Advisory Panel on Improving Healthcare Systems

March 31, 2017
8:30 a.m. – 4:00 p.m. EST
Housekeeping

• Webinar is available to the public
• Members of the public are invited to listen to this teleconference and view the webinar
• Anyone may submit a comment through the webinar chat function, although no public comment period is scheduled
• Visit www.pcori.org/events for more information
• Chair Statement on COI and Confidentiality
Welcome & Introductions

Steve Clauser, PhD, MPA
Director, Healthcare Delivery and Disparities Research
IHS Advisory Panel Leadership

• Michael Dueñas, OD
  • IHS Advisory Panel Chair

• Timothy Daaleman, DO, MPH
  • IHS Advisory Panel Co-Chair
IHS Advisory Panel Members

- Rebecca Aslakson, MD, PhD
  Associate Professor, Johns Hopkins School of Medicine
- Leah Backhus, MD, MPH
  Associate Professor, Veterans Affairs and Stanford University
- Ignatius Bau, JD
- Jim Bellows, PhD, MPH
  Senior Director, Care Management Institute, Kaiser Permanente
- David Bruhn, PharmD, MBA
  Health Outcomes Liaison, National Accounts, GlaxoSmithKline
- Bonnie Clipper, DNP, RN, MA, MBA, FACHE, CENP
  Chief Clinical Officer, Cornerstone Hospital of Austin
- Timothy Daaleman, DO, MPH
  Professor of Family Medicine, University of North Carolina at Chapel Hill School of Medicine
- Michael Dueñas, OD
  Chief Public Health Officer, American Optometric Association
- Lisa Freeman, BA
  Independent Patient Safety Advocate and Consultant
- John Galdo, PharmD, BCPS*
  Clinical Pharmacy Educator, Barney’s Pharmacy
- Ravi Govila, MD*
  Vice President, Medical Management and PPO, Blue Cross Blue Shield of Michigan
- Joan Leon, BA
  Retired Health Consultant
- James Perrin, MD
  Professor of Pediatrics, Harvard Medical School and Pediatrician, Massachusetts General Hospital Physician Organization
- Carolyn Petersen, MS, MBI
  Senior Editor, MayoClinic.org
- Alexis Snyder, BA
  Independent Contractor, Patient Family Advisor
- Jamie Sullivan, MPH
  Director of Public Policy, COPD Foundation
- Craig Umscheid, MD, MS*
  Associate Professor of Medicine and Epidemiology, University of Pennsylvania Perelman School of Medicine
- Mitzi Wasik, PharmD
  Medical Stars Business Lead, Aetna
- Nancy Yedlin, MPH
  Vice President, Donaghue Foundation
Guests

• Cheryl Pegus, MD, MPH*
  • Addressing Disparities Advisory Panel Chair

• Elizabeth Jacobs, MD, MAPP, FACP
  • Addressing Disparities Advisory Panel Co-Chair

• Ray Dorsey, MD, MBA
  University of Rochester
  • PCORI Funded Investigator
Improving Healthcare Systems Program Staff

Steven Clauser, PhD, MPA
  Director
Els Houtsman, PhD
  Associate Director
Neeraj Arora, PhD
  Associate Director
Carly Parry, PhD, MSW
  Sr. Program Officer
Penny Mohr, MA
  Sr. Program Officer
Beth Kosiak, PhD
  Program Officer
Gyasi Moscou-Jackson, PhD
  Program Officer
Jeanne Murphy, PhD, CNM
  Program Officer
Andrea Brandau, MPP
  Program Officer
Stephanie Parver, MPH
  Program Associate
Anum Lakhia, MPH
  Program Associate
Jamie Trotter
  Program Associate
Sindhura Gummi, MPH
  Program Associate
Hannah Kampmeyer
  Senior Admin Assistant
Aaron Shifreen
  Program Assistant
Allie Olender
  Program Assistant
Anushka Sindkar
  Intern
Agenda and Logistics for this Meeting

Steve Clauser, PhD, MPA
Director, Healthcare Delivery and Disparities Research
Overview of PCORI

PCORI’s MISSION
PCORI helps people make informed health care decisions, and improves health care delivery and outcomes, by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers and the broader health care community.

Assessment of Prevention, Diagnosis, and Treatment Options

Improving Healthcare Systems

Communication & Dissemination Research

Addressing Disparities Goal Statement
To support comparative effectiveness research that will identify best options for reducing and eliminating disparities.

Accelerating PCOR and Methodological Research
Healthcare Delivery and Disparities Research (HDDR)

**Healthcare Delivery and Disparities Research**

- Number of projects: **164**
- Amount awarded: **$568 million**
- Number of states represented: **28 (plus DC)**

- **Improving Healthcare Systems (IHS)**
  - Number of Projects: **92**
  - Amount Awarded: **$371 million**

- **Addressing Disparities (AD)**
  - Number of Projects: **72**
  - Amount Awarded: **$197 million**
HDDR: Defined

**Medicare reimbursement, Federal health reform, Accreditations, etc.**

**Medicaid reimbursement, Hospital performance data, etc.**

**Caregivers, friends, network support, social media, etc.**

**Socio-demographics, insurance coverage, comorbidities, patient care preferences, behavioral factors, cultural perspectives, etc.**

**Community-based resources, local hospital services, local professional norms, churches etc.**

**Organizational leadership, Delivery system design, Clinical decision support, etc.**

**Communication barriers, cultural competency, staffing mix, team culture, role definition, bias/prejudice, etc.**

**Disparities**

Figure adapted from: Taplin, SH; Clasuer, S., et al. (2012). Introduction: Understanding and Influencing Multilevel Factors across the Cancer Care Continuum. Journal of the National Cancer Institute, 44, 2-10.
## IHS Studies Comparing Interventions by System Level

<table>
<thead>
<tr>
<th>System Level</th>
<th>Examples of Comparisons in the IHS Portfolio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Patient</td>
<td>Compares the use of an electronic asthma medication tracker to standard primary care (no tracker) for children with asthma and their parents and caregivers to improve quality of life, among other patient-centered outcomes.</td>
</tr>
<tr>
<td>Family and Social Supports</td>
<td>Compares the use of advance planning tools for access to community-based and in-home services for the frail elderly and their caregivers to an electronic educational intervention of available services and programs. Measures understanding and knowledge outcomes.</td>
</tr>
<tr>
<td>Provider/Team</td>
<td>Compares nursing home staff team-based training and palliative care delivery using an adapted NQF protocol to a standard nursing home palliative care protocol to improve EOL outcomes, such as pain, shortness of breath, in-hospital deaths, hospitalizations, and presence of advance directive.</td>
</tr>
<tr>
<td>Organization and/or Practice Setting</td>
<td>Compares elements of patient-centered medical home (e.g., addition of a PCP in the context of regularly scheduled dialysis sessions and health promoters to help support patients and their caregivers) to traditional team-based specialty care for end-stage renal disease patients to improve utilization, quality of life and caregiver burden outcomes.</td>
</tr>
<tr>
<td>Local Community Environment</td>
<td>Compares an ED-to-home community health worker that links patients with community-based social-support (e.g., home-delivered meals) and medical follow-up, to care transition programs using written and verbal discharge instructions alone to improve utilization and quality of life outcomes.</td>
</tr>
</tbody>
</table>
Addressing Disparities Framework

