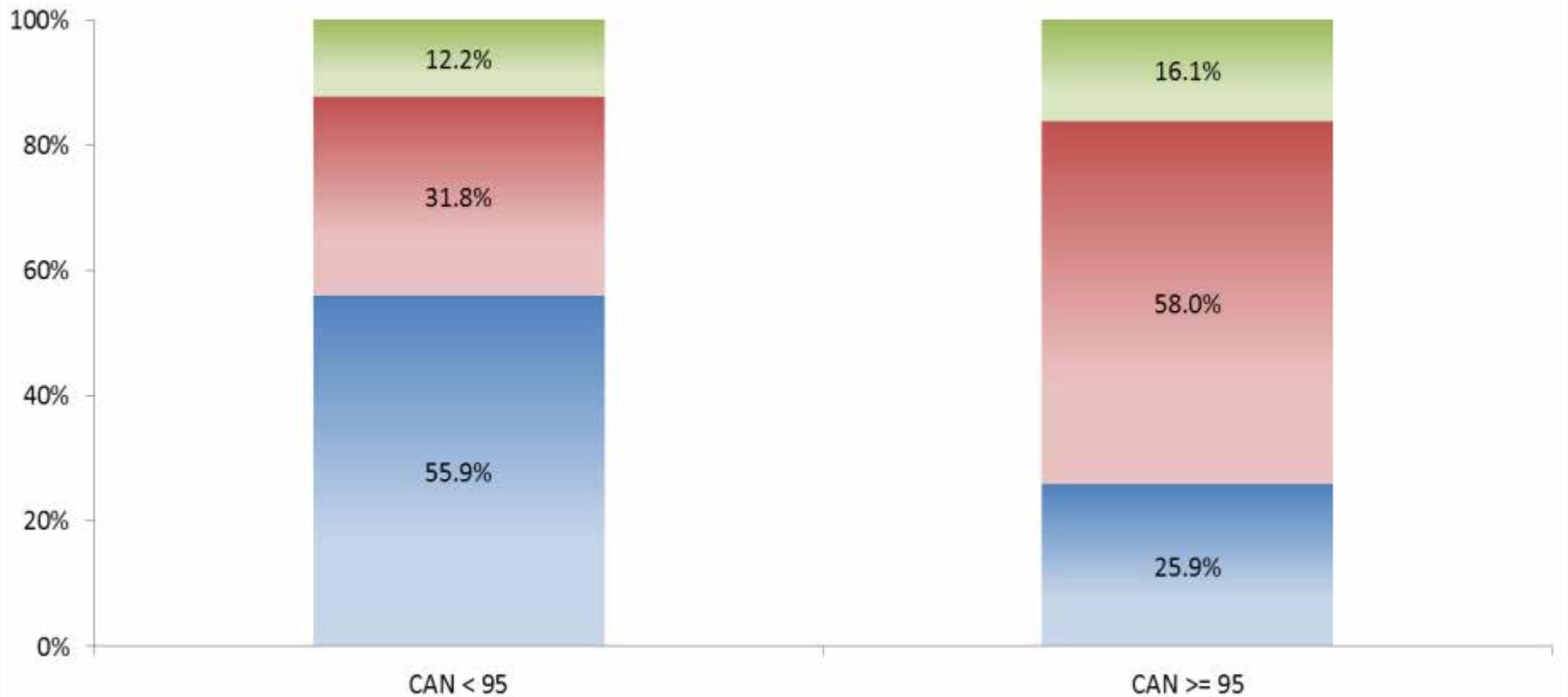


High Number of Different Drugs per Patient by CAN Score



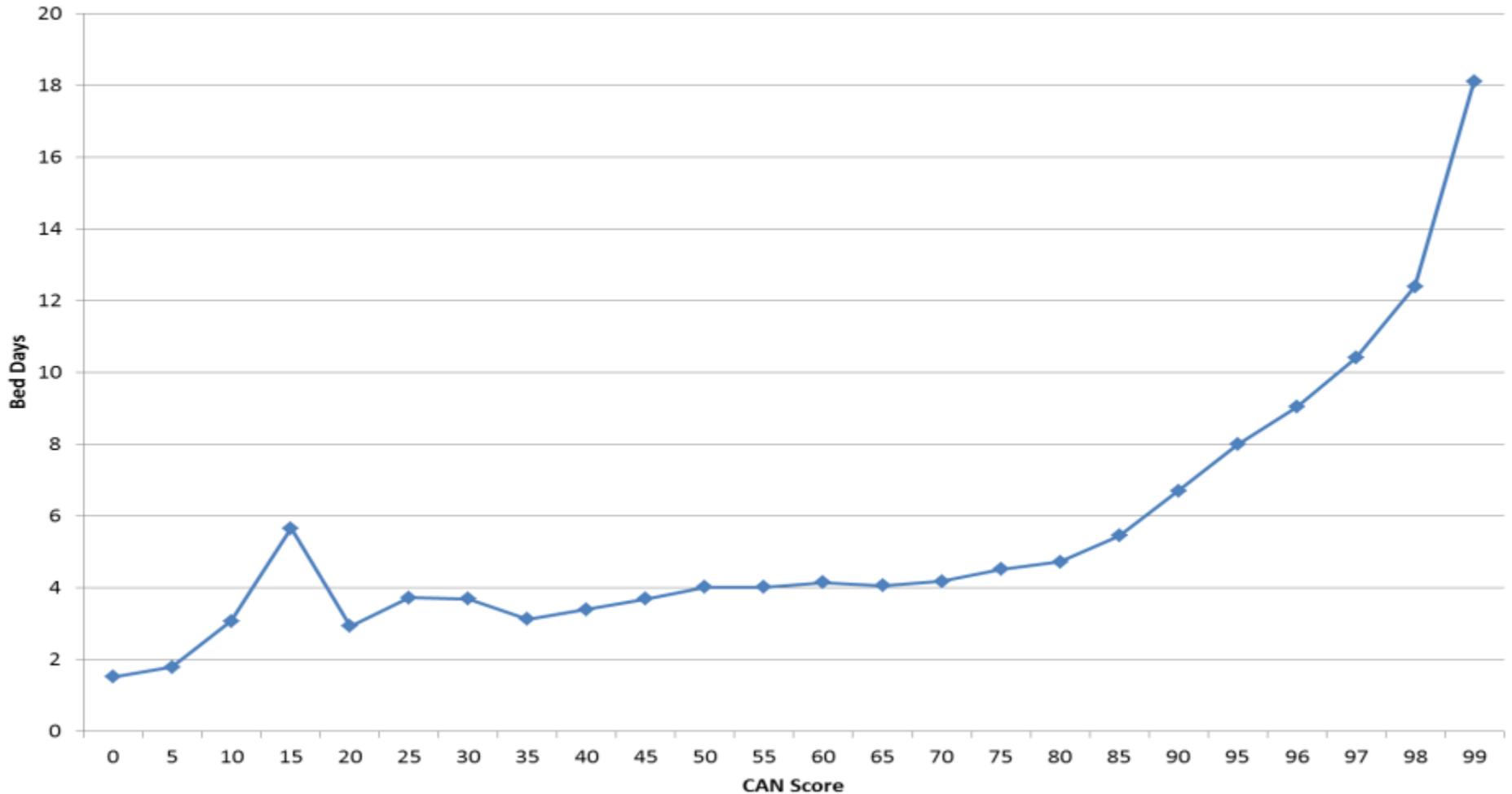
Mental Health Diagnoses according to CAN Score

