Key questions defining research program:

- How can health care systems coordinate with patients’ home and community resources to provide realistic and effective chronic disease self-management support?
- How can innovations in primary care, such as the patient-centered medical home and multi-disciplinary team population management, best improve care coordination and outcomes for patients with complex chronic conditions?
- How can we leverage technology and big data to ‘flip the clinic’, allowing professionals to make the most of their time with patients, to empower more effective and efficient primary care?

Key words describing research program:

- Complex chronic disease
- Primary care organization
- Intervention research
- Care coordination
- Health behavior change and self-management support

Titles for shovel-ready research projects:

- Membership in latent subgroupings of primary care patients with multiple chronic conditions and future health utilization and health outcomes
- Patterns of clinical quality improvement across the VA after 4 years of PCMH implementation. Differences in patterns of quality gains with PCMH implementation for VA clinics serving high numbers of vulnerable patients
- Roles family members play in helping patients with high-risk diabetes engage in medical care
- Is day-to-day social support from family and friends correlated with patient activation and engagement in medical care?

Data sources for shovel-ready research projects:

- VA PCMH program (“PACT”) – many linkable sources of data including clinic-level and patient-level administrative data, pharmacy data, VA and non-VA utilization data, patient and staff survey data, patients’ home neighborhood characteristics. Many possibilities!
- CO-IMPACT diabetes management intervention study - Baseline survey data from 240 VA patients and 240 family supporters will be complete in Spring 2018, linkable to patient medical records. Automated Interactive Voice Response phone program use data also.
- PACE study – Data from 547 surveys of Veterans with high-risk diabetes (self-management, social support, engagement in medical care), linked with medical record data (e.g. HbA1c levels). Transcribed and coded qualitative interview transcripts with 19 patients and 12 family supporters on family roles in supporting diabetes home and medical management.