Cyberseminar Transcript

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Session: PACT Care Management: An Update on the Care Assessment Needs (CAN) Scores and the (new!) PCAS 3.0

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Heidi: I would like to take this opportunity to again welcome everyone to today's PACT Patient Aligned Care Team Demonstration Lab Cyberseminar. Today's session is on PACT care management. An update on the Care Assessment Needs scores and the new PCAS three point zero. Our presenters today are Dr. Tammy Box and Dr. Steve Fihn. Tammy is the clinical scientist and health informaticist with the Office of Clinical Development and Evaluation with Veteran's Health Administration. And Steve is the director of the office of Clinical Systems Development and Evaluation with the Veteran's Health Administration. And with that, Steve, can I turn things over to you?

Dr. Steve Fihn: Yes, ma’am. Thank you, Heidi. Good morning, all. Welcome. This is an update of a cyberseminar that we've given in the past and although the title slide here has only my name on it, actually the lion's share of the presentation will be done by my colleague, Tammy. What we plan to do is run quickly through a quick overview of the CAN scores, directed mainly at those who have not had a chance to familiarize themselves with them in the past. Discuss some of the updates and the ongoing research, and then Tammy will talk about the updates in the PCAS system. So, I will just dive in here and we're going to start with a poll. We realize that the "other" category probably is many people here including investigators, but will you quickly do your poll? I think it should be online, is that correct, Heidi?

Heidi: My apologies, yes, (inaudible). I was taking a look at the handouts, I apologize. Multi-tasking. Uh, I think that the poll that was set up here is a little bit different than the poll that you had up on your screen. I apologize.

Dr. Steve Fihn: Okay, that's fine.

Heidi: The poll that had been set up in the meeting was what best describes your research experience.

Dr. Steve Fihn: Okay, that's better. Alright, so just do the poll. I like that one better.

Heidi: So, our options here are: that you have not done research; that you have collaborated on research; that you have conducted research yourself; you have applied for research funding; or that you have led a funded research grant. And we'll give everyone just another second or two to respond and we will close it out and go through the results here. I apologize, it's definitely not what I was expecting to see on my screen. I'm kind of pinch-hitting on today's session.

Dr. Steve Fihn: Well that's fine. Actually, your poll is better.

Heidi: Okay, good, I am happy to hear that. And it looks like we've slowed down so I'm going to close this out and we'll go through the results. In the audience, we have forty five percent of the audience saying that they have not done research. Thirty three percent have collaborated on research. Eighteen percent have conducted research themselves. One percent have applied for research funding. And ten percent have led a funded research grant. Thank you, everyone.

