Panel 2:
Health System Engagement: Partnership, Relationships and Transparency

Please submit questions for the panelists to: PragClinTrialsWkshp@nih.gov
Goals for today’s presentation

- Provide a general understanding of health systems and their dynamic context.
- Panelists will address the need for:
  - transparency with implementation,
  - barriers, staff/leadership turnover,
  - ways to share data and progress during conduct of PCTs,
  - researchers and health systems partners working together to sustain relationships,
  - forming true partnerships between researchers and healthcare systems,
  - and learning about implementation, scaling and spread of interventions in conducting PCTs.
**Panelists:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Institution</th>
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<tbody>
<tr>
<td>Miguel Vazquez, MD</td>
<td>Clinical Chief Nephrology Division, Professor, Internal Medicine, University of Texas Southwestern Medical Center</td>
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<tr>
<td>John J. Warner, MD</td>
<td>Chief Executive Officer, University Hospitals and Clinics, University of Texas Southwestern Medical Center</td>
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<tr>
<td>Lynn DeBar, PhD, MPH</td>
<td>Senior Investigator, Kaiser Permanente Center for Health Research, Kaiser Permanente Northwest</td>
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<tr>
<td>Andrew Bertagnolli, PhD</td>
<td>(Former) Director, Integrated Behavioral Health Care Management Institute</td>
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<tr>
<td>Vincent Mor, PhD</td>
<td>Florence Pirce Professor of Community Health, Brown University, Senior Health Scientist, Center on Innovation, Providence Veterans Administration Medical Center</td>
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Improving Chronic Disease Management with Pieces—Health System Engagement

Miguel A. Vazquez, MD
John Warner, MD, MBA
(for ICD-Pieces Team and UT Southwestern)

Wednesday, May 24, 2017
Clinical Relevance

Multiple Chronic Conditions

- CKD
- Diabetes
- Hypertension

Excessive Cardiovascular morbidity/mortality
Progression to End Stage Renal Disease (ESRD)
Vulnerable populations
Gaps in clinical practice
Public health implications
ICD - Pieces: A Pragmatic Clinical Trial in Patients with CKD, Diabetes and Hypertension
ICD-Pieces Study Hypothesis

Patients who receive care with a collaborative model of primary care-subspecialty care enhanced by novel information technology (Pieces) and practice facilitators (PF) will have fewer hospitalizations, readmissions, ER visits, CV events and deaths than patients receiving standard medical care.
# Diverse Participatory Healthcare Systems and EHRs

<table>
<thead>
<tr>
<th>HCS</th>
<th>Description</th>
<th>Location</th>
<th>EHR</th>
</tr>
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<tbody>
<tr>
<td><strong>Parkland</strong></td>
<td>Safety-net public</td>
<td>Dallas County</td>
<td>EPIC</td>
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<tr>
<td><strong>Texas Health Resources</strong></td>
<td>Private non-profit</td>
<td>North Texas</td>
<td>EPIC/All Scripts</td>
</tr>
<tr>
<td><strong>ProHealth</strong></td>
<td>Private non-profit</td>
<td>Connecticut</td>
<td>All Scripts</td>
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<tr>
<td><strong>VA North Texas</strong></td>
<td>Federal</td>
<td>North Texas</td>
<td>CPRS</td>
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What happens in the study?

1. Patients with triad identified
2. Clinicians notified
3. Clinical decision support implemented
4. Monitoring clinical measures → adjustment treatment
5. Electronic ascertainment outcomes
Before You Start: ICD-Pieces and PCT

- CKD, Diabetes and HTN—priorities HCS
- History of working together
- Early discussions: “needs”, “wants”, “coulds”
- Collaborative approach/ design
- Research team facilitates and HCS implements
Health Care System (HCS) Engagement and Embedded PCTs: ICD-Pieces

I. Early Planning

II. Delivery and Learning

III. Maturation and Study Completion
Early Planning

- Select the right question for the right HCS
- Align goals
- Plan together early
- Develop trust
Delivery and Learning

- Maximize use available resources
- Minimize disruptions
- Provide tools and resources to succeed
- Establish ongoing communication and updates
- Adapt to challenges
Maturation and Study Completion

- Create long-lasting value
- Sustain a dynamic system
- Promote dissemination, implementation and sustainability
- Start the process for future projects
Health System Engagement PCTs

