PACT! and heart failure-how can we optimize care delivery for our patients

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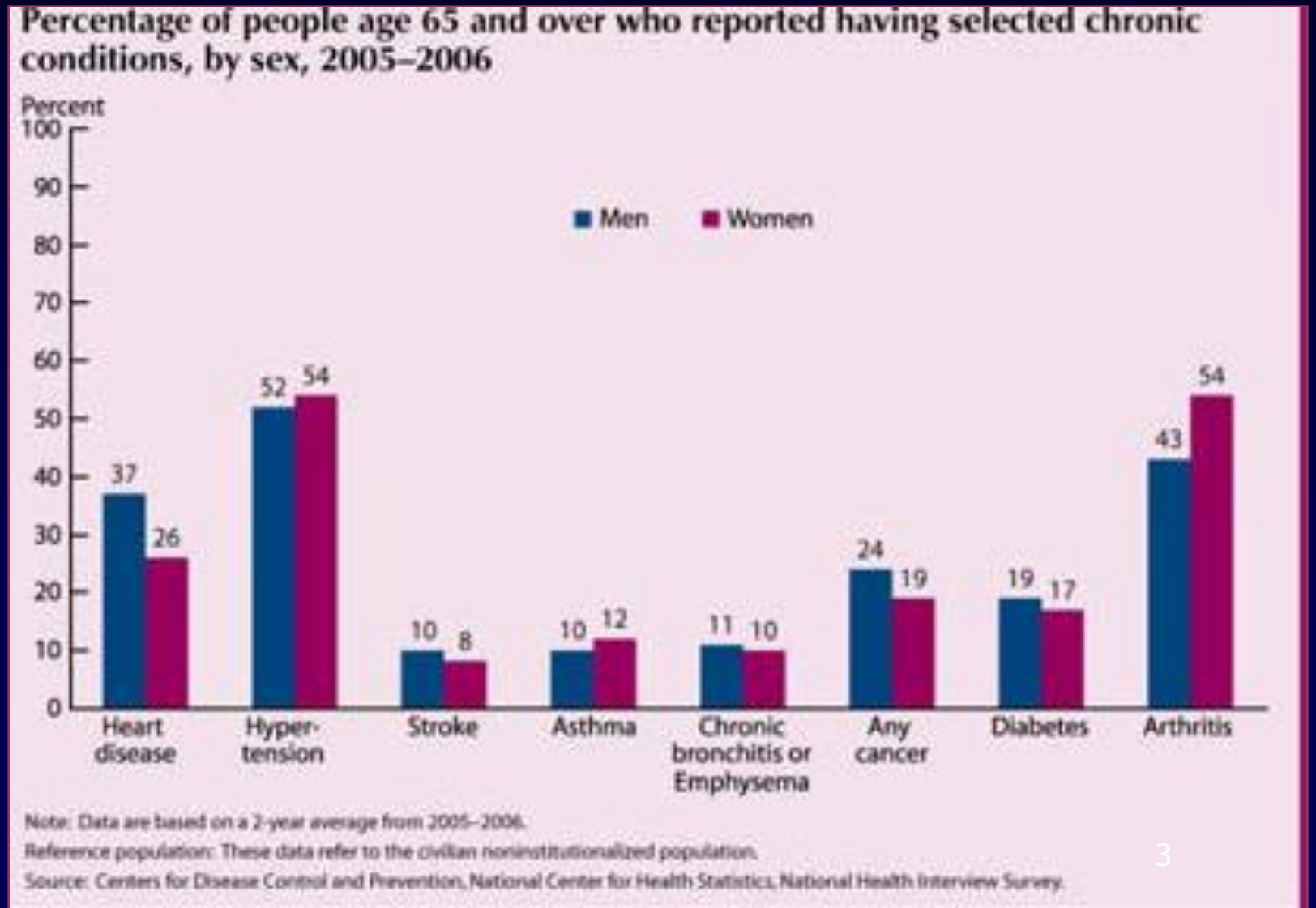
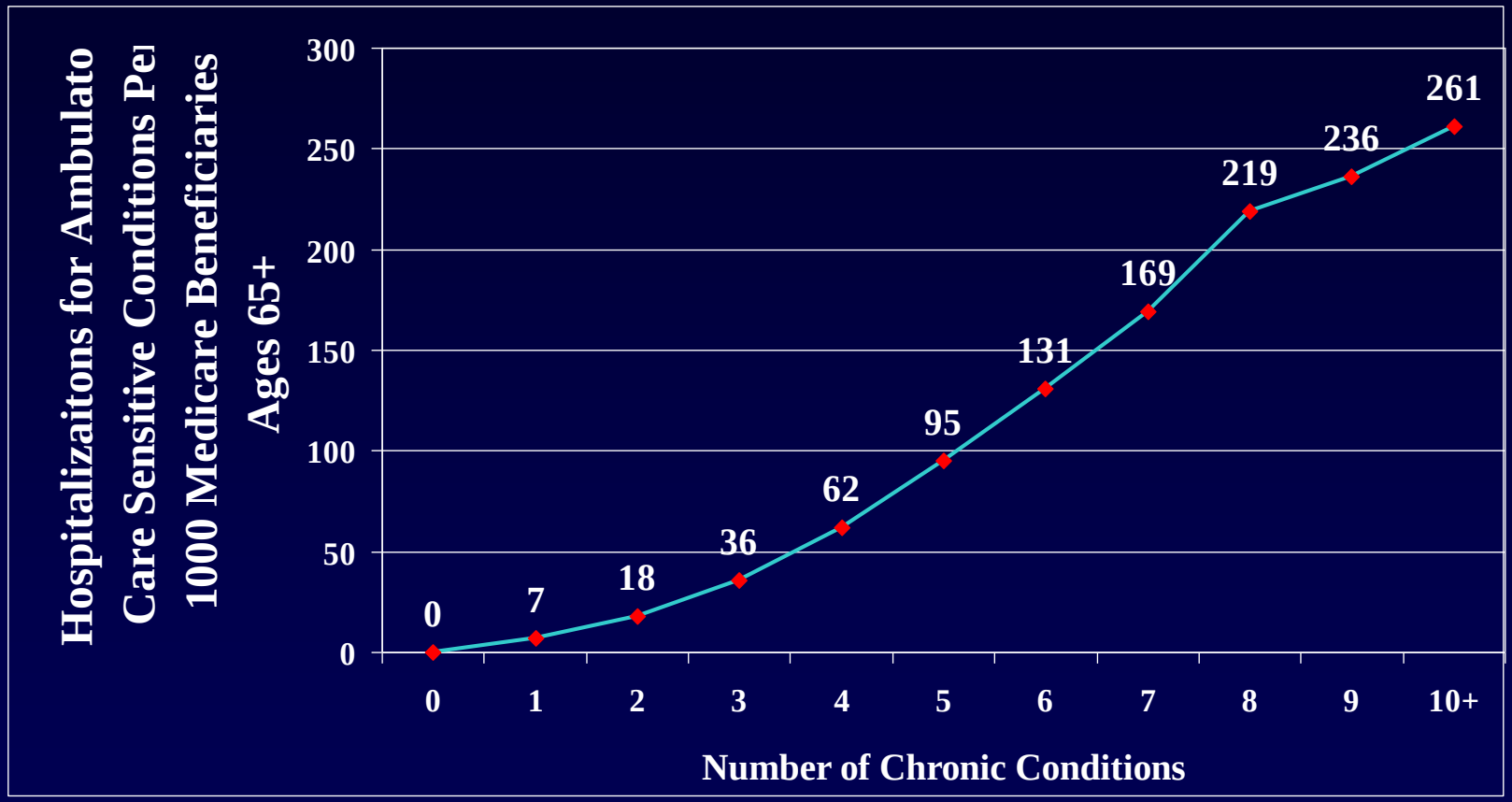
Goals and Objectives