Mental Health Diagnoses according to CAN Score



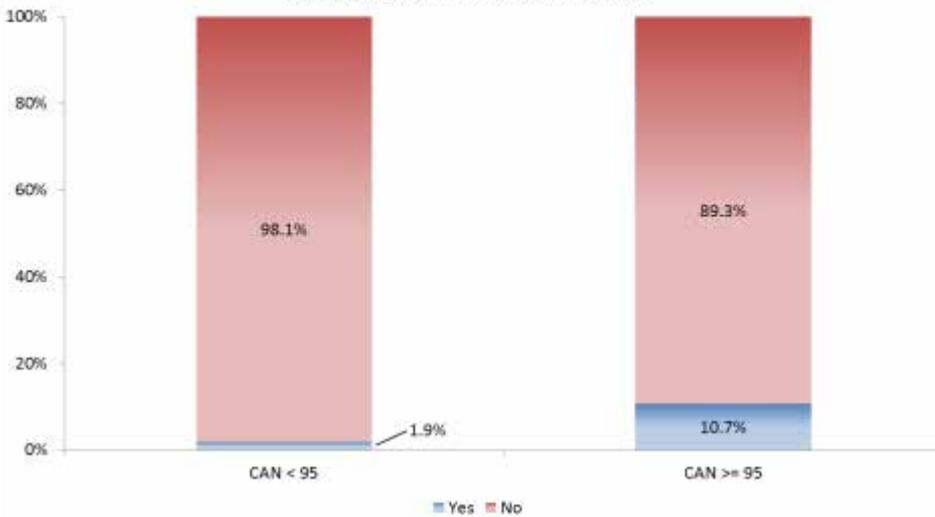
Bed Days - Per Patient, Average

Average # of Bed Days by CAN Score

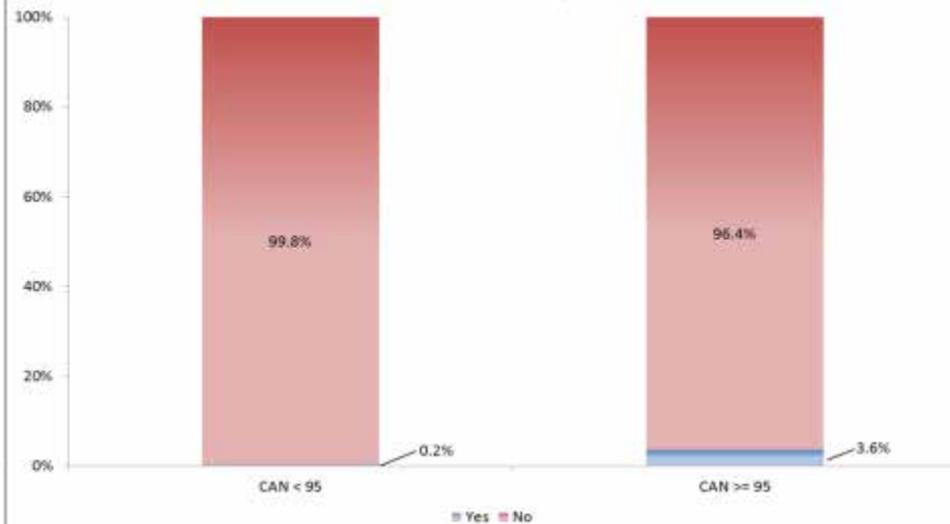


Few Patients with High Scores Referred to Coordination Programs: Telehealth, HBPC, Palliative Care, and Hospice