**Barriers**
- Personal/Family
  - Acceptability
  - Cultural
  - Language/literacy
  - Attitudes, beliefs
  - Preferences
  - Involvement in care
  - Health behavior
  - Education/income
- Structural
  - Availability of appointments
  - How organized
  - Transportation
- Financial
  - Insurance coverage
  - Reimbursement levels
  - Public support

**Use of Services**
- Visits
  - Primary care
  - Specialty
  - Emergency
- Procedures
  - Preventative
  - Diagnosis
  - Therapeutic

**Mediators**
- Quality of Providers
  - Culture competence
  - Communication skills
  - Medical knowledge
  - Technical skills
- Appropriateness of care
- Efficacy of treatment
- Patient adherence

**Outcomes**
- Health Status
  - Mortality
  - Morbidity
  - Well-being
  - Functioning
- Equity of Services
- Patient Views of Care
  - Experiences
  - Satisfaction
  - Effective partnership

*Modified from Lisa A. Cooper: Barriers to and mediators of equitable health care for racial and ethnic groups*
AD Driver Model

Tertiary Drivers
- Self-Management 40
- Community Health Workers 28
- Cultural/Language Tailoring 35
- Decision Support 15
- Team-Based Care 13
- Family/Caregiver Involvement 12
- Social Support 10
- Developmental 5

Secondary Drivers
- Training/Education 53
- Patient Empowerment 40
- Access to Care 38
- Workforce 33
- Technology 29
- Community/Home Environment 24

Primary Drivers
- Policy 1
- Organizational 17
- Point of Care/Communication 64

Reduce/Eliminate Disparities in Health and Health Care Outcomes

*Categories are not mutually-exclusive. There can be a maximum of 67 projects in each category.
HDDR: Strategic Framework

Patient and Stakeholder Engagement Throughout

Intervention Targets:
- **Technology** (e.g., interoperative EHR, telemedicine, social media)
- **Novel deployment of personnel** (e.g., nurse navigators, community health workers, home-care physicians, health care teams)
- **Creative uses of incentives** (e.g., free or subsidized preventive care, cost-sharing, patient incentives)
- **Organizational Policies**: (e.g. standing orders, policies)
- **Cultural tailoring**: (family involvement, language)

Improve Practice:
- Quality
- Coordination
- Efficiency
- Patient and Caregiver Involvement
- Access
- Equity

Improve Outcomes that Matter to Patients:
- Clinical Outcomes
- Functional Status
- Health-Related Quality of Life
- Symptoms
- Survival
# New IHS Projects – Awarded Dec. 2016

<table>
<thead>
<tr>
<th>Project Title</th>
<th>PI Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanding Access to Home-based Palliative Care through Primary Care Medical Groups</td>
<td>Susan Enguidanos, PhD, MPH</td>
<td>University of Southern California</td>
</tr>
<tr>
<td>Comparing Patient-Centered Outcomes for Adults and Children with Asthma in High-Deductible Health Plans with and without Preventive Drug Lists</td>
<td>Alison Galbraith, MD, MPH</td>
<td>Harvard Pilgrim Health Care, Inc.</td>
</tr>
<tr>
<td>Ambulatory Cancer Care Electronic Symptom Self-Reporting (ACCESS) for Surgical Patients</td>
<td>Andrea Pusic, MD, MS</td>
<td>Memorial Sloan Kettering Cancer Center</td>
</tr>
<tr>
<td>Improving Patient-Centered Communication in Primary Care: A Cluster Randomized Controlled Trial of the Comparative Effectiveness of Three Interventions</td>
<td>Ming Tai-Seale, PhD, MPA</td>
<td>Palo Alto Medical Foundation Research Institute</td>
</tr>
</tbody>
</table>
# New AD Projects – Awarded Dec. 2016

<table>
<thead>
<tr>
<th>Project Title</th>
<th>PI Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Outcomes for Low-Income Mothers with Depression: A Comparative Effectiveness Trial of Two Brief Interventions in the Patient-Centered Medical Home</td>
<td>Michael Silverstein, MD, MPH</td>
<td>Boston Medical Center</td>
</tr>
<tr>
<td>Comparative Effectiveness of Diabetes Prevention Programs</td>
<td>Pearl McElfish, PhD, MS, MBA</td>
<td>University of Arkansas for Medical Sciences</td>
</tr>
<tr>
<td>A Randomized-Controlled Trial to Compare the Reach, Effectiveness, and Maintenance of Two Family-Based Childhood Obesity Treatment Programs in a Medically Underserved Region</td>
<td>Jamie Zoellner, PhD</td>
<td>Virginia Polytechnic Institute and State University</td>
</tr>
</tbody>
</table>
New PCS Projects – Awarded March 2017

<table>
<thead>
<tr>
<th>Project Title</th>
<th>PI Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Simple Large Trial of Patient-Centered Care for Opioid Use Disorders in Federally Qualified Healthcare Centers and Specialty Care Settings</strong></td>
<td>David Gastfriend, MD</td>
<td>Treatment Research Institute</td>
</tr>
<tr>
<td><strong>Improving Transition from Acute to Post-Acute Care following Traumatic Brain Injury</strong></td>
<td>Jeanne Hoffman, PhD</td>
<td>University of Washington</td>
</tr>
</tbody>
</table>

* Priority topic endorsed by IHS Advisory Panel
HDDR Portfolio by Funding Mechanism

- 164 Projects; ~$568 million funding; 28 States, plus D.C.

