Maria: Okay, Tom, take it away.

Tom:

LaFontaine All right, thanks, Maria. Welcome, everyone. My name’s Tom LaFontaine. I’m retired from United States Air Force. I’ve been with the VA since 2008. During this time, I’ve served as Administrative Officer for the Associate Director and Chief of Staff in Omaha and I performed a short stint as the Vision ’23 Surgery Line Administrative Officer. I’ve been with \_\_\_\_\_[00:00:35] since 2013 where I’ve served as a data analyst and administrative officer. Finally, I’m here today in the supervisory analyst position.

 Thank you, Maria, for that. I would like to pass it over to Rebecca or Becky Piegari (SP) to do a self-introduction as well.

Rebecca

Piegari: Hi, I’m Rebecca Piegari. I have been with the VA since 2010 in a couple of different capacities as a program analyst, as a statistician, currently as a data scientist.

 I am the Data Manager for the PCAS that we’ll be talking about today. I am under Tom LaFontaine’s team. Thanks, everybody.

Tom

LaFontaine: Great. Thank you, Becky. Thank you all for taking the time and being here with us today. On the phone with us as well, we have Dr. Meg Plomondon who’s our Director and want to thank her for taking the time to be with us.

 Also, we have Mr. Craig Chrysler (SP), who’s a Lead Data Scientist for our CAN score, Trey Lance and Will Green who are both data scientists who helped us develop our CAN score in PCAS.

 So, all of us at the VA understand the importance of our mission, and how important it is to deliver care and quality safe and efficient manner. Many of you have used various tools that help with this process.

 Today I’m going to talk to you further about a tool that can help improve CARE and can do what people cannot—that’s harnessing predictive analytic, systematically identify and help direct services to high-risk patients.

 However, before we get into that, I’d like to take a moment to try to understand the audience just a little bit better. So, with that in mind, we have a quick poll question, I believe Maria is going to assist us with.

Maria: The poll’s currently open. Tom, could you advance your slide to Slide 2?

Tom

LaFontaine: Yes.

Maria: “What is your primary role in the VA?” The choices are “physician, nurse, other patient-related researcher”, “administrator, manager, or policymaker”, or “other”. If you want to put down “other”, please go ahead and put that in the Q&A.

 I see the responses are slowing down. So, I’m going to go ahead and close that poll.

 (Long pause)

 I can share the poll results with you. We have let’s see here, sorry. My poll results is not showing up. Ah! Actually, Whitney or Heidi, can you guys read that poll result? My poll just froze.

Heidi: No, because we’re not the Polling Coordinator, so we can’t see anything.

Maria: Okay, hold on one second.

 (Long pause)

 Before I’m able—

Tom

LaFontaine: There we go.

Heidi: Oh, there we go. There’s the results—0% “physician”, 26% “nurse”, 10% “other patient-related”, 6% “researcher”, 10% “administrator, manager or policymaker”, and 10% “other”, and 37% no answer. Thank you, everyone.

Tom

LaFontaine: All right.

Maria: Go ahead, Tom. Take it away. Sorry about that.

Tom

LaFontaine: Yeah.

Maria: My system froze up.

Tom

LaFontaine: Thank you, Heidi. Thank you, Maria.

 Okay, hold on just one second here. All right, thanks for the responses to the poll. That gives me a great understanding of who’s here and kind of maybe some ideas on how to navigate once we get into the demo version.

 The Patient Care Assessment System is a web-based application developed primarily for PAC teams with functionality to help identify, manage and coordinate care for panel patients focusing on population like high risk and others.

 PCAS was first released in 2013 and we just had our next biggest release in June of 2021.

 So, again, like I said earlier, PCAS harnesses the use of technology to bring the rich data sources the VA has into one place reducing the number of clicks for end users alike.

 This data includes data derived from within and outside the VA. Our CAN score—which is produced by our office—is also available in there. We continue to work on other data sets like the Cerner Millennium as well incorporated into PCAS.

 PCAS inside has options to do things like manage team information like adding home or community providers. We can identify patients based on certain risk characteristics such as high risk—those that need focus care management, patients that have high utilization, and cost, and even a way to identify patients based on some of your own criteria.

