Designing a Perfect Integrated System (!)

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Overview

- What are we trying to accomplish?
- How are we proposing to do this?
- What is a care plan?
- How should an idealized care plan function?
- How might care planning systems evolve?
- What might an idealized care plan look like?
- What are some issues that need to be addressed?

What are we trying to accomplish?

- Support patients in articulating and achieving health goals
- Improve outcomes and cost – individual and population

How are we proposing to do this?

- Our primary hypothesis is that patients generally can't do this without one or more of the following forms of support:
  - A care plan
    - To make explicit their goals and actions that support them
    - To track their progress toward goals and in implementing supportive actions
  - A care manager
    - To help them create and implement a care plan
    - To coordinate support resources
  - Medical services
    - To provide needed diagnostic, pharmacologic, surgical, physical, educational support
  - Mental health/behavioral services
    - To provide diagnostic, pharmacologic, individual/group counseling support
  - Social services
    - To provide programmatic, financial, and other resources

- Our secondary hypothesis is that the above support cannot be effectively and efficiently provided without a technical infrastructure that facilitates it

What is a care plan?

- Minimally, as in the proposed Meaningful Use Stage 2 rules, a care plan includes goals, problems, actions
- Content of these components is not specified. For a primary care- based plan:
  - Goals
    - Patient health-related goals, in patient language: “Less pain” “Able to dance at my child’s wedding” “Able to work again”
    - Intermediate goals, necessary to attain health goals, defined by the patient and the care manager: “10 pound weight loss” “Climb a flight of stairs” “Blood pressure control”
  - Problems
    - Medical: diagnoses
    - Mental health/behavioral: diagnoses, behaviors
    - Social: resource needs
  - Actions
    - Of the care manager
    - Of the health care, mental/behavioral, social service providers
    - Of the patient
- There may be other potential types of care plans, such as:
  - Specialty care
  - Post discharge
  - End-of-life

How should an idealized care plan function? A case scenario

- Conventional medical case summary/plan:
  - JQ is a 49 y.o. male who presents in follow up to an ER visit for chest pain in which there was no evidence of acute ischemia
  - Current medical problems include HTN, and hyperlipidemia
  - Meds: lisinopril 10 mg/day
  - Social history: Lost his job in construction 2 years ago, separated from spouse 1 year ago. Generates some income as a handyman. Non-smoker, daily ETOH.
  - ROS: difficulty sleeping, anxiety accompanied by non-exertional chest pains
  - Exam: BMI 35, BP 150/100, otherwise unremarkable
  - Assessment: HTN, hyperlipidemia, obesity, chest pain – probably functional, depression
  - Plan: increase lisinopril dose, dietitian consult, SSRI

Case scenario – care managed/patient-centered plan

- Patient goals:
  - Get a job
  - Feel better: less lonely, anxious
  - Avoid chest pains
- Assessment:
  - Patient at risk for poor outcomes and costly care: ED visits, hospitalization, ischemic vascular disease, ETOH abuse/complications
  - Depression/anxiety is in part secondary to job and relationship loss
- Plan:
  - Assess needs/eligibility for financial assistance, job counseling/retraining
  - Refer for mental health/behavioral services; individual or group-based services that include holistic approach to diet and depression
  - Create a care plan reflecting above and track follow through
  - Revise care plan and coordinate care based on assessments and interventions of social service and mental health providers

Case scenario – care coordination and keys to success

- Social services/mental health services/primary care information exchange
  - What is the care manager requesting support for?
  - What social services programs is the patient enrolled in and what do they provide?
  - What social services programs is the patient eligible for but enrollment is pending, and what will they provide?
  - What social services programs is the patient not eligible for?
  - What is mental health services is the patient receiving?
  - Is the patient reliably attending mental health appointments?

- Keys to success in this case:
  - PCP has care manager to help with care planning and coordination with other providers and patient
  - Care manager has infrastructure to make care planning and coordination effective and efficient
  - Patient has access to social service and mental health/behavioral support
  - Patient has access to care plan and reinforcement for behavior change