<table>
<thead>
<tr>
<th>Funding Mechanism</th>
<th>N of IHS Projects</th>
<th>IHS Funding</th>
<th>N of AD Projects</th>
<th>AD Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad</td>
<td>78</td>
<td>$209 million</td>
<td>58</td>
<td>$107 million</td>
</tr>
<tr>
<td>Pragmatic</td>
<td>7</td>
<td>$90 million</td>
<td>2</td>
<td>$25 million</td>
</tr>
<tr>
<td>Targeted</td>
<td>4</td>
<td>$65 million</td>
<td>12</td>
<td>$65 million</td>
</tr>
<tr>
<td>Natural Experiments</td>
<td>3</td>
<td>$7 million</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
<td>$371 million</td>
<td>72</td>
<td>$197 million</td>
</tr>
</tbody>
</table>

- **Broad**: Both small ($1.5M, 3 year) and large ($5M, 5 year) investigator-initiated studies; 2 cycles per year; competitive LOIs

- **Pragmatic**: $10M, 5 year head-to-head comparisons in large, representative study populations and settings; PCORI, IOM, and AHRQ CER priorities; 2 cycles per year

- **Targeted**: Stakeholder driven priorities with the greatest specificity in research requirements; range from $5M - $30M; often collaborations with other funding organizations.
The HDDR funded portfolio addresses multiple phases of the healthcare continuum, ranging from prevention, screening, and various phases of treatment, to survivorship and end of life.
IHS & AD Portfolios by Study Population (as of 3/2017)

% of Projects in Portfolio

- Racial/Ethnic Minorities: 76% IHS, 76% AD
- Low Income: 85% IHS, 57% AD
- Older Adults: 37% IHS, 22% AD
- Multiple Chronic Conditions: 32% IHS, 22% AD
- Women: 28% IHS, 21% AD
- Low Health Literacy/Numeracy: 28% IHS, 22% AD
- Children: 38% IHS, 19% AD
- Individuals with Disabilities: 14% IHS, 6% AD
- Veterans: 14% IHS, 6% AD
- LGBT: 1% IHS, 3% AD
- Rare Disease: 1% IHS, 1% AD

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE
IHS & AD Portfolios by Disease Focus (as of 3/2017)

Number of Projects by Disease Focus

Number of Projects

- Mental/Behavioral Health
- Nutritional and Metabolic Disorders
- Cancer
- Cardiovascular Diseases
- Neurological Disorders
- Respiratory Diseases
- Functional Limitations and Disabilities
- Trauma/Injury
- Infectious Diseases
- Kidney Disease
- Reproductive and Perinatal Health
- Muscular and Skeletal Disorders
- Rare Disease

Improving Healthcare Systems
Addressing Disparities
HDDR Portfolio by Primary Disease Focus

164 PROJECTS

- 35 Mental/Behavioral Health
- 19 Nutritional and Metabolic Disorders
- 16 Respiratory Diseases
- 15 Cancer
- 13 Cardiovascular Health
- 12 Neurological Disorders
- 11 Multiple/Co-Morbid Chronic Conditions
- 5 Trauma/Injury
- 4 Reproductive and Perinatal Health
- 3 Kidney Disease
- 3 Infectious Diseases
- 2 Functional Limitations and Disabilities
- 2 Liver Disease
- 1 Rare Diseases
- 1 Skin Diseases
- 22 Other

As of March 2017
HDDR Portfolio by Study Design (as of 3/2017)

N= 164

- RCTs, 131
- Observational, 27
- Quasi-experimental, 5
- Pre-post Interrupted Time Series, 1
HDDR Portfolio: Pragmatic Clinical Studies

IHS has funded 7 PCS studies thus far:

1. “Integrating Behavioral Health and Primary Care” – PI: Benjamin Littenberg, MD at University of Vermont and State Agricultural College *Integration of Mental Health and Primary Care Topic Prioritized April 2013*

2. “Early Supported Discharge for Improving Functional Outcomes After Stroke” – PI: Pamela Duncan, PhD, PT at Wake Forest University *Transitional Care Topic Prioritized April 2013*

3. “A Pragmatic Trial to Improve Colony Stimulating Factor Use in Cancer” – PI: Scott Ramsey, MD, PhD at Fred Hutchinson Cancer Research Center

4. “Integrating Patient-Centered Exercise Coaching into Primary Care to Reduce Fragility Fracture” – PI: Christopher Sciamanna, MD at Penn State U Hershey Medical Center

5. “Dissemination of Effective Smoking Cessation Treatment to Smokers with Serious Mental Illness” – PI: Eden Evins, MD, MPH at Massachusetts General Hospital

6. “A Simple Large Trial of Patient-Centered Care for Opioid Use Disorders in Federally Qualified Healthcare Centers and Specialty Care Settings” – PI: David Gastfriend, MD at Treatment Research Institute

7. “Improving Transition from Acute to Post-Acute Care following Traumatic Brain Injury” – PI: Jeanne Hoffman, PhD at University of Washington
# HDDR Portfolio: Pragmatic Clinical Studies

<table>
<thead>
<tr>
<th>PCS Priority Topics – IHS, Cycle 1 2017</th>
<th>Date Prioritized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatments for mild to moderate depression and anxiety</td>
<td>April 2013</td>
</tr>
<tr>
<td>Support services for infants and families/caregivers after discharge from the NICU</td>
<td>January 2015</td>
</tr>
<tr>
<td>Preventing dental caries in children in medically underserved areas</td>
<td>January 2015</td>
</tr>
<tr>
<td>Management of patients suffering from chronic, non-cancer pain</td>
<td>May 2014</td>
</tr>
<tr>
<td>Integrating pharmacists or pharmacy services into patient care</td>
<td>January 2015</td>
</tr>
<tr>
<td>Minimizing suicidality among adolescents</td>
<td>January 2015</td>
</tr>
<tr>
<td>Multidisciplinary rehab for Traumatic Brain Injuries</td>
<td>January 2015</td>
</tr>
<tr>
<td>Screening, brief intervention, and referral to treatment for adolescent alcohol abuse</td>
<td>November 2015</td>
</tr>
</tbody>
</table>
AD has funded 2 PCS studies thus far:

1. “Integrated Versus Referral Care for Complex Psychiatric Disorders in Rural FQHCs” – PI: John Fortney, PhD at University of Washington

2. “Patient Empowered Strategy to Reduce Asthma Morbidity in Highly Impacted Populations (PESRAMHIP)” – PI: Elliot Israel, MD at Brigham and Women’s Hospital

### PCS Priority Topics – AD, Cycle 1 2017

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date Prioritized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multicomponent interventions to reduce initiation of tobacco and promote cessation of tobacco use among high-risk populations with known disparities</td>
<td>April 2014</td>
</tr>
<tr>
<td>Integration of mental and behavioral health services into the primary care of persons at risk for disparities in health care and outcomes</td>
<td>January 2014</td>
</tr>
<tr>
<td>Improving outcomes in mothers and babies at risk for disparities by comparing evidence-based models of perinatal care</td>
<td>April 2013</td>
</tr>
<tr>
<td>Clinical interventions to reduce non-traumatic lower extremity amputations in racial or ethnic minorities and low-income populations with diabetes</td>
<td>April 2013</td>
</tr>
</tbody>
</table>
# HDDR Portfolio: Targeted Funding