 Additionally, you create and see all the tasks for your panel, and consults in one click. Within each characteristic, you can find one click filters to easily pull a list of patients that can be exported to Excel for further use and further refinement or developing that list.

 If you desire further patient level information, you can dive into the patient-level data detail to schedule tasks and follow items like suggested comorbidity care steps. You can see items like risk characteristic profile, patient contacts, clinical disposition which includes labs and immunizations, appointments, health factors, vital signs, and medications. You can do care planning, or you can record learning preferences and even produce a care note that you can put into the medical record.

 That sounds like a lot of information, and we’ll see how easy it is to get to it on a demonstration here at some point. But first, how do you get to PCAS?

Good question. So, the good thing about PCAS is that there’s no installation of any product. You don’t need a special log-in or any special password. If you’re a member of a PAC team, the application will recognize you automatically and filter your assigned teams.

 Non-PCM users can also have access with limited functionality in PCAS and I’ll repeat that line again. Non-PCM users can have access, but with limited functionality.

 Let me show you some of the screenshots, how you can access PCAS. There’s basically three distinct ways that you can go about getting into the application.

 One way to access PCAS is through CPRS. Based on your CPRS access setup in your facility, the Tools menu is where you can find it. It may vary a little bit based on facility.

 The method of finding it would be to go to the Primary Care Almanac’s basically is where you want to go to. So, you can see in this demonstration here—there, there and here it has you into the Primary Care Almanac.

 You can also access it through directly on the PCAS and the Primary Care Almanac on the VSSE’s page. I’m trying to see the link here circled for you on the almanac.

 All right, a third way to access PCAS is through direct URL and we’ll provide that for you a little later on as the demonstration progresses. When you get to the PCAS application, you may receive a message like the one displayed.

 If you see this—this message here—the best way to resolve that is to contact your local PCMM Coordinator. It will help you get into it if you’re on a PAC Team.

 If you see this message and you’re not on a PAC Team, it has to do with some national level access privileges.

 All right, PCAS has two levels of access. One of them is for PCMM teams and one is for those non-PCM staff who have National Service Desk access. You can tell which access level you have when you log in.

 If you have both, the system will ask you to pick one. It says, “You have PCMM access and NSSD access. Which one would you like to use?”

 So, the system lets you pick which access level you want to get in. Again, the differences are if you pick and choose PCMM, you are going to see only your teams that you’re assigned to, right?

 If you choose the NNSD access, you’ll be able to see whatever your national level data access allows you to see. So, for example, if you’re on a PAC team at one facility and you’re assigned two teams, you would see those two teams if you picked the PCMM access.

 But if you had national--we’ll say data access--you could choose that and then you would be able to see with limited functionality, patients based on your privileges for the national level, right? The differences there is that you cannot write to a database or do any task scheduling in the non-PCMM mode.

 But again, that’s a pretty key, common question here. We get a lot of people that want to be able to do things in the non-PCMM mode and you cannot. You cannot write to a database and we’ll talk more about that as we go through the demonstration.

 Looks like we’re ready for Poll Question number two, Maria, please.

 (Long pause)

 There we go. Okay, so opening the poll question.

Maria: “I have used PCAS—” “never”, “a few times”, “monthly”, “weekly”, and “daily”. That poll is open. Please go ahead and click “Submit” when you’re done answering that poll. Once it starts to slow down I’ll go ahead and close that poll.

Tom

LaFontaine: Yeah.

Maria: It is starting to slow down, so I’m going to close it. Hopefully, we’ll be able to see the poll results. There we go.

 Yeah. The poll results, we have 62% for “Never”, 25% for “a few times”, 6% for “monthly”, 4% for “weekly” and 0% said “daily”.

 Okay. Back to you.

Tom

LaFontaine: That’s awesome. That’s some great feedback. So, what a wonderful time to step over, and do a demonstration of PCAS, and see if we can get those that are “never” up a little bit, right? To maybe a few times monthly, weekly and/or daily.

 So, let’s do this. I will share my screen with you. There we go.