Dr. Steve Fihn: Okay, so sounds like we've got a varied audience, which is good, because I think we'll hopefully have some useful information for everyone. Just to review, sort of the basis for the work we're going to describe today, is that, as many of you know, as Yogi Berra said, you know, prediction is difficult, especially about the future. And predicting how a patient course will come turns out to be much harder than it seems on the surface. Substantial research indicates that providers, although we think we are very good at predicting which patients are at risk, actually we're not so good, in fact, many providers, for example, at predicting readmissions, aren't a whole lot better than a coin flip. A bit like we all think everybody is a bad driver except for ourselves, it's, predicting clinical outcomes is somewhat similar. And yet, you know, we have a broad range of clinical programs, many of them listed here on this slide, but other ones as well, that are designed to reduce risk among high risk patients, and yet we don't have good ways of matching patients to these programs and, as we'll see later in the presentation, we probably don't do a great job of that. In the PACT, in the context of PACT, every team has an RN coordinator who is supposed to help do that matching and to coordinate care for the panel of twelve hundred patients. But up until this time we hadn't had a systematic way to identify those Veterans who are at greatest risk, so we worked on developing a method for that. The CAN score now has been in use for quite some time, the original paper describing it back in thirteen, but it's been available to clinicians now for over six years. I won't go through the details, but just to say we developed it on all primary care patients. The original score was polytomous regression and I'll show you the update in a second. It had ninety terms from seven domains in the CDW. And I might add that this was one of the very first applications to use the CDW, and endpoints were probability of admission or death within specified time period. We re-did the CAN score about a year ago, reducing the number of variables from the ninety or so to less than forty. Actually, the predictive power of the model went up slightly as I'll show you. And you can see that again the variables are drawn from a wide variety of sources, including some non-VA sources. You can see some from DOD records such as branch of service, as well as rank, and we've also pulled in some SES data from HHS files as well to get some SES information. But then a lot of data largely from the CDW. And again, not using NLP, but at least looking through notes to understand how many of them there are. If you look at the new scores, these are the prediction curves. You can see the "C" statistics here which are actually pretty good. They're now individual logistic regressions, not conjoint, so there are six separate models for the outcomes of hospitalization in one year, ninety days, mortality at those intervals, or the combined outcome. And you can see here, you see how steeply the risk starts to rise as we get to these very high scores. You can see also here that the scores correlate with a lot of utilization, including bed days. These you can see here as we get to the highest scores, the bed days go up steeply. Likewise, for number of providers, which goes up fairly steeply as the scores get higher. And the number of drugs. And you can start to see that really these are patients who need coordination. These data have been posted on the primary care dashboard for some time, they are accessible through CPRS tools menu, and you can see they not only list the scores here, but give a list of the services that are provided as well. When we look at usage of the CAN scores, these are the data from FY sixteen and seventeen, these are the number of hits on the CAN website and the number of individual users, which have been fairly steady over the past couple of years. We do know that individuals access these scores in other ways. There are certain clinical facilities that download them from the regional data warehouses, and give them directly to the providers. This shows actually the number of users who access the CAN scores over that six-year period and you can see it varies widely by visit. If we look at current usage, by month, this is by region, and you can see that there is quite a difference. Almost all the usage we're seeing here is in region two, and if we go back, VISN eight accounts for a good deal of that use and this is the absolute number of users. We can say that in the National PACT evaluation that when we look at high performing PACT sites across the nation, VISN eight tends to be one of the ones that really stands out. And part of the way in which they work is to take on care management with a ferocity, I would say, in terms of every team. Now, I alluded to earlier about how well we match patients to care coordination programs, you can see here these are the CAN scores, these for admission and death, on the X axis here. And this looks at the enrollment in telehealth here, and the enrollment in home-based primary care. And what you see here is it actually looks like there's a much higher likelihood of these high-risk patients being enrolled in these programs. The difficulty is, when you look at from the other standpoint, and ask, of high CAN patients, that is patients with scores over ninety-five, what proportion of them are enrolled in telehealth. These are patients under ninety-five, five percent, over ninety-five, twenty percent. So, eighty percent of patients or so in this very high risk category are not enrolled in telehealth. Similarly, for HBPC, about seven percent of these high risk patients are enrolled. And for palliative care about two percent, and for hospice well under one percent. Now, I do not know what the correct numbers should be, although these seem rather low to me, and you could use these, these scores, to try and target to these programs. Now there are some issues with the CAN scores to be sure. One is non-specificity, and I think that's key. So, we can, as a clinician, I can know that one of my patients has a very high CAN score, but it doesn't really tell me why, or more importantly, what to do. In the primary care intensive management programs, which have been conducted through the office of primary care at places such as Palo Alto, when they go through the high-risk patients, they determine that about a third of these patients with very high scores were really appropriate for intensive management and probably the rest might be better suited to other services. And as I mentioned, these scores do not link to specific action, and because you have to go to the separate website and look at it, and there aren’t recommendations, this is really out of work flow, and our goal has been to try and correct these problems. Increasingly the CAN score may become problematic, as it depends primarily on VA data, and as we enhance care in the community, CAN scores both may lose input data and may not be as accurate. And then of course there are special populations, such as homeless patients, or mental health patients, for whom there may be more specific scores that would be useful. Now, in terms of trying to enhance specificity I'd like to cite the work of a group at Ann Arbor and Palo Alto that includes, among others, Ann-Marie Rosland, Donna Zulman, Jean Yu, Katherine Prenovost, who've been looking at taking these high-risk patients and then asking, can we group them into some logical groups? They've been using item response theory to try and look at these groups. And then what you can see here I think are a couple things, which as a clinician probably are intuitive, but they do tend to naturally fall out into about six groups here that have been given labels based on the predominant diagnosis. As you can see two of them are in mental health, there's a liver disease group, a cancer group, complex diabetes, and cancer plus heart disease. But what you can also see here, and I think this is to some extent explains why these patients are so very difficult to manage, is that they tend to have other, several other, chronic conditions, and therefore referring them to simply one program may not actually address, and it may be actually the interaction of these various illnesses that make management difficult. And you can see here, that for example, among substance abuse they tend to have other high risk problems such as hepatitis, liver disease, chronic kidney failure, and so on across these categories. Nonetheless, I think there's an effort we're going to sort of see if we can tailor specific care packages, if you will, that could be targeting towards these primary groups. And then we can know what they've also done, and I won't dwell on this, but they've taken these groups here and then looked at what their utilization patterns are, you can see they're very different, obviously. The substance abuse group is using a lot of psychiatric hospitalizations, but all of them have lots of lengths of stay, lots of ED visits, and if we look at outpatient services, these are very high utilizing patients in almost every category, which is not surprising. Jean Yun's group also has been looking at the stability of CAN scores, and as you can see here there's actually a fair amount of variation, which one wouldn’t think, you know, when diseases ebb and flow in terms of complications, etcetera, CAN scores go up and down, which we want to know really as of this point in time, since we recalculate these weekly, who are the patients in my panel this week who are at greatest risk. And that research I think is fascinating and will be ongoing. So, I'm going to stop there, and I think maybe we'll defer questions ‘til the end of the presentation and hand the presentation over to Tammy, who's going to talk about the patient care assessment system and the recent updates to that. So, Tammy, you're on.

