Active Patients in Partnership or CAUGHT IN TRANSITION BETWEEN OUR ENTERPRISES?

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- Whatcom County, Washington
- Member of faith-based three state health care system
- Community approach to healthcare design & delivery
- Whatcom Health Information Network (HInet)
- Pursuing Perfection, RWJF / IHI
- Washington State Health Record Banking pilot
- Care Transitions, QUALIS / CMS

Pursuing Perfection

Key lessons

- Patients and their families are the center of care
- Most patient decisions and behaviors occur in the home
- They want their own health care information to use
- They want navigator-coaches
- Not all patients can play the same role
- Much is yet to be learned about supporting patients and families
 - PAM will likely be key in learning how to help
 - We must tailor support to each individual and family's capabilities

Accountable Care Organizations

- THREE ESSENTIAL LEVERS (missing?)
 - To engage patients and families in a coordinated and nuanced manner with their providers
- 1. Navigator-coaches
- 2.PAM
 - Essential for optimal interaction with patients and families
- 3.Individual health management system
 - Community-wide, interoperable, rules and workflow enabled

No Silver Bullets—Only Systems at the Whole Community Level (ACO Plus)

- "Research & Learning in Health and Healthcare by the Community, for the Community"
- Western Washington University
- Healthcare community
- Broader Community



PAM--How Capable is THIS Patient?

- We had no idea how important patient activation is!
- We still have only one pool of one depth?
- We are still:
- Putting Olympic divers in the baby pool.
- Putting babies on the three meter diving board.

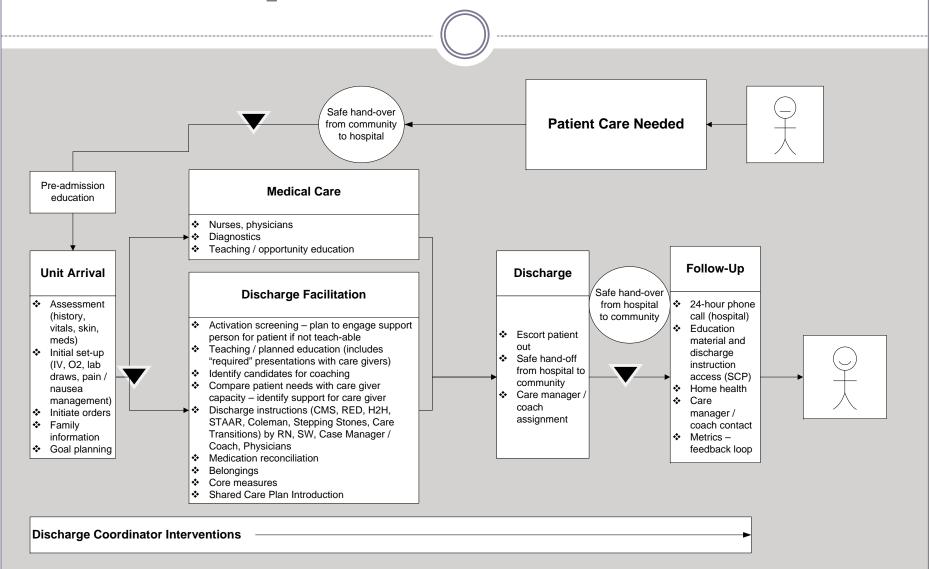
Approaches to Effective Patient Discharge

- Coleman Discharge with Coaching
- Re-engineered Discharge (RED)
- STAAR (STate Action on Avoidable Rehospitalizations)
- Center for Medicare and Medicaid Services
- Hospital 2 Home (H2H) by IHI
- Patient Activation Measure (PAM)
- Web based community care manager dashboard