 (Long pause)

 It’s thinking about it. Let me know, Maria, when you can see it.

 (Long pause)

Maria: I’m able to see it here.

Tom

LaFontaine: (Long pause)

 Okay. Can you see? Can you hear me? Somebody reported—

Maria: Yeah.

Tom

LaFontaine: -that -I was muted.

Maria: Yep, we can.

Tom

LaFontaine: You can hear me?

Maria: We can see you and hear you.

Tom

LaFontaine: Perfect, great. I love that. Okay. So, this is the training site we just released not long ago. It’s to allow end users, new users, those that want to experience it with the full capabilities without having to worry about any special PHI or any other access issues.

 So yeah, we’ll share this link with you as we go along. So, PCAS is currently on version 5.2. The Version 5.0 is the one that was released back in June of last year.

 So, since then we’ve had two micro-releases. This is our logo that always stays the same.

 We do track user information and who’s in here. We have a link that goes to a PCAS user guide that talks about how to access it using tips and tricks.

 We do have a help desk that’s run by the VSSC. So, if there are issues with that or with PCAS you can certainly submit a help desk ticket.

 This is a product. PCAS is a product of analytics and performance integration. Again, my office is the Clinical Systems Development and Evaluation. Our sister office is the VSSC. We are all part of Analytics and Performance Integration that bring this product to life for you to use.

 So, when you first come in, I’ll just do a refresh on this screen. You can see what you pick. I’ll have both here, right? You’ll have this on the training site as well. Do you want to be PCMM or MSSB?

 I recommend for those that are on a PAC team to choose PCMM. When you come in here, this whole area here is what we call a filter area. This is a way to develop your cohort that you want to look at, right?

 So, let’s take a look at some of these filters and see what we can do. So, when we first come in, we can go by name if we want. We can do the last four digits of the Social Security number.

 If you look at these question marks as you’re going through here, these question marks are kind of tool tips. You kind of hover over them and it will provide some information for you.

 So, you can see here in this case it says, “Enter the last four digits of the Social Security number to search by”. It tells you our data source and how often it’s updated.

 Again, you click on that and it goes away. So, you can go by next appointment. You can choose by gender. You can choose by team, right?

 Whatever. A lot of times, folks like to pick one of these risk characteristics down here to filter by.

 So, we have four major categories. We have a high-risk area. We have focused care management. We have utilization and we have what one called a PCAS assigned risk.

 A common one for end users to pick is a CAN score. So, if we select CAN score, well, let’s go over these a little bit more here.

 So, we have ACSC which is a patient-level risk score calculated by the OPES—Office of Productivity, Efficiency and Staffing. It tells you more about that.

 We have the CAN score. The CAN score’s a predictive statistical model to reflect estimated probability of an event i.e. admission or provide events at admission or death. So, that’s in there.

 We have COVID-19. We also have one called comorbidity group. I’ll show you about those.

 We have discharge list to five days. We have VHA emergency department and urgent care center visits. Heart failure admission. Recent it says, so what does that mean?

 Any in-patient. The VA in-patient and/or fee within 30 days of discharge for the diagnosis of heart failure from a VA in-patient or fee facility. We have that high-risk flag.

 PCAS high-risk flag with a value of yes or no is manually entered by the PAC team. This is one the PAC team of providers can use to identify key patients who require attention and maybe use separately or in concert with the clinical priority value that we have in here as well to identify key subgroups of patients.

 Again, so this PCAS high risk flag is a flag that you can use yourself if you’re on a team if you wanted to flag a patient for some reason. So, then we have suicide risk. We have a couple of different interpretations of that.

 We have one from the Care Management Tracking and Reporting Application which is CMTRA. We have the SPRITE one which is the Suicide Prevention Population Risk Identification and Tracking for Exigencies which is why we call it SPRITE.

 We have several other filters over here as well that you can experience with. We’ll do the CAN score. We’re going to pick and get our population based on the CAN score.

 So, when we click any one of these filters or fill in any one of these blocks it produces what I call a patient population grid down here for us. Once this patient population grid is here, there’s one thing here called a patient report.

