VHA Transformation to a Patient Centered Medical Home Model of Care

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VHA Mission

Honor America’s Veterans by providing exceptional health care that improves their health and well-being.
VHA Vision

VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient-centered and evidence-based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the Nation’s well-being through education, research and service in national emergencies.
Better Access, Better Care

**Before**

Hospital System

**After**

Health System

Only Hospitals

Hospitals
Outpatient Clinics
Mobile Clinics

Vet Centers
Mobile Vet Centers
My HealtheVet
In 1996, VA began the creation of Veterans Integrated Service Networks (VISNs) to transform VA Health Care from a “Hospital System” to a “Health System.” VHA currently has 21 VISNs.

- 152 Medical Centers
- 990 Outpatient Clinics
- 821 Community-Based
  - 152 Hospital-Based
  - 11 Mobile
  - 6 Independent
- 300 Vet Centers*
- 70 Mobile Vet Centers*
- 102 Domiciliary Residential Rehabilitation Programs
- 134 Community Living Centers
VA’s Health Care Expertise

VA is one of the largest civilian employers in the federal government and one of the largest health care employers in the world.

269,000+ Total VHA Employees

83,000+ Veteran Employees

20,000+ Physicians

69,000+ Nurses*

*Includes registered nurses, licensed practical nurses and licensed vocational nurses.
Veteran Demographics

21% had encounter in Mental Health

- 6.1% Female
- 44% Male
- 25% Male
VHA Medical Care Budget

<table>
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<tr>
<th>Year</th>
<th>Budget (B)</th>
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<tr>
<td>2009</td>
<td>$43.9B</td>
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<tr>
<td>2010</td>
<td>$47.5B</td>
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<tr>
<td>2011</td>
<td>$50.9B</td>
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<tr>
<td>2012</td>
<td>$53.4B</td>
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- **Medical Services**
- **Medical Support & Compliance**
- **Medical Facilities**
- **Collections**
VHA costs per capita for top 5% vs. remaining 95%

Top 5%
Mean(SD) = $73K($64K)

Remaining 95%
Mean(SD) = $4K($5K)

FY2010 data for ~5.2 million VHA patients
What the Evidence Indicates:

- Cost neutral or cost savings (modest)
- Decreased ED/Urgent Care visits
- Decreased hospital admissions
- Increased Primary Care cost and utilization
- Improved access, patient-centeredness, coordination, safety, and less disparity
VA’s PACT with Veterans-
The journey forward together

PACT emphasizes Partnership!
VHA Patient Aligned Care Teams
Comprehensive Services

- Preventive Health Care
- Chronic Care
- Women’s Health
- Urgent Care
- Mental Health Care
- Care for High-Risk Patients
- Population Management
- Patient Comfort and Pain Management
- Health Education and Coaching

Proactive, Personalized, Patient Driven Health Care Focus
### VHA Patient Aligned Care Teams
**Implementation Expectations**

<table>
<thead>
<tr>
<th>Veterans are less likely to:</th>
<th>Veterans are more likely to:</th>
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<tbody>
<tr>
<td>• End up in the hospital</td>
<td>• Have preventive care needs met</td>
</tr>
<tr>
<td>• End up in the emergency room</td>
<td>• Have good control of their chronic conditions</td>
</tr>
<tr>
<td>• Miss days from school or work</td>
<td>• Say they understand their conditions</td>
</tr>
<tr>
<td></td>
<td>• Receive good help from their practice</td>
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</tbody>
</table>
### Using Technology to Implement PACT

#### Computerized Patient Record System

**Registries**
- PC Almanac

**Care Management/Coordination Tools**
- Care Assessment Needs Score (CANS)
- Patient Care Assessment System (PCAS)

**CPRS templates**

**PACT Compass**

**My HealtheVet & Secure Messaging** (Patient Portal)

**Telehealth**
- telephone
- store & forward
- clinical video care

**E-Consults & project SCAN-ECHO**

**Patient Care Management Module** (provider assignment)
Computerized Patient Record System (CPRS)

- Progress Notes
- Problem List
- Orders
- Consults
- Vitals
- Allergy Tracking
- Pharmacy
- Lab
- Radiology
- Dietetics

VETEERANS HEALTH ADMINISTRATION
http://www.prevention.va.gov/Resources_for_Clinicians.asp
### Primary Care Almanac
CPRS Providers' Menu Data
updated through: 07/31/2011