- Chronic disease care needs improvement
- Principles of PACT!
- Examples of the Chronic Care Model and PACT!
- Applying PACT! Principles to heart failures across VA
- Opportunities for collaboration

Veterans on average have 3 chronic conditions



Poor Care Coordination Leads to Unnecessary Hospitalizations



Source: Medicare Standard Analytic File, 1999.

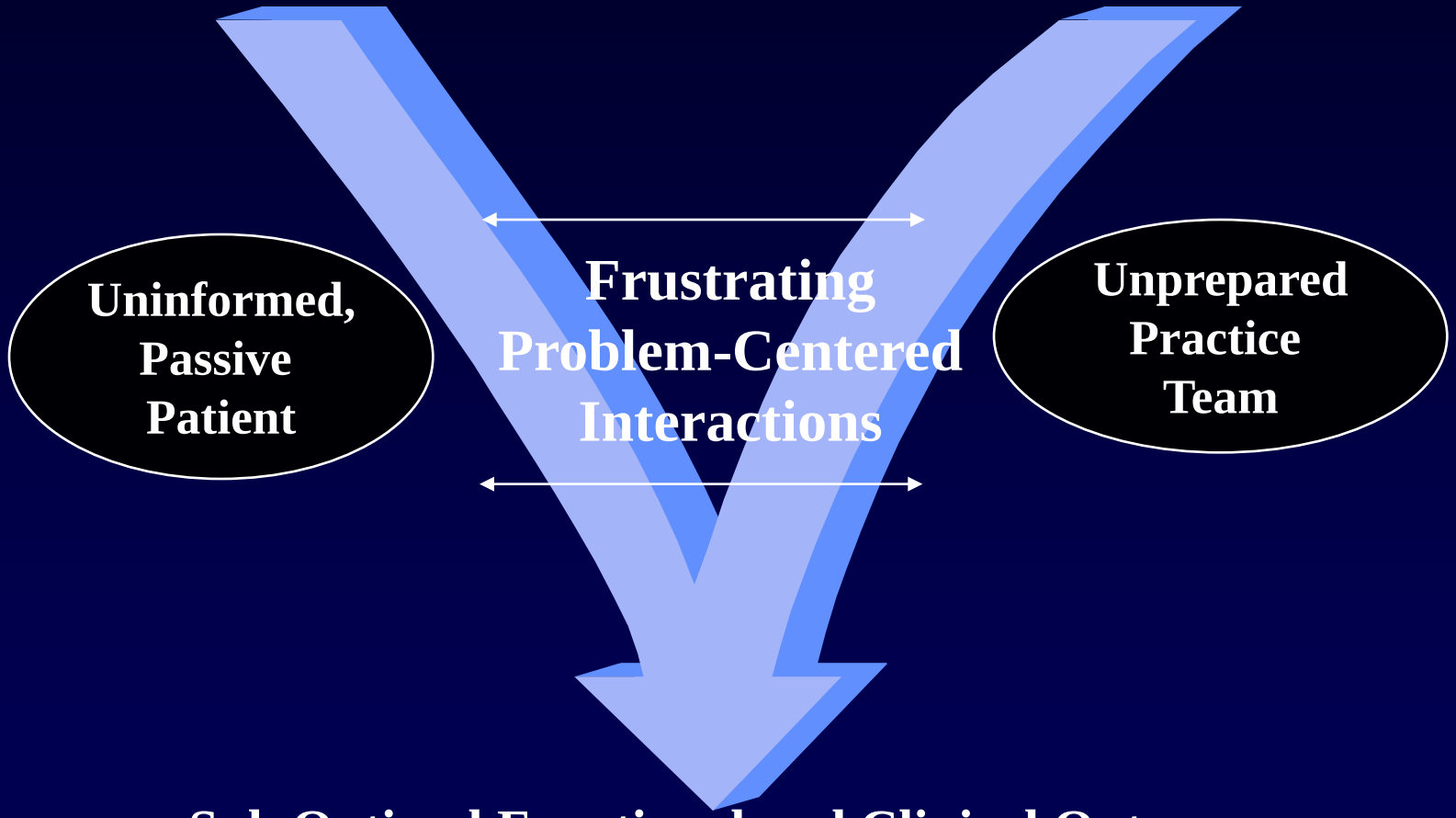
Failures in chronic disease quality

- Guidelines translate poorly into practice
- Measures not adequate
- Underuse of information management and decision support tools
- Resistance to change, even in the face of demonstrable failures
- Hard to influence public policy