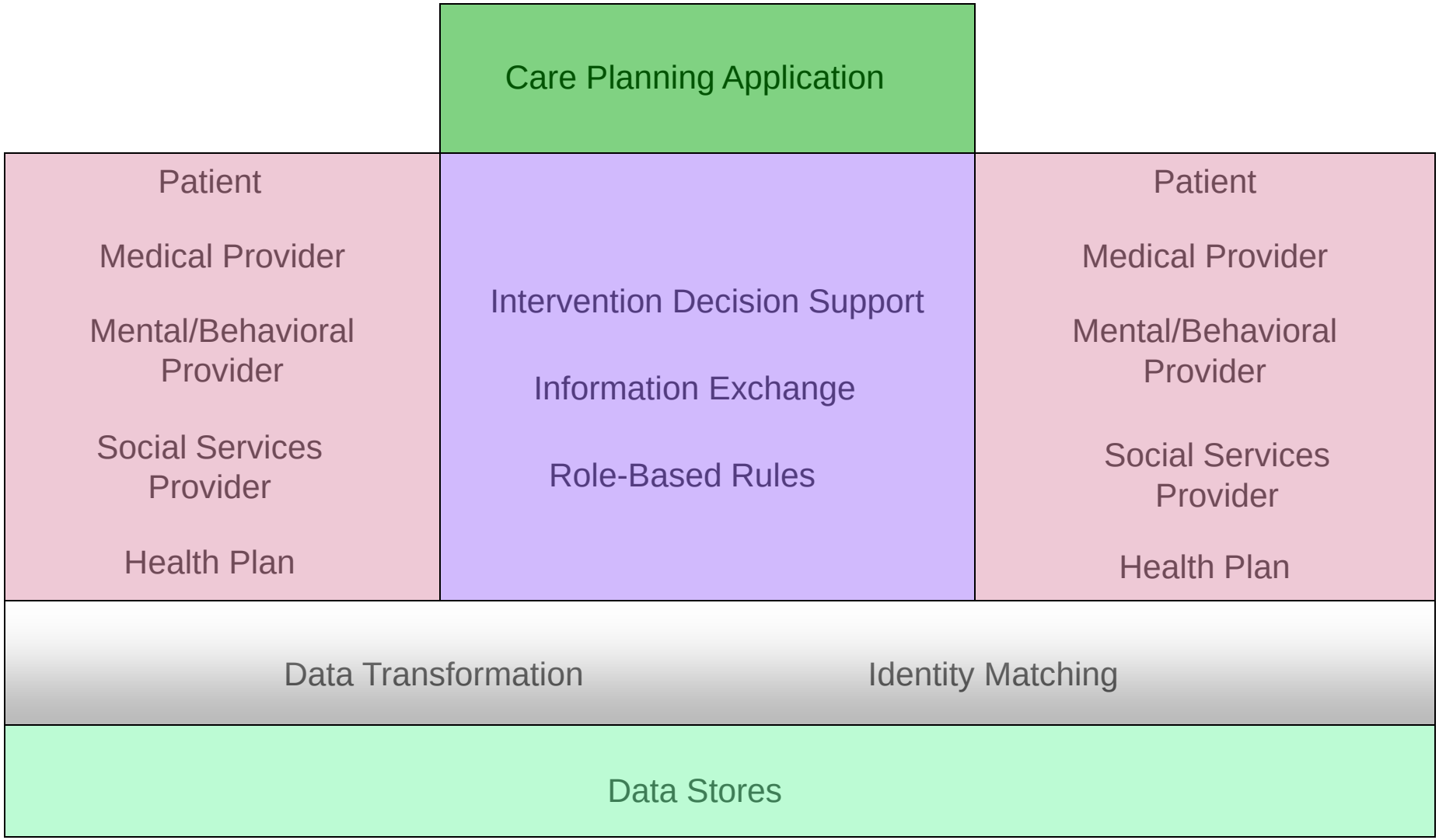
How should an idealized care plan function?

- Import and update foundational information: diagnoses, meds, demographics, contact info, care team, utilization
- Provide ability for care manager to document goals, problems, actions
- Suggest appropriate interventions for problems (decision support)
- Enable care manager to document which actions the patient has agreed to
- Accept assessments, care plans from other providers
- Link to secure email to other providers and patient
- Prompt care manager for needed actions within plan and in work queue
- Prompt patient for needed actions and accept or link to self-monitored information reporting