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<tr>
<th>Condition</th>
<th>Reports / Lists</th>
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<td>Diabetes</td>
<td>Diabetic Medication Possession Ratio Outlier Report, Diabetic Patient List by Metric Choice</td>
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<td>HTN</td>
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<tr>
<td>Ischemic Heart Disease</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td></td>
</tr>
<tr>
<td>Panel Summary</td>
<td></td>
</tr>
<tr>
<td>Patient lists by condition with drill down to more information</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Care Diabetes Patients Provider Level Summary**

- Diabetic Medication Possession Ratio Outlier Report
- 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**

- IHD Patients Report for LDL>=100 or LDL not done
- Ischemic Heart Disease Medication Possession Ratio Outlier Report

**COPD/Asthma Reports**

- COPD/Asthma Reports work in progress

**Pact Compass Provider Level Summary**
VA/DoD Clinical Practice Guidelines

Overview
Policy Guidance
CPG Links
Health Care
Site Search

VA/DoD Clinical Practice Guidelines RSS News Feed

Chronic Disease (in Primary Care)

- Asthma
- Chronic Heart Failure (CHF)
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus (DM) New
- Dyslipidemia (LIPIDS)
- Hypertension (HTN)
- Ischemic Heart Disease (IHD)
- Obesity and Overweight (OBE)
- Tobacco Use (MTU)

Mental Health

- Bipolar Disorder in Adults (BD)
- Major Depressive Disorder (MDD)
- Post Traumatic Stress Disorder (PTSD) New
- Substance Use Disorder (SUD)

Military Related

- Biological, Radiation, Chemical, and Blast/Explosion Induced Illnesses
- Medically Unexplained Symptoms (MUS)
- Post-Deployment Health (PDH)

Pain

- Opioid Therapy (OT) for Chronic Pain
- Lower Back Pain (LBP)
- Post-Operative Pain (POP)

Rehabilitation

- Concussion-mTBI
- Lower Limb Amputation
- Stroke Rehabilitation New

http://www.healthquality.va.gov/
### Care Assessment Needs Score (CANS) Tool

#### CARE ASSESSMENT NEED SCORE
- **Score As Of:** 2012
- **Almanac Data as of:** 2011

<table>
<thead>
<tr>
<th>Event Probability</th>
<th>Diagnosis Count</th>
<th>CCHT</th>
<th>Palliative Care</th>
<th>Last Pall Care Visit</th>
<th>HBPC Visit</th>
<th>2yr ER/UC Visit Count</th>
<th>2yr Disch Count</th>
<th>Last Disch Date</th>
<th>2yr PC Visit Count</th>
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<tr>
<td>58%</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
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</table>

- Last, First MI
  - 42%
  - 1
  - 1
  - 2010
  - 1

- 90
  - Last, First MI
  - 42%
  - 3
  - 2011
  - 7

- 95
  - Last, First MI
  - 42%
  - 2
  - 2010
  - 5

- 96
  - Last, First MI
  - 42%
  - 3
  - 2011
  - 7

- 85
  - Last, First MI
  - 37%
  - 7
  - 2010
  - 9
Primary Care-Mental Health Integration Dashboard

Enter at:  
VHA Level  
VISN Level  
Facility Level  
Division Level

Comparison Tools:  
Measure Comparison Tool  
Site Comparison Tool

Legend
Numbers: Proportion: Facilities with PC-MHI program, Number of facilities in VISN
Colors:
Red = Not all facilities have PC-MHI program
Yellow = Not all facility programs blended

Review the Data Definitions for PC-MHI history, definitions, metrics and instructions to use Data Definitions.
Panel Management

PRIMARY CARE MANAGEMENT MODULE (PCMM)
Virtual VA e-Health University (Web Accessible for All)

- Exhibit Halls
- Live Sessions
- On-Demand
- Social Media
- Chats

www.myvehucampus.com
My HealtheVet Overview

www.myhealth.va.gov

- Veteran’s Personal Health Record
- Self-Service Prescription Refill
- Access to Labs, Appointments, and Secure Messaging
- Ability to download Physician Notes and Other content from the Electronic Health Record (EHR)

- 82 million+ visits
- 2 million+ registered users
- 686,000 Veterans have downloaded data
- 569,000 Veterans use Secure Messaging
- 36 million prescription refills
VA Clinical Video Telehealth Programs