Dr. Tammy Box: Alright, well thank you very much. I think that this is, I think this might be there third time we've done this together, Steve, so we've usually kept up with one another, but today I'm going to talk about PCAS 3.0, and I will briefly go through some of the 2.0 things, but really the focus here is on 3.0. Before we get started I wanted to do a second poll. I'm just curious if you've ever used CAN or PCAS, and Heidi, I think you have to, alright. So, I think the poll is open. The question is have you ever used CAN or PCAS. Response options are A, no, I've not used them; B, I've only used CAN; C, I've only used PCAS; or D, I've used both of them. It does say both of them regularly, but if you've used both of them at least you can respond with D.

Heidi: The responses are coming in. It looks like we have slowed down so I'm actually going to give it another second and close things out. And what we are seeing is twenty seven percent of the audience saying that they have not used them. Forty nine percent have only used CAN. One percent have only used PCAS, and twenty three percent used both of them. Thank you everyone.

Dr. Tammy Box: Alright, well that's great. I think that's not outside of what we would expect, actually. Just some brief review here about why we constructed PCAS. PCAS is the patient care assessment system, and it began as a collaboration with primary care, the patient aligned care teams in particular, and you know Steve outlined some of the issues with CAN and using predictive models only, and he highlighted that the CAN dashboard exist outside of workflow. So PCAS was an effort at the same time as the PACT was forming to try to create a tool, a clinical application if you will, that would allow PACT providers and teams to work within workflow, and understand what was going on with their patients; identify patients that might be at high risk, and we use, I'm using high risk kind of in air quotes here to say that these could be patients that have the statistical high risk like the CAN score, it could be some other measure of high risk, which I'll show you some examples on the demo. To be able to identify key patients within your panel or panels, whatever teams you're on, and then be able to manage those patients, and coordinate their care, importantly among your team. So just briefly, we collect data for PCAS from a wide variety of sources and what we try to do is bring in, in

from CDW, raw VISTA data, and from models, non-VA care, those sorts of things. Connect them into one view within our application, and then align those so that you can use them to assess what resources and care coordination your patients actually need. When we sat down with stakeholders, it was about five years ago, to decide what should we put in PCAS, these were the key things that came up. Everything else that's listed that isn't inside that little dotted box for release three, those are all things that have been in release one and two so far. So, I'll show you examples of these, but release three is really focused on adding in care and case management and the ability to write CPRS notes back. In terms of how to get to PCAS, PCAS is not something you have to install, you do not need your IT department to do anything special for you, it's really accessible through a web browser, a web-based clinical application. So, the URL if you download the handout, the URL for PCAS is at the end of the slide deck on the last slide. You don't need a special log-in either, PCAS will recognize the network user ID of the person logged in to their computer, however, the way we manage our user access is we default to the patient care management model. So, the PCMM is how teams are constructed for PACT and how patients are associated with those teams. If you are on a team in PCMM as a provider then you automatically have access to PCAS. If you're not part of a team and you happen to be part of either clinical leadership, or training and education groups, we are working on some methods this year to be able to give you some access to PCAS, whether that's to actual panels and teams within your facility or perhaps it would be dummy data, so we're working on both of those avenues this year. And just some brief utilization data, I was looking at Steve's slides and thinking, oh I should put some lovely pictures in mine, too. I just glanced at our utilization this morning, as I said PCAS is available nationwide within the VA firewall, an we've had over four thousand users from nearly every VISN but we follow quite closely to what Steve was showing with CAN utilization in that we have our heaviest use in region two and VISN eight. And that's in part due to last year, they did a thirty-sixty-ninety structured implementation of CAN and PCAS, last part of two thousand sixteen, so we are grateful that we were able to watch that process, and see, get feedback from people as they're implementing these tools. As of the end of February I believe we have nearly thirty thousand uses so far this fiscal year. I'm going to switch over now into the demo. Some of these slides are a little bit old. For those of you who have attended this twice already, I'm going to go through the PCAS release one and release two slides pretty quickly and I'll leave time to really focus in on the release three screen.

When you open PCAS, this is the current release of PCAS, in fact I just updated this slide last night. So, this is what you will see as long as you are part of PCMM and a assigned within PCMM, at the top you'll see user where my mouse is, and that's your network user ID. In a few rare cases, and we went through this in VISN 8 during their implementation, a few rare cases we find that the network user ID information that your computer associates with you is out of sync with what was originally in VISTA. We're typically able to identify if that's an issue and we think it's less than five percent, maybe less than that of users. But, there may, if you know that you're in PCMM and you can't get into PCAS, that's ninety five percent of the time what's going on, is that there's a typo somewhere in your VISTA information, so in those cases there is a link to the help desk, top right, just send us a note, and we'll start helping you figure out what that problem is. In most cases, all you have to do is send a note to your IT help desk, locally, and they'll fix your VISTA information.