Barriers to Effective Chronic Disease Management

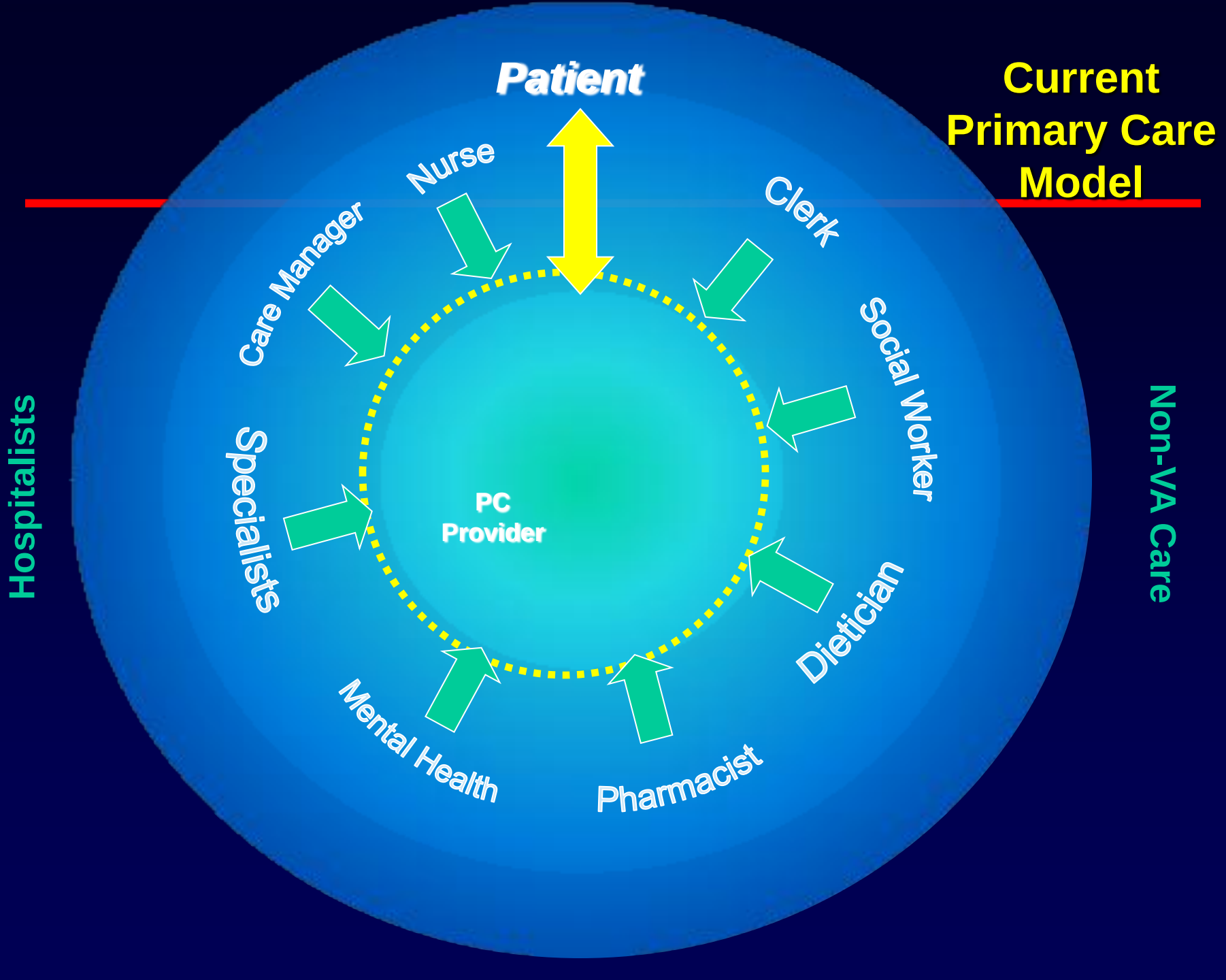
- Rushed practitioners not following established practice guidelines (according to surveys)
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Usual Care Model



improving chronic illness care

Current Primary Care Model



Chronic Care Model as a Solution/Recipe

- The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high quality chronic illness care
- There are six fundamental elements "pillars of care" of the Chronic Care Model
- Evidence-based change concepts under each element
- Source: **http://www.improvingchroniccare.org**

Joint Principles of the Patient-Centered Medical Home Tenets

"Replaces episodic care based on illness and patient complaints with coordinated care and a long-term healing relationship" in outpatient setting

