Session #79

John Kelly, Principle Business Advisor, Edifecs
Leslie Kelly Hall, Senior Vice President, Policy, Healthwise
Speaker Introduction

Leslie Kelly Hall
Senior Vice President Policy
Healthwise

John Kelly
Principal Business Advisor
Edifecs
Conflict of Interest

Leslie Kelly Hall
Has no real or apparent conflicts of interest to report.

John Kelly
Has no real or apparent conflicts of interest to report.
Agenda

• The evolving art of population health management

• Harnessing your data to achieve focused results and optimized value

• Care Planning: the emerging ecosystem for population health, shared decision making and health management across all stakeholders
  – Presentation
  – Q&A
Learning Objectives

• The industry and a shifting focus for Providers and Payers owning risk for value.

• The emerging value of data in taking a focused approach to population health management

• Describe how shared decision making can be enabled across the continuum of care, and demonstrate how the patient voice can be integrated into the care delivery design and process.

• Using real-life examples of an emerging view on population health, demonstrate how leveraging advanced clinical care models, technology and enablement systems, risk management analytics and targeted capital investment, improves health outcomes for individual members while tightly managing costs.

• Describe a model for healthcare delivery that is highly scalable and sustainable, minimizes disruption, and fosters collaboration among hospitals, physician groups and health plans.
Cliché: a phrase or opinion that is overused and betrays a lack of original thought

• “Location, Location, Location”
• “Timing is everything”
• “The teachable moment”

Aphorism: a terse saying, expressing a general truth, principle, or astute observation

• In Healthcare these notions come together as yet another cliché:
  “The right information, at the right place, at the right time”
  ➢ A cornerstone concept in population health management
The Conundrums of Broad Based Pop Health

Population Health is about an “n” of one.

- Population Health Management has no clear actuarial basis for success.
  - Payer’s invest in rewards reaped by the competition in the future
  - Providers need to be rewarded for what they can achieve with a small population but held harmless for what they can’t control

- We can’t afford to medicalize wellness

- Changing the behaviors of society is a public health issue, not one of population health management.
Success Results From Targeting Programs And Incentives

• Good programs need more than thoughtful design.

• They require significant and dedicated resources.

• Apply those resources where they yield the most return on investment.
Moving from Populations to “n of one” Care Planning

Information must interact with variety of systems (EHRs, EMRs, Legacy)

Data metrics must become transparent and reusable between all stakeholders in a unified channel

Leverage existing technology and workflows with new applications (Pop Health, Predictive Analytics)
“On-The-Wire” Processing = Dynamic care management

Learning form the financial industry and credit card networks and applying to healthcare.
Plan the Work, Work the Plan

Diligent management of dynamic Care Plans is the engine for an effective Population Management Strategy
An Introduction of How Benefits Were Realized for the Value of Health IT

Care Planning Ecosystem

- **Satisfaction**: Payer, providers, patients
- **Treatment**: All informed, all actionable
- **E-Secure**: Data sharing standards based
- **Patient engagement and population health**: Appropriate agreed upon care; prevention and education
- **Savings**: operational, efficiency and financial
An Introduction of How Benefits Were Realized for the Value of Health IT

Care Planning Ecosystem

Satisfaction: Payer, providers, patients

Treatment: All informed, all actionable

E-Secure: Data sharing standards based

Patient engagement and population health: Appropriate agreed upon care; prevention and education

Savings: operational, efficiency and financial
Care Planning?
Read Abington’s press release about the “CARE Plan” (Communication, Access to info, Resources & Education), for which they won a 2008 Magnet Prize.
Care Plan Characteristics

• Assess: collect and observe
• Diagnose: problem to solve
• Plan: goals and actions to take
• Interventions: actions or care taken
• Status/evaluation: complete, repeat or modify
Care Plans Evolving

• Reference Materials
• EHR Enabled
• EHR informing
  – Patients
  – Other providers
  – Payers
• Collaborative Care Planning Platforms
Care Plan as Reference Materials

- Static
- Template based
- Best practice guidelines
- Updates are manual and generally related to in-facility care
- Patient instructions or care summaries often are patient facing for care plans
EHR enabled:

- Reference material embedded in the EHR
- Static but template configurable
- Query based emerging (info button, FHIR)
- Actions and reactions can be documented in the EHR and shared with others in the EHR
  - Plans of care
  - Episodic care plans
  - Chronic care plans
- Interactive care planning emerging
  - INTEROPERABILITY IS NECESSARY
Interoperability as defined by ONC

“All individuals, their families, and their healthcare providers have appropriate access to electronic health information that facilitates informed decision making, supports coordinated health management, allows individuals and care givers to be active partners and participants in their health and care and improves the overall health of the nation’s population.”

Longitudinal Care Planning

• Taken from S&I framework

• *(abbreviated, all errors my own)
Patients have current conditions, risks for conditions, and concerns

Risks come from many sources

- Age, gender
- Significant Past Medical/Surgical Hx
- Family Hx, Race/Ethnicity, Genetics
- Exposures/lifestyle (e.g. alcohol, smoke, radiation, diet, exercise, workplace, sexual...)
- Environment/Home Safety
- Test Result/Examination Findings

Health Conditions

Acute Problems

- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Chronic Problems

Disease Progression

Risk Factors

Treatment Side effects
Goals for treatment of health conditions are created collaboratively with patient taking into account their values, situation, statuses, etc...