<table>
<thead>
<tr>
<th>Funded Targeted Topics - IHS</th>
<th>Total Funding Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRIDE / Falls Injury Prevention (Administered by NIA)</td>
<td>$30 million</td>
</tr>
<tr>
<td>Effectiveness of Transitional Care* (Project ACHIEVE)</td>
<td>$15.5 million</td>
</tr>
<tr>
<td>Managing Anti-Viral Therapy for Hepatitis C infected persons who inject drugs</td>
<td>$14 million</td>
</tr>
<tr>
<td>Treatment for Multiple Sclerosis</td>
<td>$6 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Topics In Progress - IHS</th>
<th>Total Funding Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Sclerosis</td>
<td>$10 million (IHS question)</td>
</tr>
<tr>
<td>Palliative Care*</td>
<td>$48 million</td>
</tr>
<tr>
<td>Preventing Opioid Misuse in Pain Management*</td>
<td>$30 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Topics In Progress - AD</th>
<th>Total Funding Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of care transitions for emerging adults with Sickle Cell</td>
<td>$25 million</td>
</tr>
</tbody>
</table>

* Topics prioritized by the IHS Advisory Panel
<table>
<thead>
<tr>
<th>Funded Targeted Studies</th>
<th>Total Funding Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative Effectiveness of Health System vs. Multi-level Interventions to Reduce Hypertension Disparities</td>
<td>$12 million</td>
</tr>
<tr>
<td>Collaboration to Improve Blood Pressure in the US Black Belt-Addressing the Triple Threat</td>
<td>$9.5 million</td>
</tr>
<tr>
<td>The Louisiana Trial to Reduce Obesity in Primary Care</td>
<td>$10 million</td>
</tr>
<tr>
<td>Midwestern Collaborative for Treating Obesity in Rural Primary Care</td>
<td>$10 million</td>
</tr>
<tr>
<td>Using Information Technology to Improve Access, Communication and Asthma in African American and Hispanic /Latino Adults</td>
<td>$2 million</td>
</tr>
<tr>
<td>Improving Asthma Outcomes Through Stress Management</td>
<td>$2 million</td>
</tr>
<tr>
<td>The Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes (CHICAGO) Trial</td>
<td>$4 million</td>
</tr>
<tr>
<td>Imperial County Asthma Comparative Effectiveness Research Project</td>
<td>$4 million</td>
</tr>
<tr>
<td>Clinic-Based vs. Home-Based Support to Improve Care and Outcomes for Older Asthmatics</td>
<td>$3 million</td>
</tr>
<tr>
<td>The Houston Home-based Integrated Intervention Targeting Better Asthma Control (HIIT-BAC) for African Americans</td>
<td>$2 million</td>
</tr>
<tr>
<td>Guidelines to Practice (G2P): Reducing Asthma Health Disparities through Guideline Implementation</td>
<td>$3 million</td>
</tr>
<tr>
<td>Preference and Effectiveness of Symptom-Based Adjustment of Inhaled Corticosteroid Therapy in African American Children</td>
<td>$2 million</td>
</tr>
</tbody>
</table>
The IHS Portfolio: Natural Experiments Network

First IHS Collaboration with PCORnet

• 3 Natural Experiments Network Projects:

1. “The Impact of Medicaid Health Homes on patients with diabetes” – What is the comparative effectiveness of the Medicaid Health Home (HH) program to treatment as usual in reducing unnecessary hospitalizations and other health disparities for Medicaid patients with diabetes? ($2,250,000)

2. “A Patient-Centered PaTH to Addressing Diabetes: Impact of State Health Policies on Diabetes Outcomes and Disparities” – What is the effectiveness of diabetes education and counseling in improving weight loss for adults either with or at high risk of type 2 diabetes? ($2,249,522)

3. “Natural Experiments of the Impact of Population-targeted Health Policies to Prevent Diabetes and its Complications” – What is the comparative effectiveness of non-face-to-face care coordination services versus treatment as usual on diabetes outcomes for adults with type 2 diabetes and at least one other chronic condition? ($2,249,676)

The Natural Experiments Network is a multi-center network intended to:

• Test the comparative health impact of naturally occurring interventions
• Improve the methods and research infrastructure for natural experiments for clinical comparative effectiveness in public health
Topics Discussed at Last Meeting

• Medication Assisted Treatment for Opioid Use Disorder
• Care Models for High-Cost High-Need Patients
• Preventing Dental Caries in Children
• Pharmacy Services Integration into Patient Care
HDDR Portfolio: Concluding Thoughts

- We continue to develop a diverse, patient-centered portfolio.
  - All studies feature novel comparators or well-defined usual care practices, and aim to address decision dilemmas faced by patients, caregivers, clinicians, and/or healthcare system leaders.
  - Research questions are based on real-world problems faced by patients as they access care in various settings.
  - We strive to address evidence gaps in the treatment of varied diseases, populations, levels of the healthcare system, and phases in the care continuum.
  - All studies undergo a rigorous vetting of the methods and analysis to be used.
  - Engagement of patients, caregivers and other stakeholders throughout the research process is an integral element of all funded studies, which we believe is essential for real-world applicability and sustainability.

Where do you see gaps and opportunities?
Morning Break
Awardee Presentation: *Using Technology to Deliver Multi-Disciplinary Care to Individuals with Parkinson’s Disease in Their Homes*

Ray Dorsey, MD, MBA
University of Rochester
Training the Next Generation of PCOR Professionals to Lead Research Within Learning Health Systems

Carly Parry, PhD, MSW

Adapted from PCORI Board of Governor’s meeting on January 24, 2017
Proposed PCORI-AHRQ Program for Training Researchers Based in Learning Health Systems

• PCORI would provide total of $30M to support up to 8 institutional training programs, each with multiple trainees over 5 years – some housed within or affiliated with PCORnet sites – administered by AHRQ through K12 traineeship mechanism

• PCORI contribution would be a major component of AHRQ’s new, national multi-pronged approach to training LHS researchers:
  • LHS training within AHRQ’s traditional NRSA training program

• Applicants may be academic institutions OR healthcare delivery systems with track records in systems-based research

• Target candidates include doctoral, post-doctoral scholars as well as masters level staff in leadership roles at participating health systems