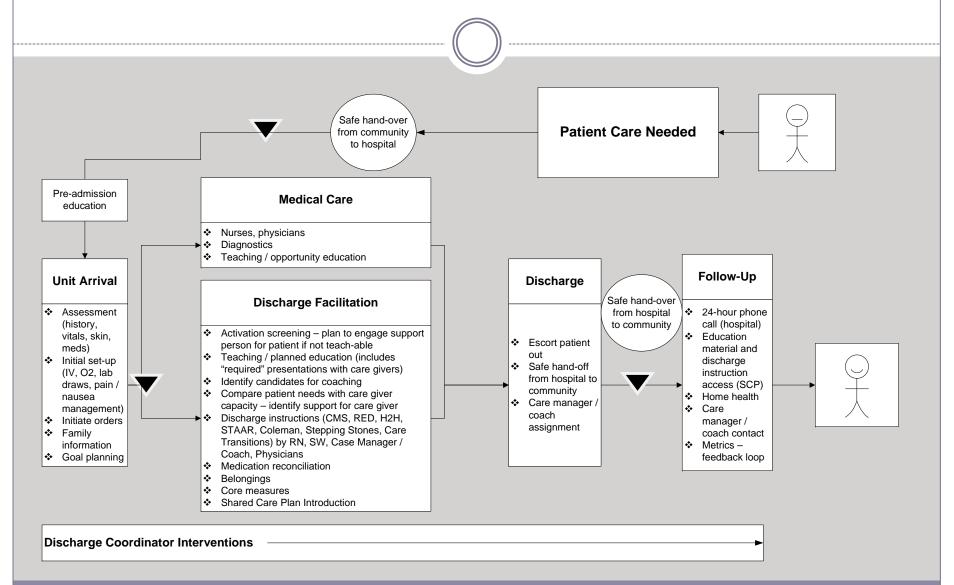
PAM as Vital Sign?

- An indispensable measurement (vital sign)
- Person-centric (fit our services to customers)
- Predictive
 - Correlates with clinical outcomes and cost outcomes
- Who and where to record it & how to use it?
 - We have just placed PAM into the PHR
- Making it available for rules based work flow electronic community health manager dashboard
 - Based upon the PAM, who should get what alerts to assist the patient?