Alright, so when you enter PCAS, you see this opening screen, which we call the manage patients page. On this screen, there are two types of ways that you can find patients. The first way is with traditional CPRS-like search tool. Currently, each of these lines is an individual search. So, you could search by a name or part of a name. You could search by last four SSN, a single date, so just put one date in at start date, or date range. And then you can also search by gender now as well. On the right-hand side, we have, we have some cohort panel one-click filters, basically. So, the top three, I'll give you some examples and we'll come back to that. But if you look down past the top tree, you'll see that a lot of these are based on data that we bring from other sources. So, for example, a Veteran that has received homeless services in the last month, we, you can click and find all of your patients that are associated with your team or teams that have suicide risk, hospice care, and some other criteria that quickly locate patients, and kind of subdivide your panel so you can pull up a sub group. So, in the example I think on the next slide, is that, pretend that I have clicked on the top CANS scores, so that would be the one year death or admission model. When you do that, and you scroll down, kind of important, you will see a grid of patient information, and these are, this is as though I have clicked on the top CAN score filter, so you get the top one hundred CAN scores. Each line in this grid represents one patient. You can click on the patient and go to additional information. We give you a lot of things right here up front. Just a couple highlights. In release two we added the goals of care conversation, that's something that's being implemented nationally, and for the most part there are only four sites that have implemented this so far, it's rolling out nationally, so you see no in this column, but if you're a site that is piloting this, you would see somewhat different responses for a number of your patients, and that's based on CAN score and the presence or absence of help factors, or past associated with goals of care conversation. If you are a person who is on more than one PACT team, you may see two teams listed here. In this example there's team A, team B. I also want to note that we have a task column here, the icon that's lit up in kind of a teal color means that this patient does have tasks associated with their care, and then I also want to point out that there's an active or pending consult column. These links, anything that's underlined and in blue, means that it links to another page. We do show you very quickly the date of care and NCA costs. And then the care plan column, sort of in the middle, we will be adding to those for release three. Now any of these column names at the top that are underlined mean that they are sortable, so you could click on the CAN score column, for example, that title, and it would sort the grid ascending or descending. So, once you've selected a patient and we'll just pretend that I've clicked on the test patient over here, you come to the page that was the hallmark of the first release of PCAS and we've added to this over time. This is the risk characteristics page. Briefly, I want to point out that just the general lay of the land in PCAS is that you have tabs along the top, all of these tabs, and no one has the administrative tab except for me, but for the rest of you, any tabs along the top are global, meaning they apply to all of your patients. We'll give a couple examples of that later. When you are at the patient level you'll see a gray box and this gray box is all the different pieces of information associated with an individual patient. This gray box happens to be from PCAS 2.0. That's the screen we're looking at. Okay, so, at the very top of this page we bring in risk indicators, so we have all four CAN scores, and then we have three other risk indicators that I'll come back to. For each CAN score you'll see these little icons here. Those mean that you can graph that CAN score over time. So, we store the historical CAN score data and you can click on those and get a graph. We also provide the probabilities associated with that score for that patient. So, in this example, this is a patient who has a one year combined death or admission score of a ninety-seven which is a fifty-three percent probability, so very high. If I click on this little graph, I get the picture of this patient's one year score over time, and this one has just risen steadily, but I can tell you that there are some that we look at that start at sixty and jut up, and then come back down and zig zag a little bit around. Steve talked about some of that fluctuation as well, but this at least gives you the ability to look at CAN scores since the second CAN score model was released. These dates at the bottom are related to the first CAN score, because this is a slightly older slide, but the graph that you'll see is since the second version of the CAN scores came out. Now going back to this risk indicator section, we have these three additional areas at the bottom: clinical priority, manual high risk flags, and then a risk flag reason. So, these are manual tools for you to use. We understand that you can't predict everything that's happening at the point of care. CAN score is based on a population-based model and so we've given you some more discreet tools to use at your disposal here. So, and I'm not going to go into these too heavily. If you're interested feel free to send me an email and I'll give you a deeper dive on these. Essentially, you're going to click on this little button at the top, the define clinical priorities and high risk flags. Clinical priority can range from one to ten, and you can chart that over time as well, and manual high risk flag is a yes or no. You can use these two fields separately or together, and they will let you essentially create your own cohorts of patients to manage and monitor. So, for example, this clinical priority is seven for this provider might be associated, it may be that they've developed a group of patients that are their mild dementia patients, or dementia patients. I've seen some providers that use a clinical priority number to associate with all their dialysis patients as well. So, it's a couple of different ways that you can use separately or together to create custom lists of patients. In this next section on this page we have our clinical risk factors. There are a lot of these. We bring them in from different data sources. Some of them are aggregated within PCAS, so for example, number of ER visits in the last twelve months. We've added to these as we've gone forward with other risk filters essentially. You'll see some of these that are on the managed patient page I showed you first. You can click click click and find all the patients. For example, this patient has received homeless services. These are color coded if they reach a threshold. I also want to point out that we don't have a large manual for PCAS. We think that the application is pretty straight forward and we want it to be approachable, so what we've done is where you see these little question marks, if you either hover over them or click on them you'll get a tool tip and it will tell you where we get that data, some information about the data, and usually if it's up- the frequency of the update, so here it's nightly. At the very bottom of this page that you can't see, we also have cost risk factors that we bring in. So, the NCA costs, beneficiary travel costs, [fee costs? 33:51], and then we also bring in [inaudible 33:54] classifications for the current and last fiscal years.