• Program will combine didactic and experiential learning opportunities within research projects to ensure core competencies are mastered

• Affiliation with PCORnet mentioned as attractive feature, but not in any way required
Research in the Learning Health System

- Concept of researchers embedded within Learning Health Systems promoted by IOM beginning in 2012 and greatly advanced in PCORnet-IOM meetings with CEOs – 2014 and 2016
- Science, informatics, incentives, and culture are now aligned to make this feasible and necessary
- In-system experiences can generate new generalizable knowledge by systematically capturing and analyzing longitudinal data from the care experience
- Best practices can be identified from in-system research as well as external sources and embedded into care processes via HER and into system culture and program to improve outcomes
- Patients, families, and clinicians expected to be active participants in all elements of the research and training program
Training A New Type of Health Services Researcher for the LHS

• **Current Training Models:** Support skills development in knowledge generation by not the additional skills or experience necessary to work and succeed within LHSs

• **Concept:** To embed and train new researchers at the interface of research, informatics and clinical operations within PCORnet and other learning health systems

• **Core Competencies:** To construct and implement training for a set of core competencies to guide the development of training programs for learning health systems researchers
Draft Core Competencies

• **Domain 1: Systems Science:** *systems theory, how systems operate*

• **Domain 2: Research Questions and Standards of Scientific Evidence:** *Asking meaningful questions and evaluating scientific evidence*

• **Domain 3: Research Methods**

• **Domain 4: Informatics:** *using IT systems to improve patient and system outcomes*

• **Domain 5: Ethics of Research and Implementation in Health Systems:** *Ensuring that research done in health care settings adheres to the highest ethical standards*

• **Domain 6: Improvement and Implementation Science:** *Reducing inappropriate variation in outcomes; ensuring systematic uptake of research findings*

• **Domain 7: Engagement, Leadership, and Research Management:** *Engaging patients, clinicians and others in all aspects of the research process*
Program Specifications

• Encourage applications from PCORnet academic institutions and/or delivery systems as training programs or partnered sites
• Require strong coordinated infrastructure at each institution to support a combination of didactic and experiential training
• Demonstrate a focus on conducting PCOR that is relevant to host health systems and that can be rapidly implemented to improve quality of care and patient outcomes
• Include research projects designed with LHS partners and conducted within LHSs with system data
• Include training and hands-on experience working with health systems data and informatics
Program Specifications, continued

- Must focus on AHRQ-sponsored LHS training competencies or identify competencies their program will deploy, with justification

- Include evidence of support from host institutions and systems (direct or in-kind) and a long-term commitment to trainees

- Applicants should recruit trainees from other health systems thereby ensuring no more than 50% of trainees can come from the applicant institution
Recommendation for PCORI

- PCORI funding would support up to 8 institutional sites
- Anticipate 5-8 trainees per site over 5 years
  - Training duration 2-3 years
- Total of $6 million/year for 5 years = $30M
- Funding mechanism: MOU with AHRQ for K12
- PCORI would participate in the review process
- Board approval granted in January 2017 to support awards to begin summer of 2017
Benefits of this Joint Activity

• This funding announcement and partnership makes a clear statement that PCORI considers system-based research to be an essential, novel aspect of PCOR in the future

• It signals PCORI’s interests and concerns for workforce training and supporting young investigators and helps to augment funding in the area of workforce training

• It builds on AHRQ’s successful track-record in the area of workforce training and aligns our legislative mandate to contract with AHRQ when appropriate

• It has the potential to strengthen PCORnet by creating a cadre of young scientists familiar with PCORnet, the Common Data Model

• It provides a further incentive for health systems to value and work with PCORnet and PCORI
Questions?
Lunch Break

Meeting will resume at 1:00 p.m. EST
Topic Presentation:
*Pharmacy Services Integration Into Patient Care*

David Bruhn, PharmD, MBA
Mitzi Wasik, PharmD, BCPS
Penny Mohr, MA
Compare the effectiveness of various strategies to better integrate pharmacists or pharmacy services in patient care on patient-centered outcomes (e.g., reduction in inappropriate medication use and polypharmacy, access to preventive vaccines (influenza, pneumonia), reduction in adverse events and hospital re-admissions, improved disease- or condition specific outcomes).
Refinement Process

- Subcommittee of the Improving Healthcare Systems Advisory Panel
  - David Bruhn, Mitzi Wasik, Jake Galdo

- Interviews with Key Informants
  - Academy of Managed Care Pharmacy
  - American Pharmacists Association
  - Pharmaceutical Care Management Association
  - Pharmacy Quality Alliance

- PCORI staff review of systematic reviews and recent literature
  - Stephanie Parver
  - Anushka Sindkar
  - Penny Mohr

Findings presented today are preliminary
Research Questions

**Question 1**: What are the comparative benefits and risks of different models of *Medication Therapy Management* in elderly patients with chronic disease (such as diabetes, COPD, CHF, or hypertension) to reduce negative clinical outcomes, and improve resource utilization, patient satisfaction/QOL, and medication concordance? In what types of patients is MTM most effective?

**Question 2**: What are the comparative benefits and risks of different models of *integrating pharmacists into the care transitions* team in order to reduce adverse drug events, improve patient-centered outcomes and lower preventable emergency department visits and re-hospitalizations post hospital discharge among patients with multiple chronic co-morbidities?

**Question 3**: What are the comparative benefits and risks of *using pharmacists to screen for substance use disorder and/or dispense naloxone* for patients who are opioid dependent SUD versus primary care physicians (usual care?)
What are the comparative benefits and risks of different models of Medication Therapy Management (MTM)* in elderly patients with chronic disease (such as diabetes, COPD, CHF, or hypertension) to reduce negative clinical outcomes, and improve resource utilization, patient satisfaction/QOL, and medication concordance? In what types of patients is MTM most effective?

*Defined as “...a distinct service or group of services that optimize therapeutic outcomes for individual patients.” It includes five core elements: medication therapy review, personal medication record, a medication related action plan, intervention and/or referral, and documentation and follow-up (Blum 2005)
There is significant harm associated with medication errors, polypharmacy and lack of concordance with prescribed therapies:

- Elderly patients are particularly susceptible to medication problems due to polypharmacy. In 2002, more than half of people aged 65+ were taking 5 or more medications, and 20% were taking 10 or more (Kaufman et al. 2002)

- Significant costs could be avoided by addressing issues related to inappropriate pharmaceutical use (IMS Institute for Healthcare Informatics, 2013):
  - Lack of concordance ($105.4 billion)
  - Medication errors ($20 billion)
  - Mismanaged poly pharmacy ($1.3 billion)

There is stakeholder interest. Recommended as a priority topic by the Academy of Managed Care Pharmacy and at a 2016 PCORI Pharmacy Benefit Roundtable. Also of interest to American Pharmacists Association, Pharmacy Quality Alliance, and Pharmaceutical Care Management Association.
What is the evidence gap?