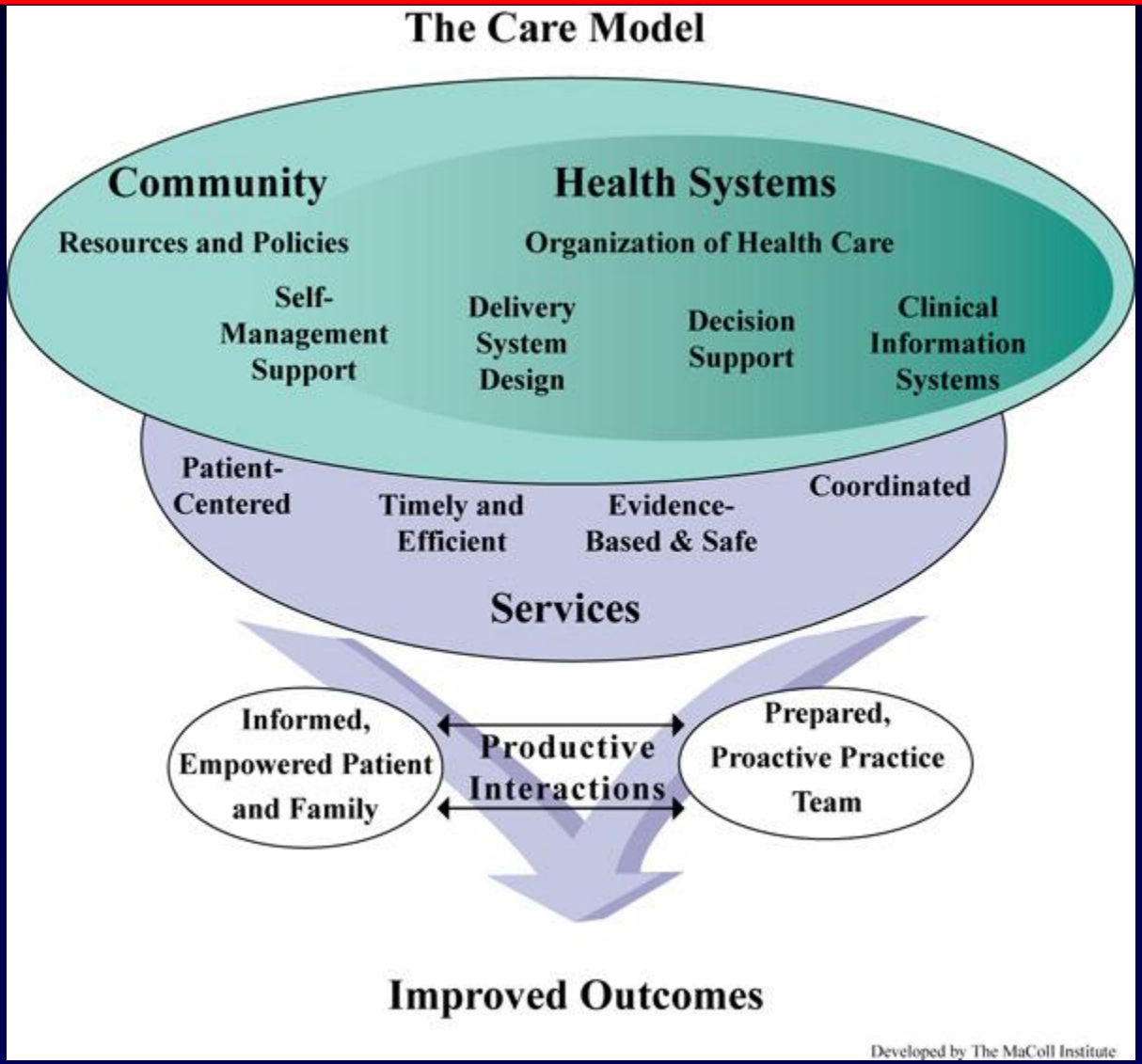
- Ongoing relationship with personal physician or team-continuity
- Physician directed medical practice-or Primary Care Provider
- Whole person orientation-Patient preferences
- Enhanced access to care-appointments/services/information
- Coordinated care across the health system-team care
- Quality and safety-performance measures, registries