That was the risk characteristics page.  If I move down the individual patient information gray menu system here, I have not shown you patient demographics or secondary contacts in the interest of time. We do, however, pull in all secondary contacts from VISTA. So, if you have next of kin, or those kinds of people associated with your patient in this, we pull that directly and so you can view it in PCAS. You can also enter additional secondary contacts that are folks that you might know associated with that patient. This shows you the team information page, and this is data directly from PCMM. This is representing one team, but if you have more than one, if this particular patient is being cared for by more than one team, then you would see both teams here. Whatever is attached to the patient within PCMS. On the far right you'll see that there's a column for PCAS notifications, so the default is to opt everyone in, however, so if this line right here my mouse is, if this were my record as a provider, you can opt yourself out. If I clicked on yes, here, it would opt me out and put no, and it would give the date that I opted out. That way your team will know that you're not receiving email notifications from PCAS. These email notifications are related to our task feature, which is this gold tab at the top, and I will come back to that and tell you more about that here in a second. I did want to point out, though, oh I apologize I could have blown that up. I wanted to point out that at the bottom, here in this red square, we also have home and community provider information. So, you are able to manually enter this right now. We have some things in the works with the Care in Community group that we hope that we'll be able to enhance that, and not make it so manual, but at least for now you can enter home and community provider information. I've seen that some people using PCAS will put in services not necessarily providers, so that's another way this can be used.

Alright. The next group of pages and group of slides that correspond with these pages, are here on the left-hand side, there's six of them in red, not counting this task and reminders at the bottom. The middle six in red are all clinical data that we pull from CDW on a nightly basis. In most cases we give you the last twelve months of data. So, we've pulled in, in one view, a summary of everything going on with your patient. So, these all function very similarly, so I'll go through them rather quickly. So, for example, this is all the outpatient visits. You can note that, again, you have headers that have, that are underlined, meaning that you can click on them and toggle sort. You also have a whole set of filters at the top to quickly find the information you need. On the far-right hand side there's also what type of data this is: VA or non-VA data. That's a blow-up of the filter that I just mentioned. This page is the same type of page, but this is the last twelve months of inpatient discharges. So as soon as the patient’s discharged we pull in that data. Again, similar filters at the top so you can quickly find information. On this one I'm showing you the health factors view. This one's quite nice, because, if you look over here in the right of the filter health factors type, these drop-down boxes, there are a lot of health factors. We don't populate all of them in this list. We only show the ones that the patient has actually had. So, you can click in there and find a specific health factor and look it up, or this is a free text search. You can put in part of a health factor so you might be looking for advanced directive and put advanced in there, hit go, and that will bring up all the health factors. So, we bring in twelve months of health factor data. We also bring in the last, excuse me, the last three months of VA and non-VA medication. So, lab data, VA lab data, is the last six months, and medications are the last three months. These are the only two that aren't twelve months and that's simply because there's so much data, and it's a lot to move on six and a half million patients on a nightly basis. So, the VA medications data functions much the same as the other clinical pages. You have a summary table at the bottom that shows you the information about the meds and then you have filters at the top that you can quickly find information about something specific.