MTM is in widespread use in the Medicare population, but there is a lack of evidence about which models are most effective, and little is known about which populations would benefit most.

MTM studies are hindered by poor methodology, the heterogeneity of study populations and the variation in the strategies studied (Viswanathan 2015).

As most MTM research has been conducted in the private insurance setting, there is a need to assess the benefit of MTM for other populations, such as elderly patients with complex conditions. (Perloth 2013)

Specifically, there is insufficient research on the effect MTM on patient satisfaction, health resource utilization, and role in achieving goals of care (Nkansah 2010)

More research is needed on mechanisms to better engage patients in programs and sustain their long term interest in medication management (Viswanathan 2015)
No clear evidence-based models of MTM;

Stakeholder interviews suggested comparing:

- MTM with collaborative practice agreements versus those without (Kiel, 2005);
- Variations in pharmacists’ scope of practice within collaborative practice agreements (e.g., allowing pharmacists to make referrals within more integrated models);
- Evaluation of specific components of MTM (e.g., allowing access to more complete healthcare data);
- Mode of service (e.g., telephone versus co-located in patient-centered medical homes)
What is the likelihood of implementation?

- There are strict eligibility criteria for patients to receive MTM services in their Part D drug plan and no reimbursement for services. This makes it difficult for health plans and community pharmacies to invest in developing MTM programs.
- Physicians have been resistant into entering into collaborative practice agreements
- Medicaid programs have greater flexibility in the design of their MTM programs (eligibility, service model) and could be a better environment to develop innovative, effective MTM programs.

Why is this research timely?

- It may not be. CMS has launched a 5-year Part D Enhanced Medication Therapy Management Model initiative that will test innovative models of care. This will not be complete until 2021.
- For this initiative, MTM standard service definitions and code sets are being developed that will facilitate future research.
Discussion

- Is this topic compelling enough to warrant further investigation and refinement? If so, how should the question be refined?

- Do the potential barriers to research seem surmountable?

- Do the potential barriers to adoption of effective models seem surmountable?
What are the comparative benefits and risks of different models of integrating pharmacists into the care transitions team in order to reduce adverse drug events, improve patient-centered outcomes and lower preventable emergency department visits and re-hospitalizations post hospital discharge among patients with multiple chronic co-morbidities?
The failure to adequately attend to care transitions increases Medicare’s annual spending by $12 billion as 75 percent of 30-day readmissions are preventable (MedPAC 2007).

Two-thirds of these readmissions are costly drug-related events (IOM, 2006).

Up to 50 percent of medication errors and 20 percent of adverse drug events have been associated with a lack of communication during care transitions (Resar 2012).

The Joint Commission’s National Patient Safety Goals for ambulatory care include reconciliation of a patient’s medication list during care transitions—and the Joint Commission has prioritized work to reduce hospital readmissions (Joint Commission 2006)

American Pharmacists Association see this as a priority area for research
What is the evidence gap?

Though there are a number of studies on the role of pharmacists in care transition to prevent poor patient outcomes, they are generally underpowered, have a high risk of bias, and provide insufficient evidence to make any conclusions about the most effective models of integrating pharmacists into care transitions (Thomas, et al. 2014).

Additional research is needed to better understand the most effective models of pharmacist-assisted care transitions, as well as the settings and populations in which these strategies can be most beneficial.
Face-to-face pharmacist-assisted discharge counseling to review medication list, provide patient/caregiver teaching, and resolve any medication issues prior to discharge (Trang 2015)

Post-discharge follow-up calls to the patient from the pharmacist, at various intervals (Budiman 2016)

Provider-to-pharmacist follow-up post-discharge to confirm medication lists, face-to-face or via telephone (Kilcup 2013)

Pharmacist as a member of the care transitions team, providing services prior to discharge (Koehler 2009)

Use of a care coordinator (case manager, advanced practice nurse, or similar) as a conduit between the hospital and the patient’s community pharmacy, and between the patient and caregiver (Walker 2009)
Likelihood of Implementation and Timeliness

What is the likelihood of implementation?

- Hospitals, health plans, healthcare quality advocates, and ACOs are interested in programs to reduce re-admissions.
- Though medication reconciliation at discharge has been shown to reduce re-admissions, a significant amount of work remains to most effectively integrate pharmacists into the current work flow of discharging and transitioning patients out of acute care (Mekonnen et al. 2016).
- Health plans, providers, and insurers will need to see considerable evidence on the efficacy of adding pharmacists to the care transitions team before investing in these programs.

Why should PCORI fund research in this area right now?

- There are some evidence-based models of integrating pharmacists into the care transition, but there are no good comparative studies.
- Such research would complement PCORI’s active transitions in care portfolio.
Discussion

Is this topic compelling enough to warrant further investigation and refinement? If so, how should the question be refined?

Which models of care are seem compelling enough to warrant further investigation and refinement?
Afternoon Break
Transitional Care Evidence-to-Action Network (TC-E2AN)

IHS Advisory Panel Meeting
March 31, 2017

Carly Parry, PhD, MSW--Senior Program Officer, IHS
Introduction and Context: The Transitional Care Evidence to Action Network (TC-E2AN)

- Purpose and Structure of the Transitional Care Evidence to Action Network
- Overview of the Studies
- Activities to Date
- Current Activities and Next Steps
Organized around strategic portfolio area: “Transitional Care”

Developed area, primed for CER and impact

Fit with PCORI’s foci on patient-centeredness, contextual factors (beyond rehospitalization → patient experience)

Impact: changing the dynamic of the evidence conversation to groups or clusters of studies, portfolios.
PCORI’s Transitional Care Evidence to Action Network

Organized around strategic portfolio area: “Transitional care”

- Facilitate engagement among awardees and cross-learning between projects studying transitional care to leverage the significant investment made to date and strengthen the impact of the individual projects.

- Promote collaboration among awardees to enhance their in-progress work by sharing best practices, measures, tools, opportunities, etc.