- 148,385 patients treated in 44 clinical specialties in FY 2012
- Linked hospital-hospital, and hospitals with clinics using real-time video
- Clinical enterprise video conferencing network has over 6,600 units
- Routine outcomes data available at national, regional and local levels
- Links sites of care using real-time video that interconnects 152 hospitals and 673 Community-Based Outpatient Clinics
- 93% mean patient satisfaction score
- Travel cost reduction of $34.45 per consultation
- Major planned innovations:
  - Tele-audiology
  - Tele-ICU
  - IP Video to the home
  - Services into community living centers
VA National Home Telehealth Programs

- Supported care of 119,535 patients in FY 2012
- Provides non-institutional care, chronic care management, acute care management and health promotion/disease prevention
- Routine outcomes data available at national, regional and local levels
- 42,699 patients supported to live independently in their own homes
- Reduced bed days of care by 58%
- Reduced hospital admissions by 38%
- Mean patient satisfaction score 85%
- $1,999 per year, per patient cost avoidance
- Future is to transition services to other information technology platforms
VA Telemental Health Services

VA’s telemental health services includes all mental health conditions, with a focus on Post Traumatic Stress Disorder, depression, compensation and pension exams, bipolar disorder, behavioral pain and evidence-based psychotherapy.

BY THE NUMBERS

- 800,000 patients treated since FY 2003 – 18-fold increase
- 217,000 telemental health consultations to 76,000 patients in FY 2012
- 1,251 video encounters to 427 patients through the National Telemental Health Center in FY 2012
- 7,100 patients with chronic mental health conditions treated in their homes in FY 2012
- 56% reduction in bed days of care as a result of clinical video telehealth
- 30% planned growth per year, shifting toward in-home IP video-based services
Reaching Rural Veterans

VA estimates approximately **43%** of all Veterans live in rural areas.

VA continues to expand health access to rural Veterans through:

- Fee basis care
- Rural health care partnerships
- Home-based telehealth
- Mobile health clinics
In many rural and remote areas, Veterans and their primary care providers do not have easy access to specialty care services and expertise.

Through VA’s SCAN-ECHO* program, Veterans and their primary care team use videoconferencing technology to seek expertise from specialists located 100-500 miles away.

*Scan-Echo: Specialty Care Access Networks-Extension for Community Healthcare Outcomes.
VA Mobile Applications for Patients and Providers

PTSD Coach

Patient Viewer – Displays EHR data

Over 80,000 downloads in 70 countries
# VHA Patient Aligned Care Team Implementation Plan

## PHASE I: Medical Home Readiness Assessment
- Baseline Assessment Completed in Oct 2009
- Reassess in July 2011 (completed)

## PHASE II: Build Staffing Infrastructure
- Staffing Ratio Baseline Completed in Oct 2009
- Ongoing......

## PHASE III: Education & Training
- April 2010 to FY 2014

## PHASE IV: Innovation & Evaluation
- March 2010 to FY 2014

## PHASE V: Measurement
- Ongoing
**Other Team Members**

- Clinical Pharmacy Specialist: ± 3 panels
- Clinical Pharmacy anticoagulation: ± 5 panels
- Social Work: ± 2 panels
- Nutrition: ± 5 panels
- Case Managers
- Trainees

**Integrated Behavioral Health**
- Psychologist ± 3 panels
- Social Worker ± 5 panels
- Care Manager ± 5 panels
- Psychiatrist ± 10 panels

**Teamlet**: assigned to 1 panel (±1200 patients)

- **Provider**: 1 FTE
- **RN Care Mgr**: 1 FTE
- **Clinical Associate** (LPN, MA, or Health Tech): 1 FTE
- **Clerk**: 1 FTE

Panel size adjusted (modeled) based on staffing, acuity, etc.

**For each parent facility**

- HPDP Program Manager: 1 FTE
- Health Behavior Coordinator: 1 FTE
- My HealtheVet Coordinator: 1 FTE

**Monitored via Primary Care Utilization Data**

**The Patient’s Primary Care Team**
PATIENT CENTERED MEDICAL HOME: VHA Patient Aligned Care Team

Replaces episodic care based on illness and patient complaints with coordinated care and a long term healing relationship

- Takes collective responsibility for patient care
- Is responsible for providing all the patient’s health care needs
- Arranges for appropriate care with other specialties

THE PRIMARY CARE TEAM
Patient Aligned Care Teams Mission

**Improved Teamwork, Work Design, Maximizing Team Function & Roles**

**Improving Care Coordination & Focusing on Critical Transitions of Care (Inpatient to Outpatient, PC to Specialty, VA to Non-VA)**