 You can click on the patient report and it will produce you a file that can be saved in Excel or PDF. It’ll allow you to do some further fine-tuning and filtering especially if you pick the Excel version, right?

 So, when you come in here, you have a header column in this table. It has last four patient name, \_\_\_\_\_[00:22:25] ranking and COVID, VA last appointment, and so on. Get rid of that question mark.

 They’re all sortable. So, any of these ones that are underlined. All the ones that are underlined are sortable. Ascending to descending, right?

 So, when you click on it, it changes the sort order of it. So, you can do that with any of these ones that are underlined all the way across.

 It tells you some key information here—their last four, the patient name, the ACSC score, the CAN score, COVID status if they had it, their COVID vaccination status, PCAS—that clinical priority that we talked about that was right here. Didn’t talk about that one, but here it is. It’s a numeric value between one and 10 which is manually entered by PAC. It may be used separately or in concert with the high-risk flag--which that is the one I mentioned a few moments ago—to identify key subgroups of patients.

 All right, so, these two can be used in concert or alone together. Tells you the VA last appointment. Tells you their next appointment. There’s a whole health system tracking. There’s any medications that would be for renewal. It would show you any tasks in here that you set up for yourself. There would be goals of care.

 These are these comorbidity groups which are suggested care steps based on what comorbidity group you’re in. So, there’d be suggested care steps in this case for this person in Cardiometabolic. This patient down here would have suggested care steps for being in the liver comorbidity group. Tells you what teams are assigned and if there are any active consults, days of care and CA costs.

 So, if you click on this here—the patient name—it’s going to bring you into some patient level details, right?

 A lot of people when they get in here want to use this system just to get this report here. Just a population grid. We’ll go ahead and click “Patient report and export”.

 You can also click on this patient. It will take you to the “Appointment Encounters” area and show you that appointment, those details, right? They’re the same. If you clicked on this, it’d take you to the Cardiometabolic suggested care steps, right?

 But we’ll start with the patient name and drill into what’s called the risk characteristics area. So, there it goes. A little bit of delay there.

 When you click on the patient name, brings you into the Risks Characteristics page for that patient. So, you’re no longer dealing with a selected population. You’re dealing with the patient level details.

 So, on the Risk Characteristics page, when you come in, you can see again. It’ll tell you if they’ve had the ACSC scores. It’ll tell you about their CAN scores and so on. It tells you about the PCAS clinical priorities and high-risk flags.

 So, in this case, they set a high-risk flag and the reason for the flag, right? You can see those little question marks for help are all over the place. If you get one that pops up, you can just click on it and it goes away, right?

 I’m sorry. I missed the top part here, but it also shows you the patient that you clicked on, their last four and their date of birth, right?

 So, you have this little ellipsis here—this little arrow—that would hide the risk factor area if I clicked on it. So, one thing. If you wanted to assign that score, we were talking about yourself, you’re going to assign the PCAS Clinical Priority and High-Risk Flag. You would click on that.

Here, you can see you can make your own note. It’s what clinical priority do I want to assign? Seven? What reason for the priority change, whatever?

 You can set a manual high-risk flag. You can write whatever reason for the high-risk flag there and save it. Anybody on your team would be able to see this as well.

 All right, so that’s the high-risk part under the Risk Characteristics. We have some key clinical risk factors. This is for the last 12 months. Kind of summarizes the information for you like the number of emergency department visits and then we do some math for you here.

 It says, “three or more in the last six months”. The number of hospital discharges in the last 12 months. Any discharges in the last five days? COVID status, National days of care, polypharmacy. Polypharmacy? What is that? That indicates the number of acts suspended or provider on hold medications for patients in the previous 12 months, right?

 We have a lot of information that you could see on the front page as well and then some. So, palliative care’s gone and suicide risk I’m stuck on. Other things, right?

 We have some key risk cost factors for the past 12 months. Obviously, patients are costing you a lot. You might want to take a look at that and make a clinical judgment or a business judgment based on some MCA costs if appropriate, right?

 It would show any type of case management activity in the 12 months. So, also under Patient Information Area, you have Patient Demographics.