Telehealth Program Usage by CAN Score



Percent of Patients in HBPC by CAN Score



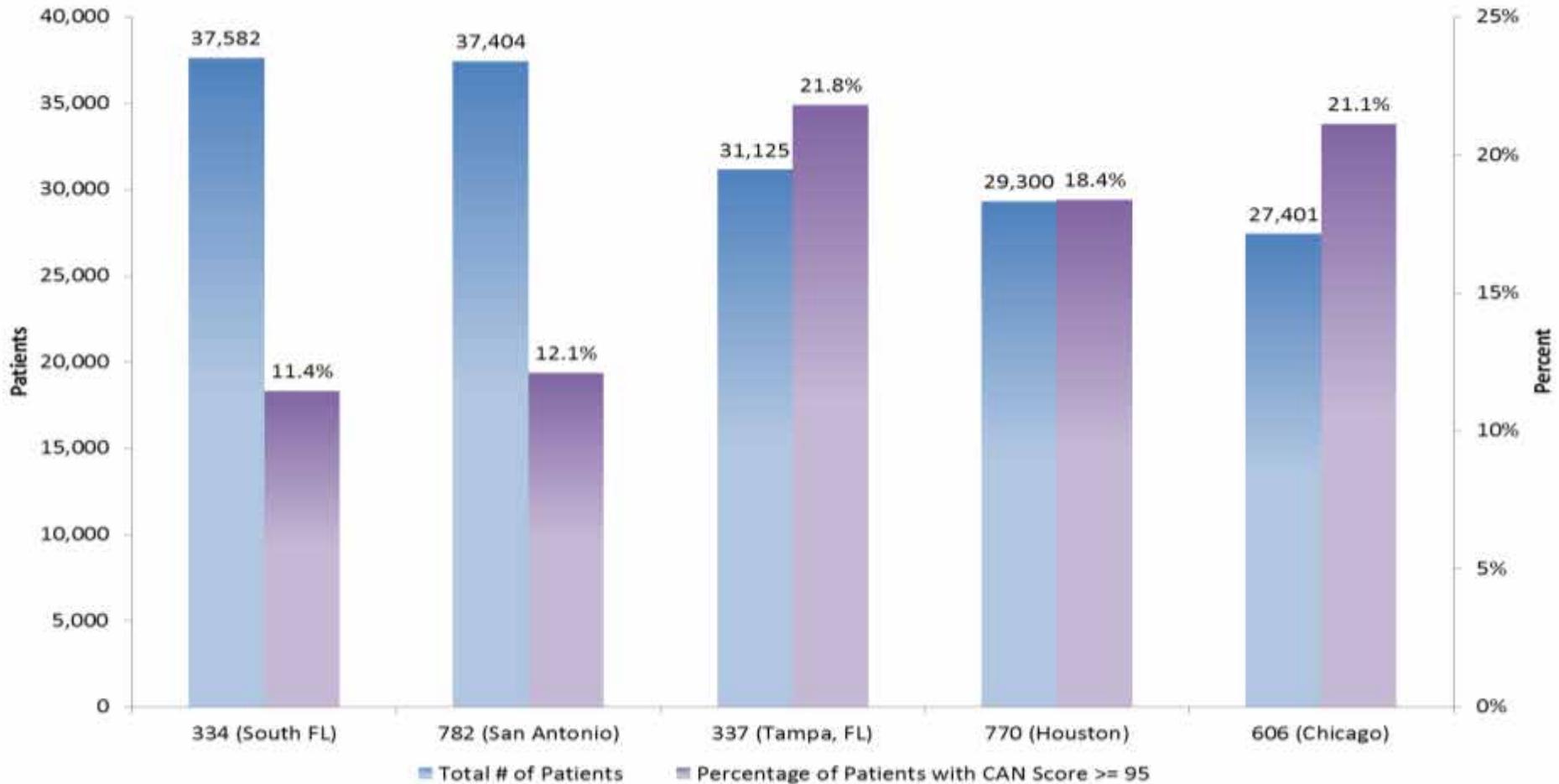
Palliative Care

Score ≥ 95 -- 1,353 of 241,917 total patients (0.6%)

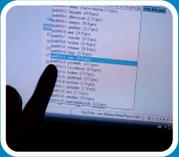
Hospice

Score ≥ 95 -- 569 of 241,917 total patients (0.2%)

Total Patients and Percentage with CAN Score ≥ 95 by Geographic Area



How might a care manager or provider use the tool?



Scan list of pts weekly to identify those who may be at high risk



Call high risk patients to check in: are questions answered? are medications taken as prescribed?



Confirm that high risk pts have visits coming up soon



Ensure that high risk patients are on appropriate medical therapy



Review resources already in use, such as telehealth or specialty care

Feedback – 6-19-13

“Attached is the PP created for local executive leadership, to gain their buy-in and support, which we have fully received. I am beginning to educate frontline staff on this structured framework so they can better understand the importance of risk stratification. This education allows them to begin connecting the dots of the different settings, how they impact the continuum of care, and how we can better serve our Veterans together, especially those suffering from chronic diseases. So far I have received positive feedback from frontline staff and leadership. Our Home Telehealth program has begun utilizing the CANS to ‘pull’ their Veterans into the program, rather than waiting for Veterans to be ‘pushed’ into the program. The PACT teams utilize the CANS for specifically for patient selection for shared medical appointments. Several PACT teams also cross-reference the CANS with the DataMart database for patient selection of chronic disease management protocols.

...continued

We plan to implement the CANS in Specialty Clinic and Case Management over the next year. We are currently developing and expanding these two areas to center our care around Veterans actively suffering from chronic diseases by establishing a partnership to assist and guide Veterans with self-management. Case Managers are currently developing inclusion and exclusion criteria for their newly developed case management programs, and will include the CANS as a criteria point to consider when consulted. Specialty Clinic will utilize CANS for patient selection in shared medical appointments and chronic disease management protocol, similar to PACT. The CANS is the missing link, as we previously had no method to stratify the patient panel, to identify those high-utilizers, high-cost Veterans. Now with the CANS we can better serve our Veterans suffering from chronic diseases in a more efficient, ideal method.