http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

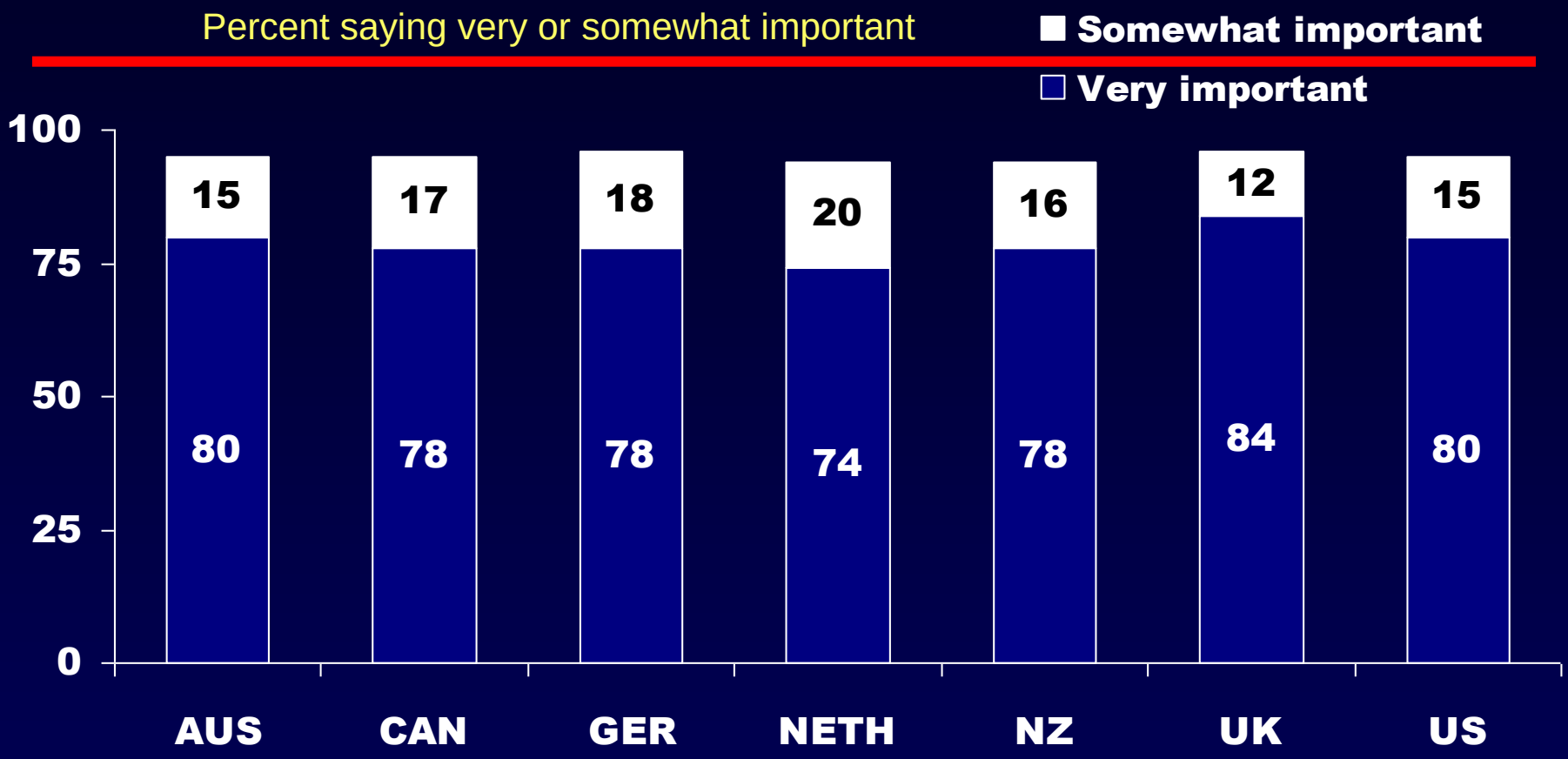
PCMH/PACT!
What it is; what it is not

- It is a series of attributes – some are very clear; some less so
- It is not a specific structure; the specific form will follow function, but is dependent on context
- It is the model the VA has chosen
- It is not carte blanche to gain resources

The chronic care model with PCMH (Patient Aligned Care Team)