 Anything in blue on this page would allow you to edit, right? So, if we wanted to edit some information, we could say, “Preferred method of contact”, “Preferred phone”, “any additional notes”, “living arrangement”, ‘caregiver name, phone” and anybody would be able to see this that has access to this team. But only those on the PCMM Team would be able to edit it.

 There you go. So, there’s yours. We have secondary contacts. You can add those as well if you wanted. You can see team information. The important thing to point out about team information is if you do not want to receive PCAS alerts, PCAS can and will send a non-PHI email to your Outlook two days before CAS is due as a reminder to you.

 So, if you create a task in here—which is down here and we’ll get to that in just a little bit—this is where you would either turn this on or off. If you just click yes it’ll change it to no and vice versa. If it was no, you would click that and it moves it back to yes, right?

 Simple, easy way to turn off your alerts on PCAS. All right, so we get into clinical disposition area. There’s a lot of medical information in here for you. Very similar to what you’d see in a patient record.

 But again, we’re bringing it all in one spot for you, tie-in with lots of information and keyways to filter it here. So, for example, this would be upcoming appointments and it would tell you why. You have all these filters up top here that you can do. Start date, end date, appointment type, right?

 Request type, all kinds of information that you can use and filter if you had a lot of upcoming appointments. We can also show you all the outpatient encounters that they’ve had in the last 12 months.

 Again, you have this form up here in which you can filter these outpatient encounters. You have in-patient discharges, labs and immunizations. You have health factors, vital signs, medications and consults which you can all see as well.

 Again, any table that you see in PCAS that’s underlined that you can sort ascending to descending. So, there you go. You see there’s three patients of labs and immunizations. I just clicked on the reference flag and it gave me all the conditional format of low, low, low, high, right?

 So, you can see that there’s basically a full page about reference labs and immunizations on that patient. All right, moving along because we want to take some time for some Q&A.

 In the Care Planning area, we have the ability in some cases to write back to a database, and to take some notes, and create some tasks to do a personal health inventory and even record some learning preferences. But you have to be on a PAC team in order to be able to do that.

 Again, that’s key. If you say, “Tom, I can’t do that. I’m in there and I just can’t create a note” or “I can’t create a task”, it’s probably because you’re not on a PCMM team. The way to address that is to go and visit with your local PCMM Coordinator.

 Okay, so let’s get into care planning a little bit further. We’ll look at learning preferences. Again, very common type of form to fill out where you can record vision, hearing literacy, and other common issues, comments. You can look in education instruction. You can look at if it requires aides. Is the patient and/or caregiver can read, and write, and other barriers to learning identified? What education, and discussion, and handouts did you have? Check all that apply, right? Some other important information to go through when recording learning preferences.

 You can do a Personal Health Inventory in PCAS. This was developed prior to your health factors being set up in the CPRS. But you can certainly do that here.

 This is the exact same form. Of note though, kif you do it in PCAS, it does not transfer to CPRS. There is no direct interface between PCAS and CPRS, all right?

 So, comorbidity groups. So, in this patient that I’m working on here, right? It’s in the cardiometabolic comorbidity high risk group. It tells you the diagnoses for this reported patient.

 So, it lists depression, coronary artery disease, heart failure, diabetes, and chronic pulmonary issues. These are suggested care steps that may be considered for this type of patient and it tells you if this has been done or not. If this care step has not been done, it would allow you to create a task here to set yourself a note up in PCAS where you could follow-up and take care of that care step if that was deemed appropriate, right?

 Additionally, on this page, there’s a prevalence of the diagnoses among all of the cardiometabolic groups. So, 61% of the people in this group have CAD, 44% have arrhythmia, 47 have CHF, pain and arthritis 61%, right? So, that’s different depending on the comorbidity group that you look at.

 This chart changes down here on this page. So, if this is what a liver comorbidity group, you would suspect to see the diagnoses change a little bit. Again, remember this part of the chart is patient specific on the diagnoses that they have.

 So, this is for the patient which diagnoses they have. This is the care steps which you might want to consider in the care setting. This is the prevalence of the whole cardiometabolic group that is identified for this patient.