Nurse Manager, Specialty & Case Management

Problems/ Limitations

- Processing requirements → recoding production process, enhancement of analytic environment
- Model performance monitoring/degradation → recalibration, updating
- Plateau in use and uncertainty about how being used → PCAS, evaluation
- Generic issues with development and deployment of predictive models

Patient Care Assessment System (PCAS)

- Integration of key data from multiple sources
- Summary of patient risk factors
- Task Lists and notifications
- Multiple VAMCs & Community info
- Ability to create a care plan and write it back to CPRS as a standardized note



Project Team

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Li Wang MS

PATIENT CARE ASSESSMENT SYSTEM

A tool to identify, manage, and coordinate patient care.



Tamara L. Box, PhD

Office of Analytics and
Business Intelligence,
VHA OFFICE OF INFORMATICS
AND ANALYTICS



6.5 Million Patients High Risk Patients

IDENTIFY
COORDINATE
MANAGE



Patient-Aligned Care Teams

- VHA Patient Care Services
- Initiative to support VHA's Universal Health Care Services Plan to:
 - Increase access
 - Improve coordination and communication
 - Enable better continuity of care

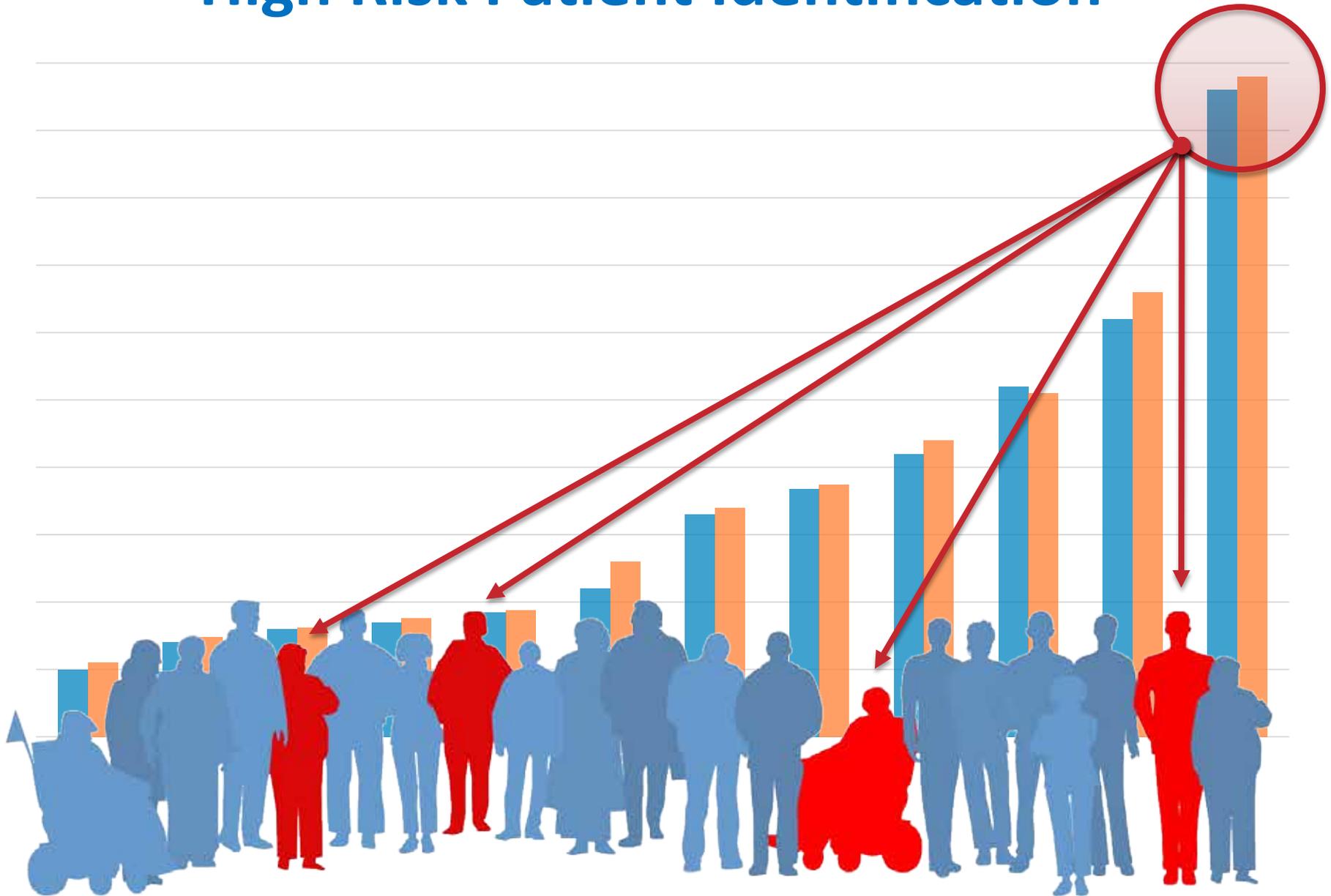


Patient-Aligned Care Teams

- Patient-centered care managed by primary care providers
- Clinical and non-clinical staff
- **Patient have more active role**