**Acute Problems**
- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

**Chronic Problems**
- Age, gender
- Significant Past Medical/Surgical Hx
- Family Hx, Race/Ethnicity, Genetics
- Exposures/lifestyle (e.g. alcohol, smoke, radiation, diet, exercise, workplace, sexual...)
- Environment/Home Safety
- Test Result/Examination Findings

**Decision Modifiers**
- Patient values/priorities/wishes/adv dirs/readiness/expectations
- Patient status (functional, cognitive, symptoms, prognosis, etc...)
- Patient access to care/support/resources/transportation

**Goals**
- Desired outcomes
- Barriers
- Progress
- Related Conditions
- Related Intervention

**Risk Factors**

**Disease Progression**

**Treatment Side effects**
Interventions and actions to achieve goals are identified collaboratively with patient taking into account their values, situation, statuses, etc...
The Plan of Care (Conditions, Goals and Interventions), along with Risk Factors and Decision Modifiers, iteratively evolve over time.

Health Conditions
- Acute Problems
  - Injury (e.g. falls)
  - Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)
- Chronic Problems
  - Age, gender
  - Significant Past Medical/Surgical Hx
  - Family Hx, Race/Ethnicity, Genetics
  - Exposures/lifestyle (e.g. alcohol, smoke, radiation, diet, exercise, workplace, sexual...)
  - Environment/Home Safety
  - Test Result/Examination Findings

Risks/Concerns:
- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Disease Progression
- Acute Problems
- Chronic Problems
- Risk Factors

Goals
- Desired outcomes
- Barriers
- Progress
- Related Conditions
- Related Intervention

Interventions/Actions
- Medications, wound care, exercise, diet, tests, behavior changes, support, calling MD for sx
- Consults, rehab, education, etc...
- Start/Stop dates
- Frequency
- Responsible parties
- Setting of care
- Instructions/parameters
- Supplies
- Status of intervention
- Related Conditions

Decision Modifiers
- Patient values/priorities/wishes/adv dirs/readiness/expectations
- Patient status (functional, cognitive, symptoms, prognosis, etc...)
- Patient access to care/support/resources/transportation
- Patient allergies/intolerances

Outcomes
- Side effects

Decision Support
- Orders, etc...

The Plan of Care, along with Risk Factors and Decision Modifiers, iteratively evolve over time.
EHR- Informing

• EHR informing
  – Patients
  – Other providers
• EHR care plans are selected and individualized
• Provider then sends care plan and supportive material to the patient for them to act on
• Actions are automatically captured back into the record
• Closed loop
Patient Facing Care Plans
Care Planning the Verb

• More participants
• Across organizations
• Across care, wellness and prevention continuum
• Medical and non medical inputs
• Patient at the center
The Plan of Care is filtered, translated and transported to meet the needs of each participant/setting in the patient’s care.

**Health Conditions**
- Acute Problems
- Chronic Problems
- Risks/Concerns:
  - Injury (e.g. falls)
  - Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

**Goals**
- Desired outcomes
- Barriers
- Progress
- Related Conditions
- Related Interventions

**Decision Modifiers**
- Patient values/priorities/wishes/adv dirs/readiness/expectations
- Patient status (functional, cognitive, symptoms, prognosis, etc...)
- Patient access to care/support/resources/transportation
- Patient allergies/int tolerances

**Interventions/Actions**
- (e.g. medications, wound care, exercise, diet, tests, behavior changes, support, calling MD for sx/s, consults, rehab, education, etc...)
- Start/Stop dates
- Frequency
- Responsible parties
- Setting of care
- Instructions/parameters
- Supplies
- Status of intervention
- Related Conditions

**Patient**
**Family**
**Physicians**
**Non-physician Providers**
**Nursing**
**Coordinators**
Patient interaction helps to achieve better outcomes

Providers
Care Coordinators
Care Managers
Population Health
Emerging Care Plan Concepts

• MY Context
  – About me: demographics
  – Phenotypic: how I live and who I am
  – Genotypic: what I am made of
  – Values, preferences, direction, decisions

• Care Platforms
  – Collaborative platforms across continuum and including the patient and families
Care Platforms..... according to Google
Care Planning Platforms

• Emerging from Population Health
• EHR episodic plans are shared and the EHR may be a repository for many
• New sources are added as interoperability improves
• The patient will be an active member of the team in care and online
Where to Start?
Team up for the Challenge
HL7 C-CDA Care Plan Document DSTU

Proof of Concept Project

“Clear and specific refinements of many clinical standards are needed and will, no doubt, come about because of careful, reality-based evaluations.”

- Health information technology data standards get down to business: maturation within domains and the emergence of interoperability,

Blue Cross Blue Shield Association
Healthwise
ZeOmega
Edifecs
GSI Health
Lantana Consulting Group

Narration by:
Tom Williams, Healthwise
Lenel James, BCBSA
Lisa Nelson, Lantana
Carolyn Brzezicki, Healthwise
APIs Create Relationships Between Systems and People.
Lenel James, lenel.james@bcbsa.com
Tom Williams, twilliams@healthwise.org
Aditya Kandregula, akandregula@zeomega.com
Gregg Prothero, gregg.prothero@edifecs.com
Leroy Jones, leroy.jones@gsihealth.com
Lisa Nelson, lisa.nelson@lantanaconsulting.com
Leslie Kelly Hall, kellyhall@Healthwise.org

Link to Care plan POC video: https://youtu.be/yPZrBuhO6Lk