 So, this should be comorbidity group. I said cardiometabolic again. I apologize for that. So yeah, this is for the whole comorbidity group.

 All right, moving along from comorbidity groups to tasks and reminders. This is a neat page and one that many like to use PCAS for. If you’re on a PCMM team, you can easily get to this page just by clicking PCMM Tasks when you first come in. It will show you the tasks that you have all set open, so it’s not just this one patient. It’s going to give you a whole list of tasks.

 In this case here, we see we have a couple of tasks that are due. Again, if you have a big, long list of tasks you can filter it. But in this case, what we’ll do is you can read it. You can delete it. You can also hit “Select” and it gives you the chance to edit it. Change the task to whatever status that needs to be appropriate.

 Of note here, if it’s not completed, you’ll continue to get those emails. One area we’ve noticed that folks should address is if you move off of PCMM teams and ensure that your tasks are complete because we’ve had some folks move to non-PCMM positions and somehow still are to a different team. They get these tasks still sent to them.

 So, make sure your task list is cleaned up the best you can. So, when you’re in here, this will be the same as looking at a new task, right?” Day Eight, Sign Two. You can assign to anyone on the PAC team.

 That’s their task request date. The task request mechanism, task type, right? So, we’ve recently added some whole health inventory into there which we know past VA’s receiving significant push.

 So, you can create a specific whole health inventory. I’ll walk back and show you one example of that—the task status, right? Schedule that task looks the same as what I was just showing you, okay?

 This is another thing people like to use PCAS for is the care notes and details. So, in this case, you wanted to create a note. So, maybe you wanted to capture most recent CAN scores. Maybe you want to capture pending and active consults. Maybe you want to do current or past tasks that are associated with a patient.

 You can click Build Care Plan Note, so it builds that for you automatically. You can see that it’s identified as coming from TCAS. Here’s the information you requested—the CAN score depending on your active consults, right? But you can also go in and type your own note, right?

 You can save it. You can copy it to the clipboard and then paste it into CPRS. That’s one way to get it into CPRS is to move it to the clipboard and paste in the CPRS.

 Save it. There you go. You can see that’s the one that I just created. All right, I wanted to show you one other thing by clicking back here. This is what it looks like when you first come in again.

 Click “CAN score”, then you can see if we just click a different way to come in. I just wanted to show you what these look like. So, first we clicked the patient name and it brought us to that Risk Characteristics page. If we click Whole Health System, you can see this is what this person has had.

 It brings you right to the Health Factors page and really identifies which health factors they’ve had. If there was none there, it would ask you to create a task back on the front page. If I do that, let’s see here if I could find one.

 (Long pause)

 Aha! Right here. So, you can see we would click “Add a task”. This patient has had no activity with whole health system tracking in the past 12 months. So, if we click “Add a task” it brings you right back to that Task and Reminders page that I was just talking to you about.

 It says, “Hey, schedule a task for the Whole Health Program” and then you just write yourself a note to whatever it is you want to do with the Whole Health, right?

 Okay. That concludes the demonstration. I want to jump back and go over a couple of slides with you.

 One of the things I talked about in the demonstration was the reminder note that PCAS will send. This is an example of what one of those would look like for you. You can see you have two urgent tasks of three medium priority tasks.

 Of those, you’ve got to call a patient. One is to follow-up and one is to send a letter. So, that’s what it would look like and it would tell you to click here to go to TCAS to take care of that or update your annotations.

 Here are some links which we’ll make available to you as well. In closing, this part of the presentation, I just like to recognize all these people on the team for their efforts with putting together PCAS for the users. Except PCAS has been going on for just about 10 years.

 So, what a wonderful accomplishment by the team of folks here. We want to make sure we continue to build a product that meets the end user needs.

 So, with that, I think we can open it up to questions.

Maria: Great, Tom. Thank you so much. We do have a number of questions. So, we’ll try and get through as many as we can.

Tom

LaFontaine: Yeah.

Maria: Which of the PCAS risk characteristic are better filters for panel management of veterans with high impact chronic pain? Such veterans often have mental health risks, may have substance use disorder risks, sometimes are on opioids.