Now this is the individual patient view of consults. We've had this in since the first release. This is, though I clicked on this blue link on the gray bar on the left here. This shows you all, all the consults associated with this patient for the last twelve months. However, we also have a tab at the top, and it's got a red square around it right now. If you click on that overall tab you can search through all of the consults for all of your patients. So, in this example, I have filtered by CPRS status as active, and this is a rather old slide, the dates are pretty old on this. Like I said, this has been in since the first release. But importantly, it shows you just the active consults and then you can see here that we have not just VA consults, but we do get choice act consults and non-VA consults that you'll see in here. If you click on any of these select blue indicators here it will go to the individual patient-level consult page, which I just showed you on the previous slide. Now, if you recall, on the ‘manage patients’ page, where we started out, there were two columns that linked out to some separate areas. One was active and pending consults, so if I clicked on this side it would have taken me to the patient-level view for those consults. You quickly work through those. Then [inaudible] there's a task column, and for the icons that are lit up, if you click on that, it takes you to the task page, and this is the individual patient view of tasks associated with this patient. This was a hallmark of the second release of PCAS and this allows you to do care coordination within your PACT team. So, for example, these tasks have been assigned, the provider types are Jane Doe and John Doe, they've been, the PHI has been masked here. When it's due, the type of task it is, when it was requested, and when it was followed up, the urgency which is color coded, and whether it's complete, or pending or on hold. (coughing) Excuse me. You are able to delete. Deleting a task currently puts it into an archival system, so it's not fully deleted, but it gets it off of your view. We also have, so that's the large view of that particular grid. We also have the task tab, and when you go to that task tab, you can search through, let me go back. When you go to the task tab you'll see all of the tasks, for all patients, and all providers, that are on your team or teams. So, when you're on that view, and I don't have that slide here, but when you're on that view you can search and see, you know, show me all tasks that are assigned to me. If you have a, if you're going out of town and you have a team member covering for you, they will be able to see all your tasks and work within those tasks, and importantly, we respect how well all of these PACT teams are working and we allow you to reassign tasks to your team members or reassign their tasks to you, if you're able to do those. So, there's a lot of flexibility in this task management system, and we're continually adding to that. I will mention a little more about that later.

When you have a task that's due, you will get an email from PCAS, and this is related to the team information page and that opt in or out column that I mentioned. So, the email is very generic, right now it's smaller than this, it just says that you have tasks due. When you click on the link it goes directly to PCAS. These emails are not encrypted, they are not rights managed or anything like that, they don't have PKI, and that's because there's PHI in these emails. They go directly to PCAS, PCAS opens up to the task page, so that then you can start working through your tasks. So, it's all within work flow. No extra steps here to log in. Now for the next few minutes I just wanted to walk through the highlights of the third release of PCAS, which is coming out imminently. We are currently putting a lot of this on our development site and we should have it out to production very soon. One of the first things that we've been requested to do is make it possible so that you can see case management of patients. A lot of, this application was born out of a need in primary care, but we've had a lot of providers that give case management to patients requesting that it's easier to find things. And so, the data are in PCAS actually, most of it, but what we're doing is creating some flags so you can more quickly see what case management is going on with my patients and also what providers are also working with me on caring for this patient. PCAS 3.0, I have brought up the side menu at patient level, so everything in blue is release one, everything in kind of orange-ish red is release two, and then the green are the 3.0 additional menus. So, this first menu is an appointment scrubbing menu, and this page shows you the next six months, and obviously, these will change fairly often. But the next six month of appointments for a particular Veteran, again this is laid out the same way we've laid out other things in PCAS, you can quickly find things with sortable columns and lots of filters at the top. But we bring in the date and time of the appointment, what type of appointment it is, the primary and secondary stop codes, and then the request type, and the length of the appointment.

In PCAS we have new capabilities to store information about the patient situation or background and write notes within PCAS that can then be included in a note to CPRS. So, for example, at the top here, you can check off the situation or background area about which this note is concerning. So, for example I checked off functional status and social concerns. And then down here where it says note columns, those will pre-populate, so this automatically starts off and says here's a note regarding functional status and social concerns, and then you can add any manual text you want to into this note. When you save that note, it will come up in this previous note grid on the right-hand side and any of these past notes that you've created about this patient, you can click on this little radio button and view those as well. Now keep this in mind because all of these individual notes, we have the capability of adding those to an overall note that can go to CPRS, which I'll show you here in a minute. And again, apologies because you could have seen that wider if I had clicked on this, sorry.