High Risk Patient Identification

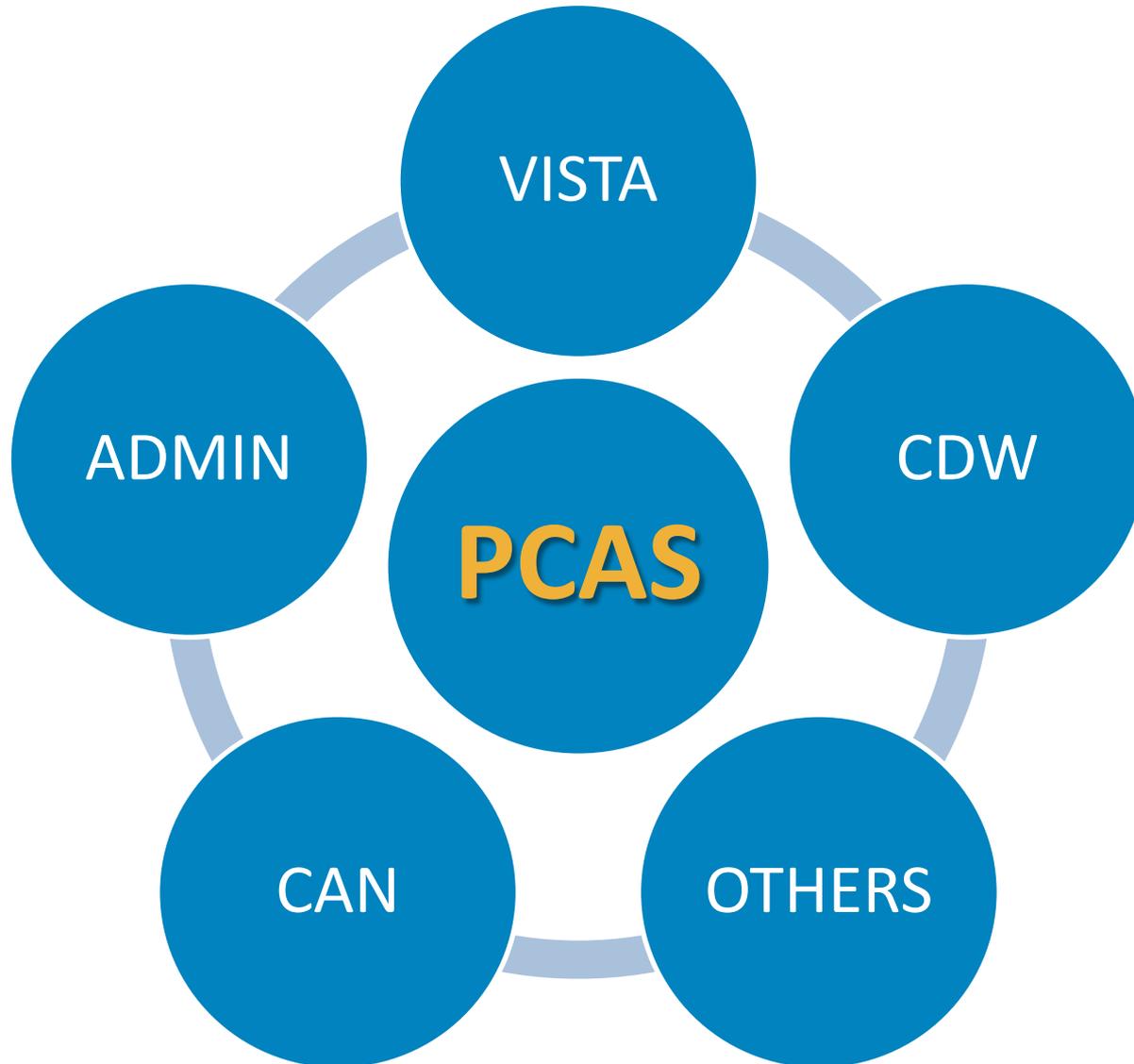


OUR MISSION

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.

Patient Care Assessment System (PCAS)



Highly Desired Functionality

- Integration of key data from multiple sources
- Summary of patient risk factors
- Task Lists and notifications
- Multiple VAMCs & Community info
- Ability to create a care plan and write it back to CPRS as a standardized note



Tools for Identifying and Coordinating Care

	CAN	PCAS
PRIMARY AUDIENCE	PACT PROVIDERS	PACT RN CARE MANAGERS
ROLE	CAN Scores Key risk data Dashboard format	CAN Scores Key risk data PACT Team Management Patient and Team Notifications Clinical data Care planning

Quick Poll

If you are involved in the VA Patient Aligned Care Teams, what do you feel is the most challenging aspect of patient care?

- A. Nothing – it's a breeze!
- B. With very large panels, understanding where to focus daily care/effort.
- C. Knowing what services are available for my patients.
- D. Coordinating care and care tasks for patients as a team.

Manage Patients

Administration

Manage Patients

Manage Patients

Filter List By Patient:

Search By Name:

Search By Last 4 SSN:

			Complication (MUET), Medication Non-Adherence, OEF/OIF High Risk, Poly Pharmacy, Statistical High Risk, Suicide Risk						
####	TEST PATIENT D			10 Feb 2012		N/A	N/A	N/A	N/A
####	TEST PATIENT E			11 Apr 2012	18 Jul 2012	N/A	N/A	N/A	N/A
####	TEST PATIENT F			21 Feb 2012		N/A	N/A	N/A	N/A
####	TEST PATIENT G			27 Apr 2012	09 Jul 2012	N/A	N/A	N/A	N/A

Manage Patients

Administration

Manage Patients

Filter List By Patient:

Search By Name:

Search By Last 4 SSN:

<u>Last 4 SSN</u>	<u>Patient Name</u>	<u>High Risk</u>	<u>Risk Type</u>	<u>Last Appointment</u>
####	TEST PATIENT A	Y	Medication Complication (MUET), Poly Pharmacy, Suicide Risk, Test This	27 Apr 2012
####	TEST PATIENT B	N	No longer has problems.	20 Apr 2012
			Clinical Priority, Flagged as High Risk - Frequent	