 Great question. I don’t know if you have some thoughts about that.

Tom

LaFontaine: I am not a clinician first and foremost. But obviously, I need to look at all the filters and we do have some on there for a specific opioids to review. Those were over in the right-hand side. I didn’t get to that, but we have an opioid use in there as well.

 I know that’s one of the reasons why that is there is somebody to ask for it with a similar question and suggested we develop an opioid filter.

Maria: Thank you.

Tom

LaFontaine: But we can also check with one of our clinical advisors and maybe respond back outside of this meeting.

Maria: Sounds good. I was thinking too it’s possible these patients might be in the Mental Health comorbidity groups as well if they have Mental Health risks and—

Tom

LaFontaine: Yeah.

Maria: --Substance use disorder.

Tom

LaFontaine: Yeah, absolutely.

Maria: For case management, does this include care management by PACT RN as well as case management by PACT social work?

Tom

LaFontaine: Ooh, good question. Case management encounter, it’s workload within the last 12 months. I don’t remember specifics about that filter, Becky. As the Lead Data Scientist for that, do you remember how that one was derived?

Rebecca

Piegari: I don’t, but I do know it includes a wide variety of clinical people. So, in terms of does it include RNs?

 Yes, it does include care by RNs. I would say we worked extensively with the CC and ICM folks. They gave us very specific guidance for which encounters and what criteria the encounters had to have in order to be considered case management.

 So, we can maybe reach out afterwards or if the person asking the question wants to contact our team, we can get maybe a little more specific in terms of the details of how those particular encounters were flagged.

Tom

LaFontaine: Great, thank you.

Rebecca

Piegari: That’s a great question. The backend database is actually developed by our Clinical Intelligence Team. We pull together data from CDW. We pull together data that comes from other program offices.

 We pull in as mentioned, the CAN scores, the ACSC risk scores. We pull in Covid 19 data. A number of other different program areas have given us access to their information. We pull all of that information together and create the PCAS Database.

Tom

LaFontaine: Correct.

Rebecca

Piegari: Can we create an inventory of all the patients that have or have not received the pneumonia vaccine on our PAC team?

 Another great question.

Tom

LaFontaine: That is another great question. I’ll say yes, that’s possible. So, how we get items and filters into PCAS is by working with our stakeholders in the Office of Primary Care.

 They help us set our deliverables and new features for it. That is one we can certainly put on our list and let them know that was requested from the field. So, absolutely something that’s possible as we work with our stakeholders in the Office of Primary Care.

Rebecca

Piegari: Are all patients in PCAS?

 Right now, PCAS shows patients that are assigned to a PCMM Team. So, that would include all patients not specifically just veterans. It does include any dependents that are also on a PCMM team. But certainly, we are aware that there are patients that come to the VA for care that are not actually assigned to a PCMM provider.

 (Long pause)

 We have someone asking, “What’s CAN?” “What’s ACSC?” “What’s AMTRA?” All really, really great questions because the VA loves acronyms, right?

Tom

LaFontaine: Yeah.

Rebecca

Piegari: I think the best way to answer that is to encourage people to try out the PCAS training, the demo site. Hover over those question marks for the filters and that will give you detailed information about those filters.

 But real quick, CAN is the Care Assessment Needs Score. ACSC is Ambulatory Care Sensitive Condition and CMTRA I’m not going to get right. Tom, do you remember what that one is?

Tom

LaFontaine: Yep, I can tell you that is the Care Management Tracking and Reporting Application. Really, the source for that is VSSC. ACSC is a product of our cousins or sisters in the Office of Productivity, Efficiency and Staffing which is OPES.

 You can find links to ACSC on the VSSC website as well on their data portal.

Rebecca

Piegari: Great.

Tom

LaFontaine: Which will take you to the OPES area.

Rebecca

Piegari: Okay, and then continuing on the abbreviations—PCMM is the Patient Centered Management Module. SPRITE I know you mentioned what it is. I don’t have that one off the top of my head either.

Tom

LaFontaine: Oh yeah, that’s a big one. I do have it. Give me a second here.