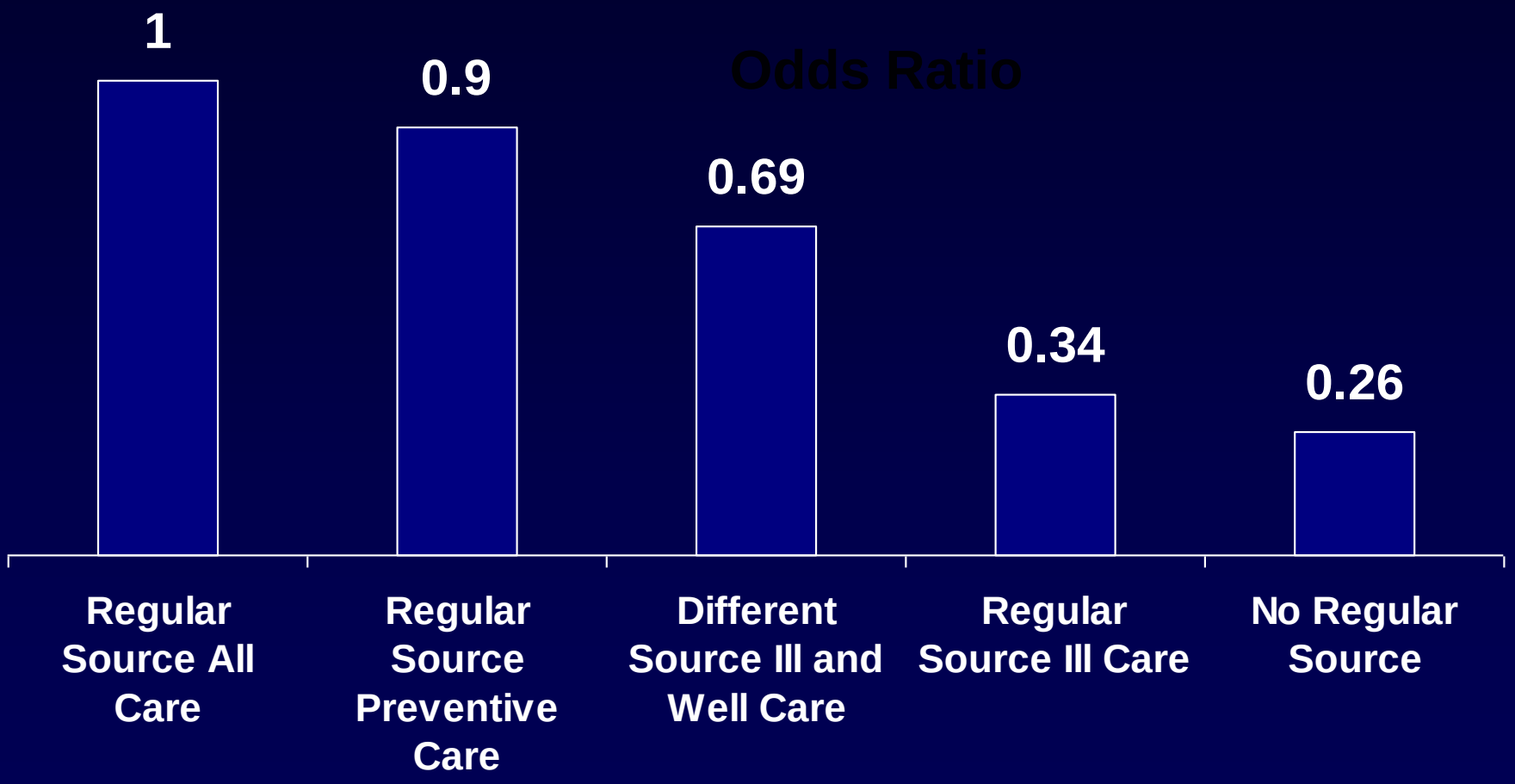
Adults Across Countries Place High Value on Having a "Medical Home"—Accessible, Personal, Coordinated Care