Complication (MUET), Medication Non-Adherence, OEF/OIF High Risk, Poly Pharmacy, Statistical High Risk, Suicide Risk

####	TEST PATIENT D		10 Feb 2012		N/A	N/A	N/A	N/A
####	TEST PATIENT E		11 Apr 2012	18 Jul 2012	N/A	N/A	N/A	N/A
####	TEST PATIENT F		21 Feb 2012		N/A	N/A	N/A	N/A
####	TEST PATIENT G		27 Apr 2012	09 Jul 2012	N/A	N/A	N/A	N/A

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PACT RN Care Manager

[Note](#)

Risk Characteristics

Hide Page Overview... (x)

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

Patient Name: [TEST PATIENT A](#)

SSN: #####

DOB: [MM/DD/YYYY](#)

Hide Risk Indicators... (x)

Care Assessment and Needs Score

Care Assessment and Needs Score

Clinical Priority (0-99)

Risk Type:

Manual High-Risk Flag:

Risk Type:

Hide Key Clinical & Cost Risk

Number of ER Visits (last 6 months)

Number of Admissions:

DSS Cost:

National BDOC:

Beneficiary Travel Costs:

Fee Cost:

Pain Scale:

High Risk for Medication Problems

VERA Classification Last Fiscal Year

VERA Classification Current Fiscal Year

Polypharmacy Count:

Hide Care & Case Management

High-Level Primary Care Management

Primary Care RN Case Manager:

Primary Care MSW Case Manager:

Other Case Manager Activity (case)

Risk Characteristics
 Patient Demographics
 Team Information
 Discharges
 Encounters
 Diagnosis List
 Clinical Data
 Medications
 Consults
 Tasks/Notifications

Priority & High Risk Flag

RISK INDICATORS

CAN Scores (all models; 0-99)
 CAN Score Graph Over Time
 Clinical Priority (0-10)
 Manual High Risk Flag
 Risk Type



- Statistical High Risk
- High Intensity Medical Management
- Suicide Risk
- Homeless
- Frequent ER User
- Polypharmacy
- Frequent PCP Visits
- Frequent Admissions
- Medication Non-Adherence (MUET)
- OID/OIF/OND High Risk

Background interface showing navigation tabs: Reports, Administration, Add Task.

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- [Evaluation & Monitoring / Plan Update](#)
- [PACT Interdisciplinary Care Plan Note](#)
- [PACT RN Care Manager Note](#)

Hide Key Clinical & Cost Risk Factors (for the past 12 months) ...

- Number of ER Visits (last 6 months):
- Number of Admissions:
- DSS Cost:
- National BDOC:
- Beneficiary Travel Costs:
- Fee Cost:
- Pain Scale:
- High Risk for Medication Problems:
- VERA Classification Last Fiscal Year:
- VERA Classification Current Fiscal Year:
- Polypharmacy Count:

Hide Care & Case Management ...

- High-Level Primary Care Management Provided (from service selection and PCMM case mgmt report):
- Primary Care RN Case Manager:
- Primary Care MSW Case Manager:
- Other Case Manager Activity (case mgmt report):

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PACT RN Care Manager

[Note](#)

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Other Case Manager Activity (case mgmt report):

KEY CLINICAL & COST RISK FACTORS

(past 12 mos)

Number of ER Visits

Number of Discharges

DSS Cost

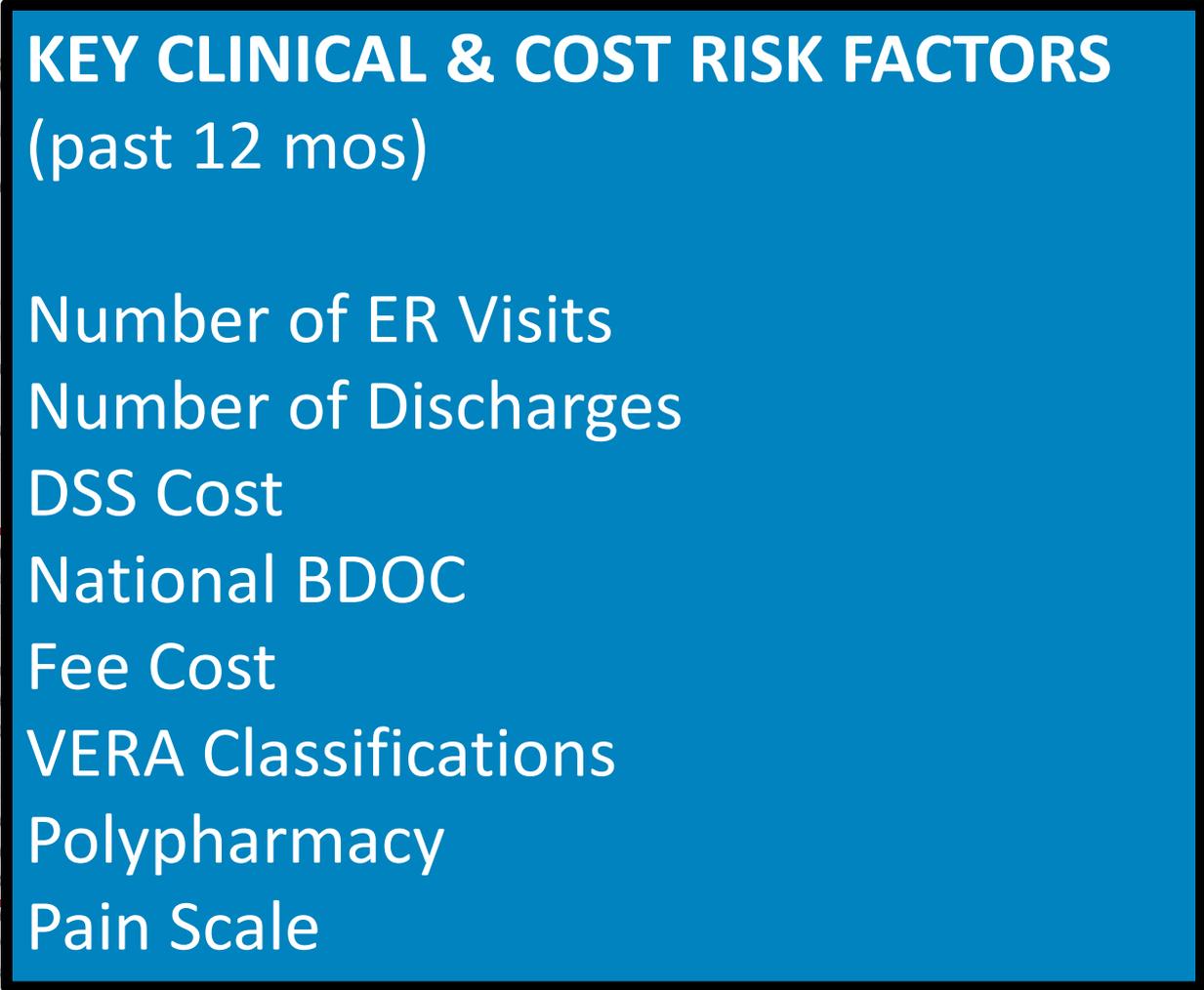
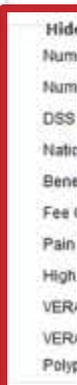
National BDOC

