BOOMERS--PARTNERS through PERSONAL HEALTH SUPPORT SYSTEMS

Whatcom County, WA
Experience & Current Projects
Spring 2007
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Who is “We”?  
Where is “Home”?  

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Care is Broken  
Between our Organizations and Industries  

Where the Patient Lives
Boomers

• Heightened Expectations
• Partners
• Most Connected
• Access to Global Health Recourses

• Not enough professionals for current model of caring — *a new model will emerge!*
Partnership or Paternalism

• Partnership
  – Peers are more fun

• Paternalism
  – Dependency is difficult for everyone

• Consumers have better ideas
  – Design based upon experience of care
  – More effective
  – Cheaper
IOM

RWJF & IHI

pursuing perfection

Internationally Raising the Bar for Health Care Performance
STANCE MATTERS

• Pursuing Perfection shifted our stance
  – From hospital & physician office
  – To patient’s home

• A workable solution requires multiple stances, but the most value derives from decisions & behavior change of consumers

• Keep in mind, US outpatient medicine provides only 55% of the care we know we should provide.
Virtual Care Teams

• INSIGHTS:
  – We do not function as isolated individuals
  – We exist in small social networks
  – Robust, not fragile
  – Capable, not incompetent
  – Behavioral change—the key to health—is most often socially stimulated and socially supported
TRANSFORMATIVE IDEAS from PURSUING PERFECTION (P2)

1. Patients as designers
2. Navigator Coaches
3. Community-based Personal Health Record
   - “Shared Care Plan”
   - Patient centered and patient controlled
FOCUS ON DATA or ACTIVATION?

• The goal should be consumer behavior change!
  – All other goals are secondary and outcomes are derivative
  – Patient Activation Measure, Hibbard & Mahoney

• Patients using the Shared Care Plan (PHR) report much more confidence in making decisions and in actively participating in their care
Socio-Technical Solutions

• We providers only deliver 55% of the care consumers should receive (outpatient). We need help.

• Much health care is local—engage communities
  – EMS
  – Schools
  – Churches
  – Agencies
  – Workplaces
  – Etc.
Principles of Improvement

Institute of Medicine (IOM) National Aims

- Safety
- Effectiveness
- Patient-centeredness
  \((\text{non-paternalistic, radically engaged})\)
- Timeliness
- Efficiency
- Equity
P2 Participating Orgs

1. Family Care Network
2. Sea Mar Community Health Clinics
3. North Cascade Cardiology
4. St. Joseph Center for Senior Health
5. St. Joseph Hospital
6. Group Health Cooperative
7. Community Health Plan of Washington
8. **AND LOTS OF PATIENTS**
In Whatcom County, WA we invited patents to redesign the system to support those with chronic conditions.

They created the Shared Care Plan, a personal health communication tool & Clinical Care Specialist Role
Involving Patients in the Process
Debilitating Assumptions

1. Chronic care is like acute care
2. Old people are incompetent
3. Doctors and hospitals are the center of health caring
4. People cannot get access to the web
5. Everyone needs to work on line and work from a computer
6. Business medical records must be adopted before personal health records/support systems
7. Everyone must adopt PHRs before they are useful
8. It’s OK for every business to “provide” a different PHR
We offered them our electronic medical records.

They had a choice and the politely declined.

Then they created the Shared Care Plan, a collaborative personal health “record.”

What they created is much more than a record. It is a conversational artifact for cooperation, behavior change, and shared responsibility.
Patient Designed Features

- Control of access
- Audit trail
- Advanced directives
- Printing for refrigerator, purse and glove compartment
- Printing for wallet
- Connection to EMR medications for “reconciliation”
  - AHRQ single accurate medication list
LOOK & FEEL

Shared Care Plan
PERSONAL HEALTH RECORD
It’s your health – you can take charge!

Secure login
Username:
Password:
Sign In
Forget your password?

Learn more about how the Shared Care Plan can help you take charge of your health.

Find out more!

Get your own FREE Shared Care Plan.

Sign up now!
For news & updates enter your email address:

www.sharedcareplan.org
A Shift in Focus / the Missing Gear

Two Focuses Will be Better than One

• EMRs focus on the physician or hospital enterprise
• Personal health records can focus on the individual and their network of supporters.
• PHRs can be a quick path to very useful health information integration focused on the patient.
  – By importing all labs, all prescriptions, pointers to electronic images, and all payer diagnosis codes
  – Along with patient entered information
• PHRs can support the patient’s side of the partnership for their health.
A Patient Health Record, of a particular kind

- “Shared Care Plan” (http://www.sharedcareplan.org)
  - Supported by RWJF, Whatcom County patients and providers, including PeaceHealth. Original software available for other communities for “free”.
- Patient designed for self management and communication
- Invite providers, family, friends
- Includes
  - Patient preferences, goals, plans, actions
  - Medications (linking to EMRs supported by AHRQ)
  - Diagnoses
  - Linked to Healthwise
  - Medical history
  - Advanced directives
  - Future--Test results & images
- We are committed to deep interoperability
- 1100+ users in Whatcom
PATIENTS’ EXPERIENCE

http://www.wwpp.org/media/fla/whatcomProf/whatcomProf.html
PURPOSE – 1995 until today

• EVERYONE has the
• INFORMATION they need
• WHEN and
• WHERE they need it.
• PATIENTS are at the center.
THE BIG SHIFT

Patient

Hospital

Physician's Office

Physician Home

Pharmacy

SNF

OP Surg. Radiation etc..