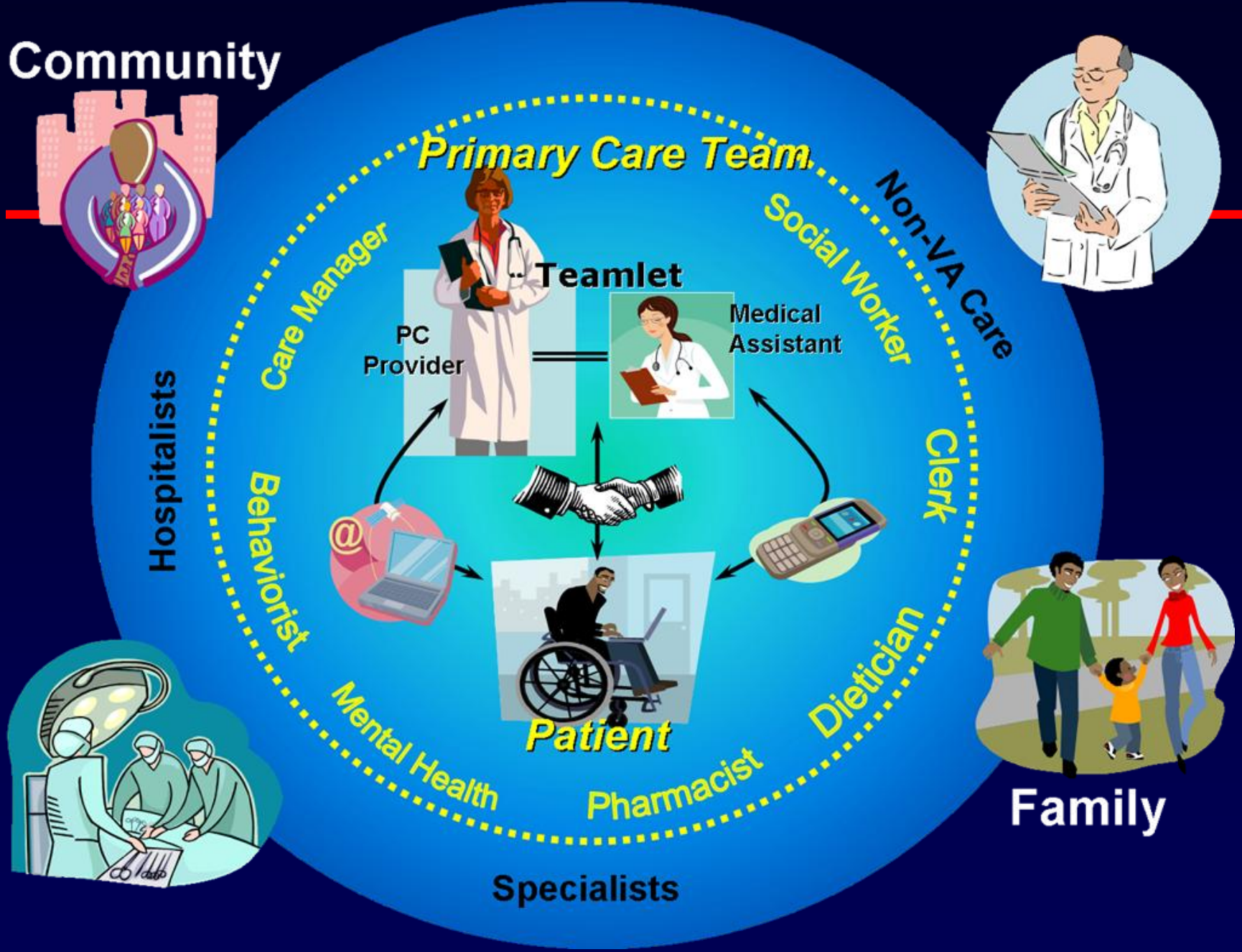
When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.

Medical Home Increases Odds of Getting Preventive Care



Ryan, Riley, Kang & Starfield, 2001


Community
Primary Care Team
Non-VA Care
Social Worker
Care Manager
Teamlet
PC Provider
Medical Assistant
Hospitalists
Clerk
Behaviorist
Dietician
Mental Health
Pharmacist
Patient
Specialists
Family

Current PACT! initiatives

- Demonstration labs
- IHI style improvement or learning sessions-6-share information
- Teamlet training
- Tool development in CPRS
  - Primary care almanac, decision support, risk tools
- Additional staff
  - nurse care coordinators
  - health promotion disease prevention staff
- National evaluation-ACP biopsy

Learning Sessions Focus on Pillars

- Enhanced access to care
  - Telephone clinics, CCHT (telehealth), my health e vet, secure text messaging, huddles for daily open slots
- Coordinated care across the health system
  - TEAMS and populations-Shared medical appointments, nurse and pharmacy planned care, nurse protocols, innovation for homeless, mental health, CKD, service agreements with specialists

Attributes in Primary Care

- Quality and Safety
  - Performance measures, next available appointment, post-hospitalization follow up, medication reconciliation
- Whole person orientation
  - Patient preferences, shared decision making, **patient understands the disease process, realizes his/her role as the daily self manager, family and caregivers engaged, provider is a guide on the side**

HF Clinic as a Medical Home

- Class III/IV HF-Cardiology is their home?
- Principles can be applied to enhance care delivery
  - Improve Access: Telephone clinics, CCHT, telehealth consultation Cardiologists
  - Care Coordination: HF SMAs-MANUAL, NP or Pharmacists following sickest patients with registries, close post-hospitalization clinics, electronic reminders to patients for labs, follow up appointments

Opportunities for Collaboration

- Go to staff
- Shared templates
- Service agreements
- Hospital discharge coordination
- Other suggestion-we need sharing of best practices!