Fee Cost

VERA Classifications

Polypharmacy

Pain Scale



[PCMSW Case Manager]

[Yes/No] View Case Management Report

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Note

Risk Characteristics

Hide Page Overview... [X]

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

Patient Name: TEST PATIENT A

SSN: #####

DOB: MM/DD/YYYY

Hide Risk Features... [X]

CARE & CASE MANAGEMENT

High-Level Primary Care Management

Primary Care RN Case Manager

Primary Care MSW Case Manager

Other Case Manager Activity

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Pain Scale: [pull from CPRS] Graphical View
High Risk for Medication Problems: [Yes/No]
VERA Classification Last Fiscal Year: [units]
VERA Classification Current Fiscal Year: [units]
Polypharmacy Count: 6

Hide Care & Case Management ... [X]

High-Level Primary Care Management Provided (from service selection and PCMM case mgmt): [Yes/No]

Primary Care RN Case Manager: [PCRN Case Manager]

Primary Care MSW Case Manager: [PCMSW Case Manager]

Other Case Manager Activity (case mgmt report): [Yes/No] View Case Management Report

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PACT RN Care Manager Note

Team Information

Hide Page Overview... 

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.

TEAM MANAGEMENT

All PCMM Team Members – any location
Expanded Team Members
Home/Community Providers

Add Expanded Team

Expanded Team Member Information

No Expanded Team Members Found

Add Expanded Team Member

Home/Community Provider Information

No Home/Community Provider Information Found

Add Home/Community Provider

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PACT RN Care Manager Note

Diagnosis List

10 Most Recent (last 24 months)

Major Category	Diagnosis	Diagnosis Date

DIAGNOSIS LIST

10 Most Recent (last 24 months)

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Export

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PACT RN Care Manager Note

Clinical Data

Immunizations (last 2 years)

[View All Immunizations](#)

Immunization	Date	Facility Location
--------------	------	-------------------

CLINICAL DATA

Immunizations (last 2 years)

Lab Values (with extended filter capability)

Community Labs

Clear Filter

Facility Location

Add Community Lab

Community Labs

Test Name	<input type="text"/>	Date	<input type="text"/>
Results	<input type="text"/>	Unit	<input type="text"/>
Reference Range	<input type="text"/>	Reference Flag	High
Facility Location	<input type="text"/>		

Save Cancel

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Encounters

10 Most Recent

Scheduled Date	Encounter With	Encounter Type	Facility	Clinic Name	Primary Stop Code	Diagnosis

ENCOUNTERS

Date

Provider Name

Type

Facility

Clinic Name

Stop Code

Diagnosis

Print Export

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Query

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Administration

Add Task

[View Consults](#)

[View Appointments from CPRS](#)

[View Completed Tasks](#)

Tasks/Notifications

TASKS & NOTIFICATIONS

Team & patient-related
 Scheduling
 Reminders
 Priorities
 Historical Tracking

Appointments	Complete Task?
View	<input type="checkbox"/>
View	<input type="checkbox"/>
View	<input type="checkbox"/>

Patient Information

- [Risk Characteristics](#)
- [Patient Demographics](#)
- [Secondary Contacts](#)
- [Legal Documents](#)
- [Team Information](#)
- [Discharges](#)
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PACT RN Care Manager Note

Set Due Date:

Request Date:

Task Type:

Priority:

Brief Description:

Task Comments for <follow up task>:

Assigned To: *

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Patient Consults

[Hide Page Overview...](#)

Consults for patient, select consult for more details.

