Patient / Consumer Engagement - Key to Successful Population Health Management

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Conflict of Interest

Kamahanahokulani Farrar, MRHM
Has no real or apparent conflicts of interest to report.

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Has no real or apparent conflicts of interest to report.
Learning Objectives

• Identify Clinical and Business Intelligence (C&BI) strategies to support patient outreach.

• Synthesize strategies to manage complex patients that supports multiple providers using shared Electronic Health Record (EHR) resources.

• Evaluate the use of consumer health informatics (CHI) applications in improving self-management, adherence to prescribed treatment regimens and health behavior.

• Identify the benefits and incentives in a Patient Centered Medical Home (PCMH) model in providing continuous and coordinated care.
A Patient’s Story
Patient, Caregiver, Family
Data
Patient Voice
Recovery

Image source: Kate Sheridan
Cultural Shift

Current

Clinical & Passive Patient-Generated Health Data

Future

Engaged Patient and Active Patient-Generated Health Data

Patient-Provider Partnership

Image source: BigStock

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A Patient’s Ecosystem
Impact and Cost of Chronic Conditions

Almost 1/3 people in the US manage at least one chronic condition
More than 3/4 of US healthcare dollars are spent on their behalf

Data extrapolated from
Reality for Patients and Caregivers
Value to Patients and Caregivers

healthAction Patient Toolkit – A. Daily Chronic Care Process

Activities are marked with ○ to show how these can be enhanced/supported through the use of a Patient Toolkit

Track - Manage - Share

Images source: The MITRE Corporation

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Value to Providers

![Graph showing important factors for treating chronic care patients]

Source: MITRE Corporation/Heinz College Carnegie Mellon University Fall 2014 Capstone Project

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A Patient’s Value
Patient Engagement Principles

2. The MITRE Corporation healthAction Patient Toolkit research

EASY
EFFECTIVE
PATIENT-CENTRIC
Tracking Symptom Severity

Images source: The MITRE Corporation

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Tracking Medications

1. Pharmacy Management Strategies for Improving Drug Adherence. William K. Fleming, PharmD. S16 Supplement to Journal of Managed Care Pharmacy.

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Managing Day-to-Day Care


Image sources MITRE Corporation and BigStock

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Informing Care Team Decisions

How did they respond to that new medication?

Are they developing a new comorbid condition?

Let me find out why their mood is so low

2. Image sources: The MITRE Corporation

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Integrating Patient-Generated Health Data

- Logical Observation Identifiers Name and Codes (LOINC)
- Vital Signs
- RxNorm Medications
- Systematized Nomenclature of Medicine--Clinical Terms (SNOMED-CT)
- Patient/Family History
- Symptoms
- Problems
- Procedures
- Allergies

Images sources: Microsoft Clip Art and BigStock

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Measuring Patient Outcomes

Should I check-in with my doctor?

Am I really getting better?

Is that medication working?
Patient-Provider Partnership

3. Cleveland Clinic © 1995-2013. All Rights Reserved. 9500 Euclid Avenue, Cleveland, Ohio 44195 http://my.clevelandclinic.org/patients-visitors/prepare-appointment/appointment-checklist.aspx
4. Image source: The MITRE Corporation
A Patient’s Care Model
Patient Centered Medical Home (PCMH) Scenario: John and Mary

- John, 75 year old diabetic with comorbidities
- Mary, 45, daughter and caregiver
- Dr. Jones, General Practitioner
- Dr. Smith, Psychiatrist
- Dr. Brown, Physical Therapist
- Nurse Practitioner Davis
Patient-Centered Access

Patient-Facing Tools

Empowering Patients

Online Access
Download Record
Secure Messaging
Two-Way Communication
Schedule Appointments

Empowering Caregivers


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Team-Based Care

Team Meetings

Patient and Caregiver Engagement

Behavioral Health

Language Support

Self Management Support

Continuity of Care


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Population Health Management

Proactive Population Management

Complete Patient Information
Clinical Data
Evidence-based Decision Support
Comprehensive Health Assessment

John
Mary
GP
Psychiatrist
NP
PT


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Care Management and Support

Identify Patients for Care Management

Self Care Support

Medication Management
Care Coordination and Care Transitions


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Performance Measurement and Quality Improvement

- Improved Outcomes
- Patient-Generated Health Measures
- Patient & Caregiver Engagement
- Reduced Hospitalizations

Image sources: The MITRE Corporation and Microsoft Clip Art

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Patient Engagement Strategy
Patient Centered Medical Home Strategies

• Demonstrate active engagement of patients and families in patient care and quality improvement activities

• Use payment strategies to support the active engagement of patients as partners in their own care and in practice-level quality improvement

• Support practices with technical assistance, tools, and shared resources to engage patients

• Require health information technology standards to recognize and promote patient engagement

• Require meaningful patient input in the design, implementation, and evaluation of medical home programs

Support additional research on the feasibility and impact of patient-engagement strategies.

Source: The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care, Feb 2011, AHRQ (publication No. AHRQ 11-0029)
Patient Engagement Policy/Standards
Meaningful Use Stage 3

• 25 percent of a provider's patients must access their records through View/Download/Transmit or an ONC-certified app

• 35 percent of patients must receive a clinically relevant secure message

• Providers must incorporate information from patients on "non-clinical" settings from 15 percent of their patients.

IMPACT Act

• The Improving Medicare Post-Acute Care Transformation Act of 2014 “IMPACT Act of 2014”
• Standardized Patient Assessment Data to enable
  – Assessment and quality measure uniformity
  – Quality care and improved outcomes
  – Comparison of quality across PAC settings
  – Improve discharge planning
  – Interoperability
  – Facilitate care coordination

Care Coordination Services
Reimbursement

• Supports Chronic Care Coordination
• Reimbursement of $42 for the service which applies to

"chronic care management services furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

Extrapolated from: CMS.gov:https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-P.html
Summary

• Including Patient-Generated Health Data in Clinical and Business Intelligence (C&BI) strategies improves outcomes

• Providing patient-facing tools to manage complex conditions and integrating Patient-Generated Health Data (PGHD) into Electronic Health Record (EHR) resources enhances coordination between multiple providers

• Designing tools and processes to support Patient and Caregiver needs can significantly improve self-management, adherence to prescribed treatment regimens and health behavior

• Patient Centered Medical Homes (PCMH) provide continuous and coordinated care and benefit from including patients and caregivers as valued partners

• The combination of patient-centric strategy, policy, tools and processes will enable patient engagement and lead to successful population health management
Questions

Thank You

If you have questions please contact:

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