 It’s the one produced by the Office of Mental Health. It is Suicide Prevention Population Risk Identification and Tracking for Exigencies. SPRITE.

Rebecca

Piegari: Great, thank you. Okay, we have someone saying, “I created a task while assigned to a team. I have sense been moved to another team and can’t access this task. How do I cancel? I can find it using non-piecemeal searches, but can’t complete or delete.”

 Tom, correct me if I’m wrong. But I think probably if the person could reach out to the VSSC Help Desk—click the link in PCAS for that VSSC help desk and submit a help ticket, I believe that can be resolved.

Tom

LaFontaine: Yep, I would agree with that. That’s a resolution for that process.

Rebecca

Piegari: Does the data that goes into PCAS originate from CPRS, or Vista, or CDW?

 So, primarily the data that we use come from CDW which I’m sure people know also means that it came before that from Vista and may have come from CPRS.

 We have somebody asking for the link to contact our data team and it is currently displayed on the screen right now—that contact email.

 We have someone asking for a link to the training site. I think I can probably pop that one in there. I’m also going to put in the chat a couple of other links. The first one going out—hopefully people get that—is for the SharePoint site, so people can access that way.

Tom

LaFontaine: AKA user guide I would call it if you see that link in the application or our SharePoint is the user guide we call it as well.

Rebecca

Piegari: Yes. Hopefully people will see this link as well for the training site. “Could there be patients benefitting from Care Coordination Services that are not in the PCAS?” Another great question.

 Do you have some thoughts about that, Tom?

Tom

LaFontaine: Yeah. I just wonder what other areas would we be discussing? If this was developed primarily for Primary Care, I know that there have been some other tracking systems that are out there for patients, and maybe have been shut down.

 Unfortunately, right now PCAS would have to undergo a major overhaul to expand outside of Primary Care. It has to do with the way the security of the system and access is granted.

 So, anything’s possible. We’ll say that. But it has to be worked out through our stakeholders, and be coordinated properly, and thoroughly.

Rebecca

Piegari: Sure.

Tom

LaFontaine: Yeah.

Rebecca

Piegari: I think the user asking the question added a little bit more—“specialty surgery, care coordination nor maternity care coordination”? So, some other specific areas.

Tom

LaFontaine: Right, so, in PCMM, if folks are on a team, right?” On that team, we can have this PCAS look up to see if you’re on a team or whatever.

 In the case of maybe surgery or folks outside of it, I don’t know of a list of people that we could use to automate the lookup process to make sure we’re giving you the right level of access. That’s where it becomes an issue for us and we don’t have the manpower to set up, “If you need access contact this person and we’ll work through it.”

 So, that’s kind of an issue that we run into. We have the PCMM list of providers that helps us grant privileges and that’s why we tell you to always visit with your local PCMM Coordinator if you’re supposed to be on a PCMM team.

 So, in this case, I would have to say visit your local surgery coordinator to put together a good list for us. That’s hypothetical. I don’t think that exists.

 But I understand what you’re asking for. It’s possible, but it’s not on the short list.

Rebecca

Piegari: Okay, thanks. So, it looks like we are now to the bottom of the question list. I don’t know. There’s a moment or two left if somebody has a question that they want to drop into the Q&A. We’re happy to try and take that. But right now, it looks like we’ve gotten to the bottom.

Tom

LaFontaine: Oh great. I just want to say thank you to everyone for taking the time to listen to me today. Thank you and I hope if you have additional questions about it that you’ll reach out to our team here. We’ll do our best to honor requests.

 Thank you to my team, and our Director, Dr. Plomondon and Maria for this time today as well. Yes, thank you all.

Maria: I want to thank everyone for preparing and presenting for today’s cyber seminar. Sorry for any technical issues that occurred. It has not happened throughout any of our practice sessions. Of course, it happens live.

 For the attendees, I want to thank everyone for joining us for today’s HS R&D Cyber Seminar. When I close the meeting you’ll be prompted with a survey form. Please take a few moments to fill that out. We really do count and appreciate your feedback.

 Our next PCAT Cyber Seminar will be in September. Have a great summer and stay safe out there. Thank you.

[End of Interview]