The next category under care planning, is we are documenting in 3.0, learning preferences for a patient. So, this includes their vision, hearing, and literacy capabilities, communication preferences, a way to do an educational assessment, and understand what their educational level is, and then understand what the patient's style of learning and barriers might be. We are also working with the office of Patient Centered Care. This is just a holder picture here, but essentially this is their patient health inventory. So, it's the whole patient model and includes a personal health inventory that the patient does for themselves. It covers also professional care and their reflections on their care. And then finally in our care planning section we've added in the ability for you to work with the patient and look at assessment and goals. So, the assessment section, and we were just looking at this yesterday, and I think this might end up being two pages, one would be assessment and the second one would be goals. But in the assessment section you have things like problem identification, functional status assessment, activities of daily learning, pain, mental health, mobility. And then in the goals section, these are the goals for your care plan. So, you work with the patients to define ‘I'm going to work on my high blood pressure’ and with the patient you construct the basic care plan goals that you can track over time. Now, I mentioned the care plan note. This is the note that goes back to CPRS, and I will blow this up. In this note, this is constructed much the same as the situation background note, but instead this is comprehensive to many of the things that are in PCAS. So again, at the top you check off the things that you would like PCAS to dynamically include in your note. So, I've checked off the most recent CAN score, I would like to include the clinical priority score that I've noted, and the description of why I have that clinical priority score. And then I'd also like to include the current task that are associated with this patient's care. You can check off as many of these as you would like to. But in this example below, the note text is auto populated, and you see that all the CAN scores, the last ones have been brought in, and I think we're actually adding date to this as well, the date of the CAN score. So that would be, they're done weekly as Doctor Fihn mentioned. And then we brought in the PCAS clinical priorities score. So, for example this patient has a ten and that was based on their high risk, and their, they have dialysis, and cancer. And then again at the bottom you can always add your additional notes to this dynamic PCAS note. Now you, there’ll be lots of times where you don't really need to but we give you the option to go ahead and add additional notes to that. Click save and it will show up in the previous care plan notes listing on the right. Click send to CPRS and it will direct this note to the [TIU? 49:27] section of CPRS for you to then sign off on. Any of these previous care plan notes you want to view within PCAS easily, you just check the radio button and hit view. Much like the situation and background notes. Now you see on the left, let's see, right here, the fifth one down, most recent patient notes. Those are the situation and background notes. We're going to be testing this and it may be that we add in here that you can include more than the most recent one. Maybe that you want to check off the ones that you'd like to include. So, we'll be testing that and we'll be looking from feedback from users. The same is true with the goals section. There are multiple goals that get described, so we might change this up as we move forward.

Now I wanted to briefly talk about some of the other things that are on the horizon for PCAS this year. Right after the release of three-point o we've launched a collaboration with the Care in the Community non-VA care folks, and we will be giving access to PCAS, and these are VA providers that coordinate non-VA care. We are going to enhance our tasks section of PCAS greatly to accommodate non-VA care tasks that these Care in the Community providers have to track and manage. And we'll also be linking consults to appointments directly, and also to tasks. And that's so that you can continue to facilitate within work flow linkages. So, if you have a consult that is for non-VA care it's linked to one appointment and the tasks associated with that would depend on the complexity of care that patient needs, so some of that is being defined by the Care in the Community group. Later this year, on the heels of that, we are also going to be releasing the tab at the top in red. It's a query and report functionality. This allows you to quickly find patients. We haven't previously done a lot of reporting in PCAS but we added this in to combine things like show me all my CAN scores over ninety-five who are coming in in the next thirty days. Or diagnostic look-ups. Those sorts of things.

Alright, and then I have one final poll question for you. Now that you've seen PCAS, what function...

Heidi: Tammy, Tammy, I apologize for breaking in. This poll question did not get set-up.

Dr. Tammy Box: Okay. Alright. No problem.

Heidi: It would take me a minute or two but I don't think we have the time.

Dr. Tammy Box: No, that's okay. But I would be interested in your feedback, so my email is at the end of this presentation and feel free to send me an email and let me know if there's, there are specific functionalities that you'd like to have more information about. I'm grateful to the team who has worked on this. It's a very small and mighty team, in fact two of these people just came on a couple months ago, so for the most part we have done all of the work in PCAS within Doctor Fihn's office and relying on collaboration and the kindness of colleagues across various sections of the VA. Here are our email addresses if you'd like more information and as I mentioned the URL for PCAS is at the bottom of this page. You'll find 2.0 right now, 3.0, that will switch over to 3.0 in the next few weeks. I'll stop there and we can take questions.

Heidi: Sounds great. I was going to start at the top and we'll work our way down through the questions. The first question here, are the differences in users by VISN based on population?

Dr. Steve FIhn: No, although, let me put it this way. Some of our high user VISN's are also high population, but we have not calculated rates, which would be an interesting thing to do. No, I think they’re more attributable to the organizations within those VISN's and how aggressively they've implemented PACT.

Heidi: Okay, great, thank you. The next question, has there been any investigation into why CAM scores are being utilized less frequently at non-VISN eight PACTs.

Dr. Steve Fihn: No, you know we, some of it as I mentioned, may be that they're getting it from other sources. You know part of the national PACT evaluation, some of you may know, we've presented data before. There's just a very wide variation across the VA, as there are for many things, in the way in which PACT has been implemented, and you know some facilities and some VISN's have really invested a great deal and do a lot of panel and population management, and have emphasized that, and others, not so much. But, and we've looked at some of the barriers as you know. Some of it has to do with staffing. Teams that aren't adequately staffed really don't have time to deal with the care management. It has to do with leadership. It has to do a lot with distractions, you know sort of attention to performance metrics, and so there are a lot of factors I think that play into that. But, other than sort of generically, we haven't asked the question specifically why PACT scores are used or not used.

Heidi: Great, thank you. The next question here, I have not been able to get the task notifications to work via email. Where does this info pull from?

Dr. Tammy Box: Could you read that last sentence for me please.