- Engage key stakeholders/end-users, facilitate exchanges between awardee teams and these groups to convey the relevance of the findings.
PCORI’s Transitional Care Evidence to Action Network

- **20 PCORI awardee teams:** ~$69M
- **E2AN members accelerate research & its impact:**
  - Identify common *challenges, strategies*
  - Highlight *lessons learned & best practices*
  - Identify useful (common) measures/tools
  - Maximize utility of *patient engagement* throughout the research process
  - Synthesize *portfolio contributions* in a manner that is actionable and relevant to end users
PCORI’s Transitional Care Evidence to Action Network

- PCORI has made a $69M investment in 20 projects in Transitional Care in 16 states
  - 1 Project (Williams $15.0M) funded through an IHS topic-specific PFA
  - 1 Project (Duncan $14.2M) funded as an IHS Pragmatic Clinical Study
  - 18 projects ($39.7M) funded via the Broads mechanism
    - 14: Improving Healthcare Systems
    - 2: Addressing Disparities
    - 1: Assessment of Prevention, Diagnosis and Treatment Options
    - 1: Improving Methods for Conducting PCOR
Project Characteristics

- 20 patient-centered CER studies*
  - 12 RCTs (patient level)
  - 1 interrupted time series
  - 2 cluster randomized
  - 2 quasi experimental
  - 2 stepped wedge
  - 2 observational
- 2 studies focus on children, while the remainder focus on adults (all ages)

- Interventions are all multi-component and include:
  - Rehabilitation
  - Counseling
  - Community health workers
  - Peer support
  - Care coordination
  - Self-management
  - Technology (patient portals)
  - Clinician/patient education

- Interventions take place in the hospital, ambulatory, ED, community, virtual, and home settings
Number of Awards by Disease/Condition
(N=20 studies; studies may include multiple diseases/conditions)
Characterization:

- Many efficacious studies conducted >10 years ago
- Primarily hospital-focused, less evidence re: role of primary care teams during care transitions
- Dearth of high-quality evidence in MH or surgical populations

Evidence gaps identified:

- Extent/for whom post-discharge home visits are necessary component of TC interventions
- Which strategies should be employed to improve safety and reduce post-discharge adverse events
- No patient population within which transitional care interventions are uniformly successful. Suggests role of contextual factors…

Contextual Factors

- Target population
- Patient and caregiver capacity for/engagement in self-care
- Intervention setting/s
- Provider authority and self-efficacy
- Technology environment
- Community resources (rehab facilities)
- External policy, incentives, pressure to implement
- Fee for service vs. Integrated delivery environment

Duration and Overlap of Studies

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bettger</td>
<td>June</td>
<td>May</td>
<td>Mar</td>
<td>May</td>
<td>May</td>
<td>Jun</td>
<td>Nov 2020</td>
</tr>
<tr>
<td>Jones</td>
<td>Mar</td>
<td>Oct</td>
<td>Oct</td>
<td>May</td>
<td>Jul</td>
<td>Sep</td>
<td>Oct 2019</td>
</tr>
<tr>
<td>Zatzick</td>
<td>Oct</td>
<td>Sep</td>
<td>Oct</td>
<td>Sep</td>
<td>Oct</td>
<td>Sep</td>
<td>Oct 2020</td>
</tr>
<tr>
<td>Krishnan</td>
<td>Oct</td>
<td>Mar</td>
<td>Oct</td>
<td>Feb</td>
<td>Apr</td>
<td>Mar</td>
<td>Dec 2020</td>
</tr>
<tr>
<td>Velligan</td>
<td>Sep</td>
<td>Apr</td>
<td>Apr</td>
<td>Sep</td>
<td>Apr</td>
<td>Sep</td>
<td>Oct 2021</td>
</tr>
<tr>
<td>Whooley</td>
<td>Apr</td>
<td>Mar</td>
<td>Apr</td>
<td>Mar</td>
<td>Apr</td>
<td>Mar</td>
<td>Oct 2020</td>
</tr>
<tr>
<td>Brooks</td>
<td>Mar</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>Oct 2021</td>
</tr>
<tr>
<td>Carden</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>Oct 2021</td>
</tr>
<tr>
<td>Shah</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>May</td>
<td>Oct 2021</td>
</tr>
</tbody>
</table>

Data Preparation (non-interventional)
Project Gear Up, Training & Intervention Design
Patient Enrollment / Piloting / Data Collection Prep.
Intervention and Data Collection
Analysis and Reporting
Shift in Network Focus

*Away from Dissemination and Implementation

*Toward Portfolio Communication

• Changes to affinity groups
• New ways to communicate about the portfolio in progress: evidence mapping, website, video work
**TC-E2AN Overarching Goal:** Connect investigators across projects to facilitate collaborative learning and problem solving, accelerate the research process, and maximize the impact of investments in TC services to support the overarching goals of improving patient-centered outcomes, engaging patients and other stakeholders, and communicating value.
Overview of the Goals of the TC-E2AN Affinity Groups

**Measurement:**
1) Map measures to conceptual model and end-user metrics; and
2) Identify any gaps in measurement
3) Map measures to conceptual model and end-user metrics; and
4) Identify any gaps in measurement

**Portfolio synthesis:**
1) Contextualize the transitional care studies in the literature and practice context
2) Synthesize the contributions of these studies including patient centered outcomes, stakeholder engagement strategies, subpopulation analyses, and unique study characteristics
3) Develop a searchable interactive web-based platform

**Stakeholder relevance:**
1) Gather information from TC-E2AN awardees and key stakeholders regarding best practices for promoting implement-ability and sustainability of evidence-based transitional care services; and
2) Deliver a summary of common approaches, effective D&I strategies, and key factors that influence implement-ability and sustainability
Activities to Date

Panel Presentations

- IPFCC International Conference on PFCC Poster (7/2016)
- 2016 Advancing the Science of Community Engaged Research Conference Learning Lab (8/2016)
- American College of Surgeons Policy Summit (9/2016)
  - Hosted by the Zatzick team featuring Julie Gassaway (Jones’ team)
Activities to Date (cont.)

TC-E2AN Working Meeting (Nov. 16-17, 2016)

• Network input on:
  – Research synthesis, website=portfolio communication
  – Lessons learned
  – Writing Opportunities
  – Conceptual Model
Activities to Date (cont.)

TC-E2AN Working Meeting (Nov. 16-17, 2016) (cont.)