**Improving Access to Care:** Visits with Provider, Team Members, & Non Face to Face Care (telephone, My HealtheVet, Secure Msg)

**Improving Chronic Illness and Health Promotion/Disease Prevention**

**Pt Centered Care**
Redesigning Care for Teams: A Typical Primary Care Panel

- High Risk Admissions
- ED visits

High Risk – Complex Problems

One or More Chronic Health Problems

Lower Risk Frequent User
- No/Low-risk Chronic Health Problem
PACT Access and Care Delivery

- **In-person, face to face**: 1:1 or group visits
- **Non-face to face**: Telephone, Home Telehealth
- **Virtual face-to-face**: Clinical Video Telehealth
- **Virtual non-face-to-face**: Secure messaging
PHASE III: Training & Education

PATIENT CENTERED MEDICAL HOME SUMMIT APRIL 2010

Collaborative
For Trailblazers

- 5 Regions: 300 Teams
- 6 Learning Sessions every 3-4 months
- Comprehensive
- Start: June 2010
- End: FY 2012

Consultation Teams
For Special Settings

- ~25 Site Visits yearly
- On site evaluation and training
- By Network/facility request
- Start: Oct 2010
- Ongoing

Learning Centers
For Everyone

- 5 Regions
- 1250 Teams yearly
- PACT 101
- Start: Fall 2010
- Ongoing

Continuous Improvement
Team Based Care
Patient Centeredness
PHASE IV: Innovation & Evaluation
Demonstration Laboratories

- Evaluate the effectiveness and impacts of VHA’s PCMH model
  - Apply robust research designs and methods
  - Different practice settings
  - Different geographic locations
- Develop and test innovative solutions for the core components of the PCMH model
- Evaluate solutions for effects on
  - Costs
  - Clinical outcomes
  - Patient and provider experience
PHASE: IV: Innovation & Evaluation
Centers of Excellence in Primary Care Education

Develop and test innovative approaches to prepare for Primary Care practice in the 21st century

- Physician residents
- Students
- Advanced practice nurse
- Undergraduate nursing students
- Associated health trainees
- Utilize VA primary care settings

NEW!!—July 2011
PHASE V Measurement: PACT Process Targets:

- They will be assigned to an adequately staffed team (3 support staff to 1 provider per panel).
- When they make an appointment it will be within 7 days of when they want or need it—2012 Target 90%.
- When they want to see their own provider today, they can frequently do so—2012 Target 66%.
- They will usually see their own provider—2012 Target 75%.
- Not all their needs require a face-to-face visit but can be handled over the phone, or by email—2012 Target 20%.
- If they are discharged from a VA hospital, someone from their PACT will check on them within 2 days—2012 Target 50%.
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<th>Clinical Indicator</th>
<th>VA Average Percent</th>
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<td>2010 (6)</td>
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<td>Smoking Cessation - Discussing Strategies</td>
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PACT Outcome: Admission Rates

VHA Acute Admissions per 1000 unique PC patients

Represents avoidance of 36,279 admissions
Urgent/Emergent Care

Visits per 1000 unique PC patients

- July 2010
- July 2011
- July 2012

VHA Urgent Care
VHA ED

Represents 21,802 additional visits
VETERANS HEALTH ADMINISTRATION

PACT Staff Satisfaction

***Adequately Staffed Teams Experience Less Burnout and Better Job Satisfaction
PACT Training, Burnout and Job Satisfaction

- **Burnout**
  - Training not avail/Not involved (14% of respondents)
  - Somewhat or very helpful (66% of respondents)

- **Job Satisfaction**
  - Training not avail/Not involved
  - Somewhat or very helpful
Patient Satisfaction
Based on data Mar-Jul 2012 encounters. N=51,233 responses
**PACT Process and Outcome Improvements**

- **Overall ACP Medical Home Builder score** improved from 69% to 80%.
- **Telephone visits** increased to over 30% of Primary Care encounters.
- **Over 300,000 patients** opted in to Secure messaging.
- **90% of patients** seen within 7 days of Desired Date.
- **Patients see their own provider/team** approximately 75% of the time.
- **Time to 3rd next available appointment** decreased.
- **55% of patients discharged from VHA facilities** are contacted by their PACT within 2 days.
- **Urgent care visit rates** decreased 17%.
- **Acute admission rates** to VHA facilities decreased by 5%.