Heidi: Where does this info pull from?

Dr. Tammy Box: The task, I think they mean the PCAS email maybe. I'm going to guess. So, if that is the question, the PCAS reminder emails are, they will only be sent to you if you have a task that's assigned to you, and it's within, that task is due in the next two or three days. If you are not getting those emails and we saw that in a few places in Florida, in fact. Then what you'll want to do is send us a note, either to the help desk or you can email me directly and we'll troubleshoot that for you. The reason that happens, typically, is because of an error in your old archival kind of VISTA data, so that's one of those VISTA issues we can help you resolve. It will also help you outside of PCAS because there are other reports and things that use the same mechanism.

Heidi: Great, thank you. The next question here: will there be an encounter associated with this note for work load?

Dr. Tammy Box: I think you're talking about the PCAS note, and as of right now there's not a plan for that. We're not involved in work load capture, but, and Steve might have ideas about that in the future, but the current, there's nothing currently in the works for that.

Dr. Steve Fihn: Yeah, that's a, that's a, you know, I have to say, we hadn't really looked at that. And let us pursue it, we'll put that on our list, because that is a big deal, and you know I'm sort of surprised that I hadn't really considered it, and this is the first time actually someone's brought it up, which is also surprising, but I think it is important, and we'll try and figure out a way. It's hard, I can tell you that, we've struggled with that in the CART program, which is the cath lab program, for years to figure out how to activate work load and opening a consult, and then closing it out, and so on and so forth. So it may require a kludge, where you know, you open a care coordination note in VISTA, you know, put in there ‘see attached, see’ you know, PCAS note and close it out for work load, but that would be unfortunate. Let us pursue that. Great, great question.

Heidi: See, that's what Cyberseminars are great for. People come up with wonderful ideas that you never even thought of. The access to this large audience, I love it when stuff like that happens. The next questions here, are there any sites using PCAS in VISN one?

Dr. Tammy Box: I can tell you yes, but I can't tell you off the top of my head what site that might be. I know that we have users in every VISN.

Heidi: Okay.

Dr. Steve Fihn: Isn't Donna. Wait wait. Hold on a second. Isn't Donna Vogel at Canandaigua?

Dr. Tammy Box: Yes, I believe so.

Dr. Steve Fihn: That's VISN one, right, or is that VISN one, or which VISN is that?

Dr. Tammy Box: I'm not sure I know.

Dr. Steve Fihn: That's England, alright that's New England, I got it wrong. Never mind.

Dr. Tammy Box: But a nice footnote to that is, that if you are interested in PCAS and you would like to get together a group of clinical PACT team members, anyone you'd like, send me an email and I'm happy to do a live demo.

Heidi: Tammy, Steven, I'll say as we've been taking questions I've been getting a ton more questions, and here, we've probably, I'm going to guess, just off hand, I probably have logged thirty more questions here, obviously we're not going to get through those, as we're at the top of the hour here. I know that you both have said you're okay with people emailing you with questions. I don't know how else you want to deal with these, but I also know that the audience has a great desire for information on this topic, so just so you know that there is still a huge amount of, a huge desire for information out here. I can probably compile some of these and get them sent over to you, I'm not sure.

Dr. Tammy Box. Yeah, Heidi if you were able to compile them with the names of the people who asked them.

Heidi: Yep.

Dr. Tammy Box: I'm happy to go through the remaining questions and work with Steve to get answers out to people.

Heidi: Oh, the audience would be thrilled. Yes, I can get those compiled and sent over to you this afternoon. Because, yeah, they're still, they just keep coming in, we definitely have a bunch of questions here.

Dr. Steve Fihn: I want to thank everyone, and we apologize for not leaving sufficient time for questions, but we will get back to you and my, you know, I would just suggest, if you haven't used it and you are a primary care provider, go look at this and give us feedback, because we're very, very interested.

Dr. Tammy Box: I second that and I will say, we have adapted PCAS, unlike, this is not software that just gets installed, this is software that grows with the user, so when you give us feedback we take it very seriously. We put in a couple dozen different changes over the last few years just based on user feedback. We're usually able to respond pretty quickly to those things.

Heidi: Fantastic, since we are past the top of the hour here, I'm going to wrap things up. Tammy, Steve, I really want to thank both of you for continuing to come and present here. We really do appreciate your continued desire to get information out, the audience definitely appreciates that. The audience, thank you everyone for hanging in with us, we still have a huge number of people who stayed just past the top of the hour here, I know a lot of people are hoping to get questions answered. Hopefully we will get those responses out to you shortly. When I close the meeting out here in a moment, you will be prompted with a feedback form. Please take a few moments to fill that out. We really do appreciate all of your feedback. I want to thank everyone for joining us for today's HSR&D cyberseminar, and we look forward to seeing you at a future session. Thank you.

[END OF AUDIO]