- Sustainability and translation fishbowl with AHIP and Doris Lotz
- Video filming for Website Phase 1 (challenges, innovations)
- Highlighted work of 4 awardee teams (various stages)
- Brainstorm D&I and Eng. opportunities
- Journey mapping exercise for patient partner → engagement AG
Activities to Date (cont.)
TC-E2AN Panel at the Annual Meeting

Led by Carly Parry, highlighting 2 awardee teams: PI and Patient Stakeholder (Zatzick and Thomas, Carden and Rosini)
1. TC Portfolio Synthesis and Communication
   – Research synthesis, portfolio synthesis, evidence mapping and data visualization, communication incubator
2. Website
   – Video, Lessons Learned, For Patients, Portfolio work
3. Measurement
   – Conceptual Mapping
   – Mapping to metrics that matter
Purpose

- Visualize Transitional Care (TC) evidence landscape/gaps, showcasing PCORI contributions to TC evidence
Various levels and methods:

1. **Evidence Synthesis** (e.g., synthesis of systematic reviews)
   Qualitative and/or quantitative methods

2. **Synthesis of PCORI’s research investments** (e.g., portfolio “cluster” analyses, portfolio mapping)

3. Identification and **communication of a body of relevant research** (e.g., evidence maps)
Process Evidence Synthesis

Develop analytic framework

• Determine criteria, search terms, abstraction database to track articles and key elements of eligible syntheses
• Conduct broad search of peer-reviewed literature
• Identify evidence syntheses that meet criteria
• Abstract, analyze data and develop evidence map
Analytic Framework

Target Population, defined by:
- Disease/Condition and/or
- Demographics and/or
- Transition Type and/or
- Organizational Context

TC Intervention
- Component 1
- Component 2
- Component 3
- Etc...

Intermediate Outcomes
- Coordination
- Communication
- Care Experience
- Patient Empowerment
- Adherence
- Clinician Experience

Health and Utilization Outcomes

Association

Unintended Effects

Key Questions:
1 – Is there direct evidence that the TC Intervention, or some of its components, improves health and utilization outcomes for this target population?
2 – Is there direct evidence that the TC Intervention, or some of its components, improves intermediate outcomes for this target population?
3 – Are intermediate outcomes reliably associated with health and utilization outcomes for this target population?
4 – Does the TC Intervention result in unintended effects for this target population?

---

4 Based on the approach to reviewing evidence used by the USPSTF. See section 3.2 on page 20 of the USPSTF Procedure Manual for an explanation of this type of Analytic Framework at https://www.uspreventiveservicestaskforce.org/Home/GetFile/6/7/procedure-manual_2016_v2/pdf.
Process PCORI portfolio

- Inventory portfolio
- Categorize studies
  - Transition type
  - Interventions
  - Outcomes
- Analyze and map to evidence map
Sample Evidence Map: Effects of Acupuncture for Pain

This shows a summary of 59 systematic reviews on the effect of acupuncture on pain.

Source: http://www.ncbi.nlm.nih.gov/books/NBK185071/
TC-E2AN Website and Video

• Version 1.0 of the site undergoing final design refinements and review

• Version 2.0 in planning stage
  – User testing
  – Additional content
  – Enhanced features
During transitions between healthcare settings (e.g., hospitals, long-term care facilities, home) or providers (e.g., primary care, specialists), patients and their families may experience fragmented, poor-quality care, which can lead to unsatisfactory outcomes. To address this problem, PCORI has invested $69 million in research to understand which approaches work best to improve transitional care.

Through its Transitional Care Evidence to Action Network (TC-E2AN), PCORI links 20 PCORI-funded research teams to facilitate collaborative learning and share lessons learned in conducting patient-centered research on transitional care. The overarching goal of the Network is to produce actionable and relevant evidence to indicate which approaches to transitional care are most effective in specific populations, and ultimately to improve delivery of transitional care services.

The PCORI Approach to Transitional Care

Why Study Transitional Care

The videos above discuss how PCORI-supported projects address transitional care challenges in ways other research has not, and why transitional care is an important area to study.
PCORI launched the Transitional Care Evidence to Action Network (TC-EZAN) in 2015 to support and connect PCORI-funded research teams studying transitional care. The Network seeks to facilitate collaboration and share lessons learned about conducting patient-centered research in transitional care.

The 20 projects currently composing the TC-EZAN are comparing which approaches work best to reduce readmissions and improve patient experience and a wide range of outcomes important to patients and other healthcare stakeholders. The overarching goal of the Network is to cultivate a body of evidence on transitional care that is actionable and relevant to patients, families, clinicians, healthcare delivery systems, and payers.

The Network includes projects funded under the following PCORI National Priorities for Research:

- Improving Healthcare Systems
- Addressing Disparities
- Accelerating Patient-Centered Outcomes Research and Methodological Research
- Assessment of Prevention, Diagnosis, and Treatment Options

These projects are located across 15 states and the District of Columbia.
Research We Support

PCORI's research in transitional care generates evidence that will help patients and their families, clinicians, payers, and policymakers make better-informed decisions about which transitional care services are most effective, given patients' needs and circumstances.

$69 Million Awarded
20 Funded Projects
15 States with Research Funded

To date, PCORI has funded 20 transitional care projects ($69 million) across 15 states and the District of Columbia. These target a range of diseases and conditions (e.g., stroke, heart disease), patient populations (e.g., Medicare beneficiaries, long-staying patients, children), and settings (e.g., hospital, emergency department, home). Funded between 2013 and 2018, these studies are at varying stages of research.

Explore Our Studies

Learn more about the studies in our transitional care research portfolio.

- Explore the transitional care studies by title or location;
- Find studies by health condition, population, setting, or intervention strategy by selecting a category below.

What We've Funded

Awards by Funding Type
- $29.2M From Broad Funding Announcements
- $39.7M From Targeted Ongoing Programmatic Clinical Studies/Funding Announcements

Awards by Patient Transition Setting
- 15 Projects
- peasant to Home: 3
- Hospital to Home: 1

Conditions Studied

- Cardiovascular Disease: 22.2
- Non-Disease Specific: 18.9
- Mental/Behavioral Health: 11.3
- Multiple Chronic Conditions: 5.6
- Kidney Disease: 5.6
- Trauma/Injury: 3.2
- COPD: 2.1

Populations Studied

- General Population: 12
- Medicare Beneficiaries: 3
- Children: 2
- Low Socioeconomic Status: 1
- Rural: 1
- Veterans: 1
Measurement

• Catalogue measures used on TC-E2AN studies based on conceptual framework
• Catalogue core measures used and classify what does/does not work in context
• Identify measurement gaps (e.g., acceptability, feasibility)
Questions?
Recap of the Meeting & Looking Forward

Timothy Daaleman, DO, MPH
IHS Advisory Panel Co-Chair
Concluding Remarks

Steve Clauser, PhD, MPA
Director, Healthcare Delivery and Disparities Research
Adjourn

Thank you for your participation!
Find PCORI Online

www.pcori.org