Early Planning
- Align Goals
- Plan together
- Develop trust

Delivery
- Minimize disruption
- Provide tools
- Adapt

Completion
- Create value
- D / I / S
- Next project
PPACT - Collaborative Care for Chronic Pain in Primary Care: Engaging Health System Partners

Lynn DeBar, PhD, MPH  
Kaiser Permanente Center for Health Research, Portland OR

Andrew Bertagnolli, PhD | Optum  
Vice President, Behavioral Health Clinical Products  
Formerly: Director - Integrated Behavioral Health Care Management Institute, Kaiser Permanente

Project support by NIH Common Fund and by NINDS through cooperative agreement (UH3NW0088731)
PPACT Overview

AIM: Coordinate and integrate services feasible/sustainable in primary care for helping patients adopt self-management skills to:

- Manage chronic pain
- Limit use of opioid medication
- Identify exacerbating factors amenable to treatment

DESIGN: Cluster (PCP)-randomized PCT (106 clusters, 273 PCPs, 851 patients)

ELIGIBILITY: Chronic pain, long term opioid tx (prioritizing high utilizers of primary care, ≥120 MEQ benzodiazepine use)

INTERVENTION: Behavioral specialist, nurse case manager, PT, and pharmacist team; 12 week core CBT + adapted movement groups

OUTCOMES: Pain (3-item PEG), opioids, pain-related health services, and cost
Many stakeholders no “one size fits all” engagement strategy…

Each KP region includes 3 distinct organizations:
- Permanente Medical Group
- Kaiser Foundation Health Plan
- Kaiser Foundation Hospitals

AMD: Associate Medical Director
Q1  NW  Chief champion for PPACT (VP for Quality) retires; replaced with split position
Q2  G  Primary care liaison/PPACT champion steps down from her position
Q3 
Q4  H  Behavioral health director retires; addiction medicine management reshuffled
Q1  NW+H  NW: Chief of pain medicine resigns; STORM MD takes her place
        H: Chief of addiction medicine/behavioral medicine steps down
Q2 
Q3  NW  New leadership in mental health (both Perm and Health plan)
Q4  KP  OUI group membership reformulated, requiring new PPACT advisory group
Q1 
Q2 
Q3  NW  Chief of internal medicine steps down and new leader in place
Q4 
Q1  NW  Shift in specialty pain clinic leads (Permanente and Health plan)
Q1 2013
Pharmacy implements opioid pill limit

Q1 2014
Regionwide opioid taper initiative - letters sent to pain patients < 120 MED

Q1 2015
Regionwide opioid taper initiative - letters sent to pain patients < 90 MED

Q1 2016
Benzo reduction initiative for COT patients rolled out
Physiatry-led comprehensive Back Pain clinic rollout

Pain One Stop: Triage process for Pain Clinic & STORM

Comprehensive outer-island pain assessment initiative

Spine center of excellence rollout

Nurse-led initiative PEG assessment calls to patients on COT as PCP burden offload

Hiring of two primary care-based behavioral health consultants for pain-specific initiative in response to Medicaid LBP service change
Complex conditions primary care clinic initiative rollout

Behavioral health integration into primary care
KPGA loses state contract, reducing nurses staffing PCMH in each primary clinic to 20%.

Health plan restructured under KPSC leadership, affecting PPACT clinical stakeholders.

Significant shift in retirement medical benefits in 2017; vast wave of retirements.
Key Learnings from PPACT and integration of broader KP Behavioral Health Initiatives re: engagement

#1 Stakeholder involvement: early, often, continuously and at multiple levels of the partnering organization (everything is dynamic)

#2 Compensate for the “ask”: work to create early and useful products that support/ease clinical work in the delivery system

#3 Carefully consider “fit” of core intervention approach for frontline clinical staff and congruence with the organization’s quality improvement approaches
PROVEN

PRagmatic Trial of Video Education in Nursing Homes

Susan L. Mitchell, MD, MPH
Vincent Mor, PhD
Angelo Volandes, MD, MPH

UH3AG049619

NIH Collaboratory Steering Committee Meeting
Panel: Health System Engagement: Partnership, Relationships and Transparency
May 24, 2017 – 10:30 am – 12:00 pm
PROVEN: Overview

- **Objective**: To conduct a pragmatic cluster RCT of an Advance Care Planning video intervention in NH patients with advanced comorbid conditions in two healthcare systems

- **Intervention NHs**: Suite of 5 videos to be offered facility-wide: All new admissions, care-planning meetings for long-stay and readmissions
  - Flexible: Who, how (tablet or web), which video
  - Training: corporate level, webinars, toolkit