ED & EMS

Patient's Home

Payer

Home Health

For acute patients...
Four Points

1. Patients are competent in their world and we are not the center of their worlds and never will be nor should be.

2. We need patients as partners if we are going to take responsibility for the quality chasm
   - Symmetric relationships are more fun and human for everyone

3. Personal HIT must work for the patient across organizations, including providers and payers.
   - This should not be a “marketing” ploy.
   - It should add value to providers’ (workflow) and payers.

4. Health information, technology and interactions can and will move to their world. We should all help.
   - Especially for chronic conditions, prevention, and lifestyle.
What Is Most Important about PHRs

• It’s not us geeks and our toys (technology)
• It’s not so much about data or databases or even electronics
• It’s about BEHAVIOR CHANGE
• It’s about missing conversations that result in behavior change
  – Which occur more often when two people have the printed PAPER shared care plan between them.
• It’s about Patient Activation
  – Which results in better health outcome and lower costs
Supporting the Continuum of Care--Electronically

- Life style choices
- Wellness
  - & Screening
- Acute episodes
- Chronic conditions
- Palliative care
- End of life, Hospice
The Winning Solution Will Accommodate these Facts

- Americans get their care from multiple organizations
- Our payers change frequently
  - We don’t all have payers
- We need to be active in our own health no matter who delivers our care or who pays for it.
  - The cost issue is a matter of global competitiveness and for a matter of national security in the broadest sense
- Any successful solution must also provide some value to physicians and purchasers
Overview of the Chronic Care Model
Robert Wood Johnson Foundation/Sandy MacColl Institute

http://www.improvingchroniccare.org/sitemap.html

Community Resources and Policies

Self Management Support
- Advocacy
- Resources
- Skills Training
- Role adaptation

Delivery System Design
- Providers
- Roles Clear
- Communication & Follow-up system

Decision Support
- Guidelines
- Provider Education
- Specialty support
- Feedback

Clinical Information Systems
- Registries
- Reminders
- Measurement
- Feedback

Health System Organization of Health Care

Informed, Activated PATIENT

Productive Interactions

Prepared, Proactive Practice TEAM

Functional and Clinical Outcomes
Overview of the Chronic Care Model
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Community Resources and Policies
- Patient Action Committee

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  - Specialty support
  - Feedback
- Clinical Information Systems
  - Registries
  - Reminders
  - Measurement
  - Feedback
- Clinical Care Specialists
- Shared Care Plan (PHR)

Productive Interactions
- Informed, Activated PATIENT
- Prepared, Proactive Practice TEAM

Functional and Clinical Outcomes
MY THOUGHTS ON “PHRs”
‘Homes” with PHMS

Communication, Collaboration, Data, & WORKFLOW

Care Manager, Coordinator, Coach

Family & Friends

Physicians’ Offices

Pharmacies

Hospitals & ERs

Insurers

In-home Devices

Voluntary Participation in Research

Employers (their agents)

Decision Support Resources

Like rural electrification.
GOAL?

• From: “Transform American Healthcare”
• To: Enable every “family” on earth to actively engaged in wellness and health to maximize their health within their social context
  – Connectivity
  – Tools
  – Information
  – Workflow
PERSPECTIVE / CONTEXT

- Patient-designed
- Collaborative “space”
- Community resource integration network
- Supra-organization
- Supra-business sector
- Global scale
MINIMUM STAKEHOLDERS

- Individuals and their “families”
- Healthcare professionals
- Healthcare institutions & agencies
- Employers
- EMS
MINIMUM DATA

• Anything and everything the patient wants to enter
  – “Virtual care team members”
  – Personal goals and progress toward
  – Advanced Directives
  – Conditions and diagnoses

• Lab tests

• Medications
  – Prescription history
  – Pt accounting

• Images & reports
MINIMUM COMM

• E-mail
• Instant messaging
• VOIP
• Live video
• Collaborative spaces
TECHNOLOGY

• Service architecture
• Collaborative communication tools
• Data and communication standards capable
• Workflow framework
• Globally scalable infrastructure
ESSENTIAL

• Federated identity and authentication management
• Single sign-on across secure web sites
DESIRABLE

• No (limiting) cost to the individual
• Ultimate business model is “click through”
• Patients control all the access to the data in their “PHR” and they benefit from any use of the data aggregated from their PHR.
TRUST & VALUE

• The keys to all else
• The starting points
• The path

Without both trust and value, “Build it and they will NOT necessarily come.” --CHINs, Santa Barbara, RHIOs?
EARLY EFFECTS OF USE

• Patient activation
• Clinical outcomes
• Cost effects
LOCAL TRAJECTORY

- Original locally developed HTML
  - Announced at HIMSS that it is available free
- Vendor transformed to asp.net 2.0, AJAX, web service enabled, workflow foundation
  - Pilots in NZ, Sweden, several WA counties and US states
- Integration with e-prescribing, labs, images, clinic intake forms, hospital transition of care
- Community-wide “marketing”
  - EMS, Churches, Clubs, Associations, Employers, Hospital, Physicians, Agencies & individual initiatives
TIPPING POINT FOR WHAT?

• Think about what happens when 20% or more of any community all use the same platform?
• Transformation will happen.
• Almost everything about the current system will be affected.
• The important question is, “Who is in control?”
  – The answer must be “INDIVIDUALS”
THANK YOU

COMMENTS?

QUESTIONS?

DISCUSSION?