CONSULT TRACKING

Full Panel Overview
 Search/filter – date range, patient, status
 Per-Patient Consult Report
 Per-Consult Details

Patient Information

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PACT RN Care Manager Note

Select	ANTICOAGULANT CLINIC	09/18/2012	
Select	HOME OXYGEN REQUEST - DEN/ECHS 11/11	09/19/2012	
Select	FIRM C INJECTION CLINIC	09/19/2012	
Select	HOME OXYGEN REQUEST - PROSTHETICS NEW/RENEW WITH EQUIPMENT	09/19/2012	
Select	PROSTHETICS REQUEST - Replacement Of Issued Stock	09/19/2012	
Select	PROSTHETICS REQUEST - Medical Alert Device	09/20/2012	

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Assessment and Goals

CARE PLANNING

Situation/Background

Learning Preferences

Assessment/Goals

Planning/Implementing

Evaluation & Monitoring/Plan Update

PACT Interdisciplinary Care Plan Note

PACT RN Care Manager Note

Functional Status Assessment

Fall Risk:

No-Risk

Low-Risk

High-Risk

[View Morse Scale](#)

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Assessment and Goals

Receiving Case Management Outside of Primary Care? Yes

[View Case Management Report](#)

Source of Care Plan Information: <Last Entered> [edit](#)

Not assessed

ASSESSMENT & GOALS

Case Management Report

Problem Identification

Functional Status Assessments

[Problem Identification](#)

Other

Functional Status Assessment

Fall Risk:

No-Risk

Low-Risk

High-Risk

[View Morse Scale](#)

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PACT RN Care Manager Note

Planning & Implementing

[View All Resources](#)

Existing Services:

VA Case Management Services:

	Phone	Last Date	
<name>		Select	<Location>
<name>		Select	<Location>

[View National PCMM and Referral Case Manager List](#)

[View Facilities Locator & Leadership Directory](#)

[View Case Management Tool](#)

[View All VA Services](#)

[View Open Consults](#)

[Appointments from CPRS](#)

Close

Services By State

Add Home/Community Service

Enter Service Information:

Contact Name:

Location:

Release of Information

Add

Cancel

PLANNING & IMPLEMENTING

VA Case Management Services

Home/Community Services

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PACT RN Care Manager Note

PACT Interdisciplinary Care Plan Note

[View Previous Care Plan Notes](#)

[View Original Care Plan Note](#)

all initial care plans should have all sections completed

Care Plan Elements

Sections with changes are preselected

PACT Interdisciplinary Care Plan Note

Dynamically created

Include specific Care Plan sections if changed

Include any option patient information

- Team Information
- Discharges
- Diagnosis List
- Clinical Data
- Medications
- Encounters
- Tasks/Notifications
- RN Care Manager Notes

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Query Criteria

QUERY FUNCTIONALITY

Appointment Range

Risk Types

Risk Categories

Care Plan Evaluation

Panel Manager

Patient Popula

Primary Care P

Provider Type:

PC Appointment

Evaluation Stat

Re-evaluation

Notification Ty

Task Type

Task Due:

From To

Task Status:

Select

Task Priority:

Select

Risk

High-Risk Patients:

- Select High-Risk Type
- Clinical Priority
- Statistical High Risk
- High Intensity Medical Managemer
- Flagged as High Risk
- Suicide Risk
- Homeless
- Frequent ER User
- Poly Pharmacy
- Frequent PCP Visits
- Frequent Admissions

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Nationally-Standardized Reports

Clinic Overall Summary

Case Management

Upcoming PC Appointments

Intensive Care Management

Functional Status Trends

Open Consults

MY REPORTS

Standardized Ad Hoc #1

Standardized Ad Hoc #2

PCAS Functionality and Release Schedule

RELEASE	highly desired FUNCTIONALITY	implementation GOAL
1.0 ONGOING Pilot Site review initiated 09. 2012.	<ul style="list-style-type: none">• Infrastructure• PACT Team management• Administrative access management module• Panel overview• Consults• Patient demographics & contacts• Risk characteristics (including CAN)	IDENTIFY 1. National awareness of PCAS 2. Manage PACT teams 3. Identify highest risk patients 4. Track consults

PCAS Functionality and Release Schedule

RELEASE	highly desired FUNCTIONALITY	implementation GOAL
2.0* To pilot 07.2013	<ul style="list-style-type: none">• Outpatient encounters• Discharge summaries• Care management tasks and notifications• Query functionality	MANAGE Adoption for tasks and notifications

PCAS Functionality and Release Schedule

RELEASE	highly desired FUNCTIONALITY	implementation GOAL
3.0	<ul style="list-style-type: none">• Medications• Problem lists• Additional clinical and vitals data• Legal documents	MANAGE Establish routine tasks for patient management to facilitate implementation of care planning

PCAS Functionality and Release Schedule

RELEASE	highly desired FUNCTIONALITY	implementation GOAL
4.0	<ul style="list-style-type: none">• CARE PLANNING Service (VA and community-based) administration	COORDINATE Adoption of care planning
5.0	<ul style="list-style-type: none">• CARE PLAN NOTES Advanced reports and query• Additional community integration (where possible)	COORDINATE Full use of PCAS for PACT care plan documentation

Ongoing Evaluation

- Implementation
- Standards of care
- High risk ambulatory patient evaluation
- **Primary Care Services**
- **Office of Nursing Services**



Ongoing Evaluation

PILOT SITE EVALUATION SUPPORT

- Implementation
- Standards of care
- High risk ambulatory patient evaluation
- **Team-Based Care vs Episodic Care**
- **Workflow Patterns**
- **Bugs/Issues/Suggestions!**



TEAM

- PACT Nurse and Provider Members of Requirements Team
- Stephen Anderson, MS
- Tamara Box, PhD
- Chris Bryson, MD MPH
- Stephan Fihn, MD MPH
- Kathleen Frisbee
- Betsy Lancaster, MS
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THANK YOU



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