- **Control NHs**: Usual ACP practices

- **Primary outcome**: Number of hospitalizations/person-days alive among patients \(\geq 65\) years old who are in a NH \(\geq 90\) days ("long-stay") and who have EITHER advanced dementia OR advanced congestive heart failure/chronic obstructive lung disease

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*NIH Collaboratory Steering Committee Meeting*
*Panel: Health System Engagement: Partnership, Relationships and Transparency*
*May 24, 2017*
PROVEN: Implementation

• **Sample:** 359 facilities total (across two partners)
  – 119 facilities randomized to intervention
    • Rolled out over 4 months/waves
  – 240 facilities randomized to control (2:1)

• **Compliance:**

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<thead>
<tr>
<th></th>
<th>Partner 1</th>
<th>Partner 2</th>
<th>Total</th>
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<tbody>
<tr>
<td>Admissions (MDS from partners)</td>
<td>3782</td>
<td>21665</td>
<td>25447</td>
</tr>
<tr>
<td>Videos offered</td>
<td>2014</td>
<td>16788</td>
<td>18802</td>
</tr>
<tr>
<td>Videos shown</td>
<td>1345</td>
<td>3402</td>
<td>4747</td>
</tr>
<tr>
<td>Residents EVER* long-stay</td>
<td>2499</td>
<td>10308</td>
<td>12807</td>
</tr>
<tr>
<td>Video EVER* offered</td>
<td>869</td>
<td>4153</td>
<td>5022</td>
</tr>
<tr>
<td>Video EVER* shown</td>
<td>511</td>
<td>872</td>
<td>1383</td>
</tr>
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*Since the start of the ACP Video Program

Run with MDS and Video Status Report User Defined Assessment data through March 2017

NIH Collaboratory Steering Committee Meeting
Panel: Health System Engagement: Partnership, Relationships and Transparency
May 24, 2017
PROVEN: Health Systems Engagement

• Trust
  – Partners are willing to engage with us because of our reputation

• Shared goals
  – Must be important to the partner and offer possible solution to a systemic problem
    • Reducing hospitalizations
    • Advance care planning needs to be done anyway

• Joint planning
  – Must be a “good fit” and be integrated into standard operating procedures

• Learning from shared experiences
  – Ongoing communication / transparent reporting about implementation and participation
  – When increased effort or changes are needed, our partners agree
Genesis Overview

**Genesis HealthCare** is now one of the largest providers of post-acute care services in the nation.

**Publicly Traded**
Ticker: GEN

- ~80,000 dedicated teammates
- ~60,000 beds

**Average Occupancy**
88.1% over the last 3 years

**Competitive Strengths**
- More than 450 facilities across 30 states
- More than 200 clinical specialty units.
- More than 425 Genesis physicians and nurse practitioners.
- Strong referral network with hospitals.
- Genesis also supplies contract rehabilitation services to approx. 1,700 locations across 45 states.
Operating With Geographic Scale and Scope

- Geographic density = operating efficiencies, strong hospital relations & coordinated sales/marketing strategies
- Geographic diversity reduces regulatory risk

- More than 450 SNF and ALF facilities across 30 states
- Top 5 states by licensed beds:
  - PA: 10.6%
  - NJ: 11.5%
  - MD: 7.6%
  - CA: 7.0%
  - MA: 7.1%
Genesis Rationale for Engagement in PROVEN:

Seeking increase in horizontal partnerships with hospitals to reduce unnecessary readmissions

Genesis’ commitment to innovation in delivery of quality care.

Interest in improving advance care planning to align family and patient/resident goals with patient care plans.

Genesis physician/nurse practitioner practice designated as accountable care organization, driving need to improve care in all aspects secondary to valued based payment models/shared savings programs.
Barriers Impeding Implementation:

Staff turnover, especially in leadership positions who serve to support the study.

Time constraints and workflow challenges with chronically understaffed centers.

Lack of appreciation for advance care planning as an ongoing activity versus reliance on management of required advance care planning forms.
Partnership with researchers/primary investigators:

Consistent support, communication, and collaboration in internal data collections.

Frequent and routine conference calls allowing for free flow of discussion regarding overcoming barriers.

Flexibility in study design allowing for required changes/innovations in keeping staff involved in adhering to study components.

Helpful recognition of challenges in the long term/post acute care environment which differ in reason and scope from acute care.
Questions and Answers

Please submit questions for the panelists to:
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