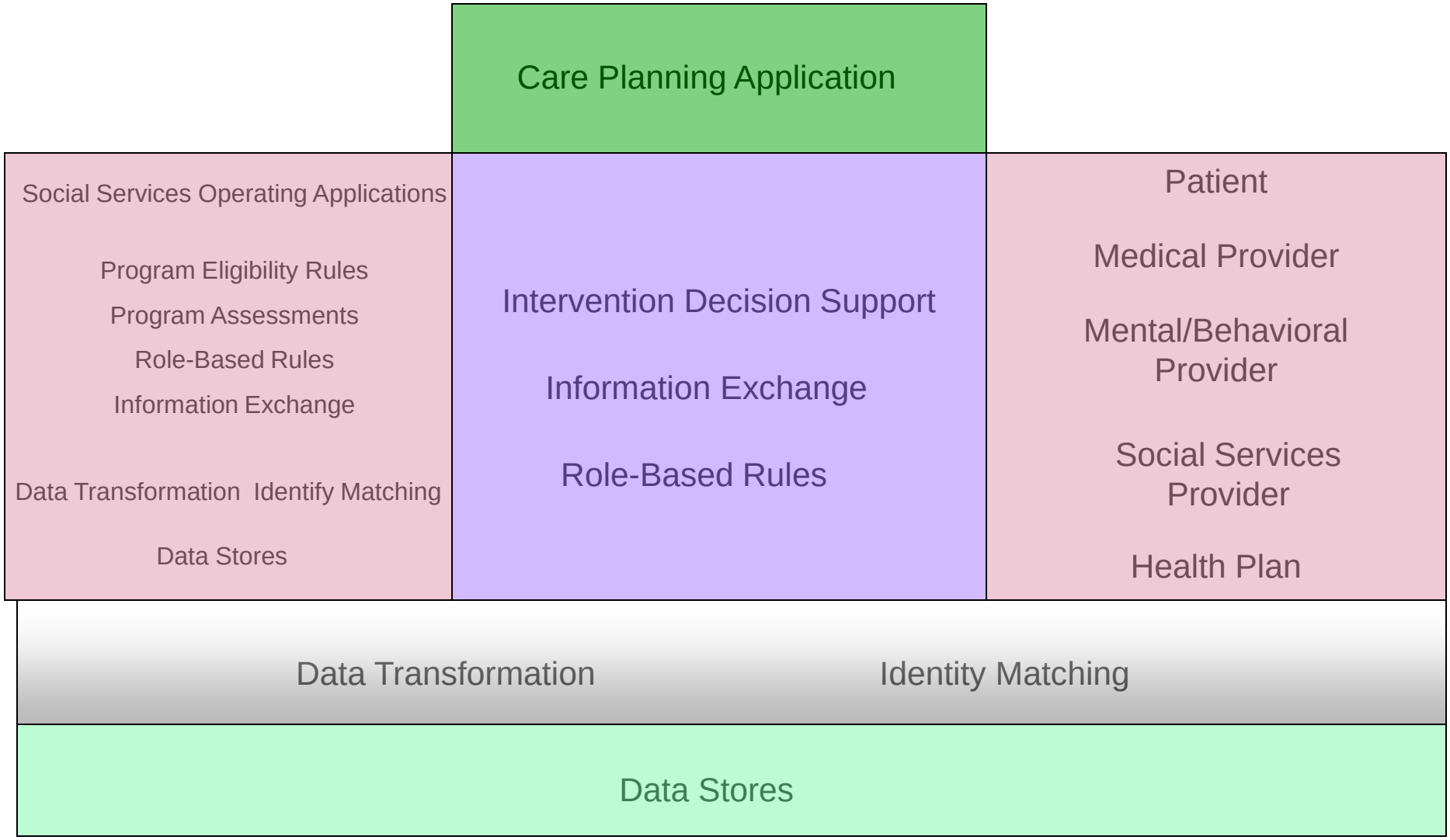
How might care planning systems evolve?

- Basic care plan
  - Goals, problems, actions
  - Differentiates patient agreed actions
  - Printable, emailable version for patient
- Decision support care plan
  - Basic plus suggested interventions for specific problems
  - Prompts care manager for follow up actions
- Coordinating care plan
  - Imports foundational data
  - Imports assessments and care plans from other providers
  - Links to secure email of other providers/patient
  - Prompts patient and accepts self-monitored information

What might an idealized care planning system look like?



Each coordinating entity may require its own infrastructure, eg the social services provider



What are some issues that need to be addressed?

- Assessment
  - Is there potential for standardized content? (?consensus opportunity)
  - Can the data be structured? (?consensus opportunity)
- Care plan
  - What the required functionalities (?MU Stage 2 – may not create value)
  - Is there a standard format?
  - Is there some standard content and which data are structured? (?problems, actions)
  - Will the market drive availability of care planning applications?
- Social services information
  - Is there a standard format? (?consensus opportunity)
  - Is there some standard content and which data are structured? (consensus opportunity)
- Privacy
  - When is it ok to share data? (?consensus opportunity)
  - How does consent relate to other data sharing consent? (?consensus opportunity)
  - How are privacy preferences effected? (?open source services opportunity)
- Data exchange
  - What is the messaging format?
- ???

Input is welcome!

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