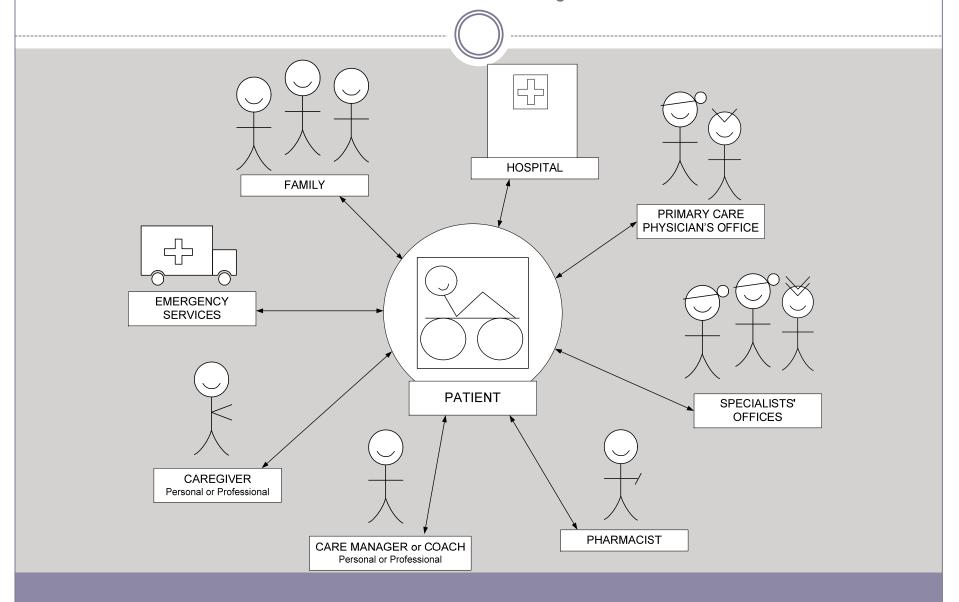
Hospital-Based Patient Flow

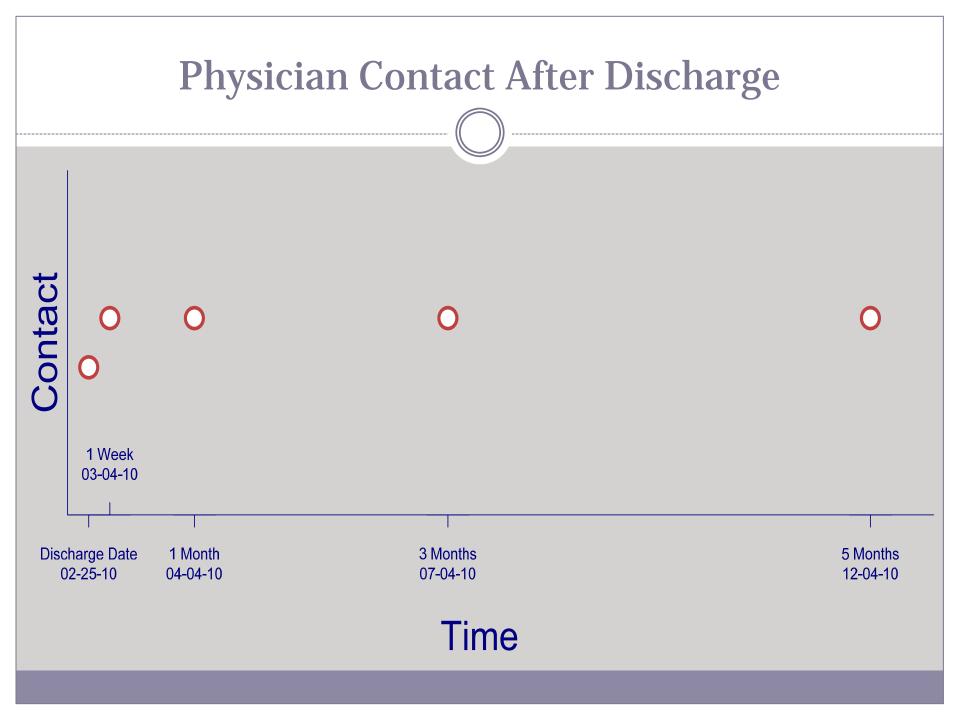


PAM and Patient's Role

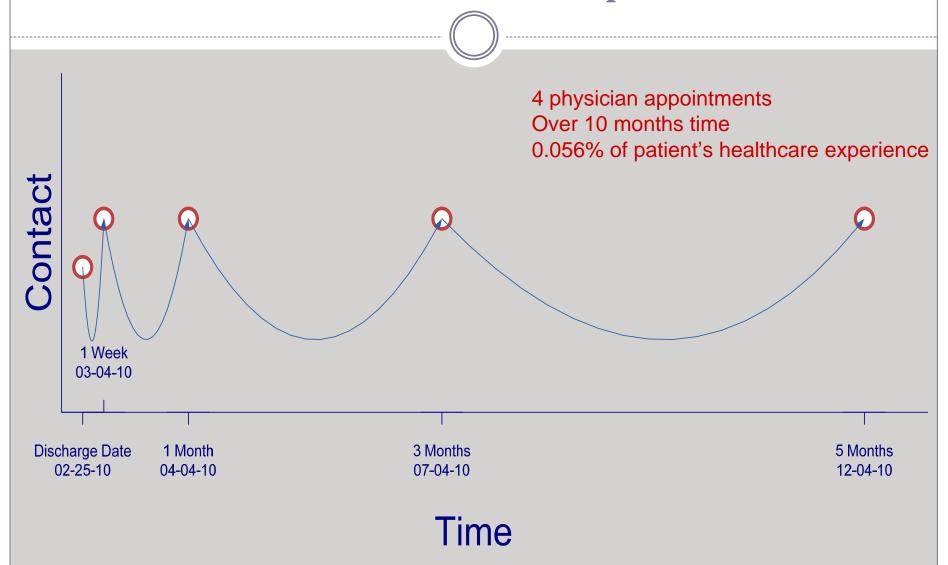


Patient-Centered Community Healthcare Model





Patient's Healthcare Experience

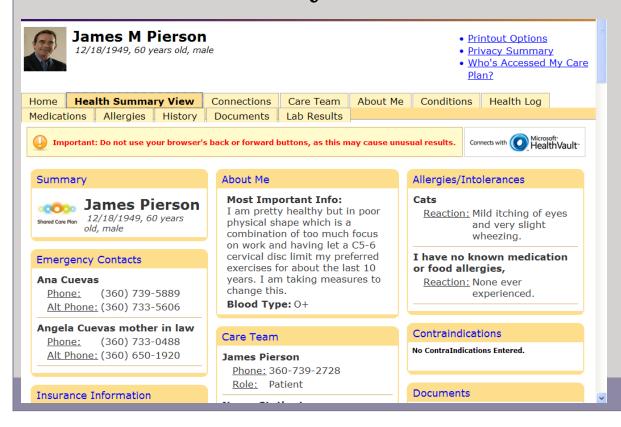


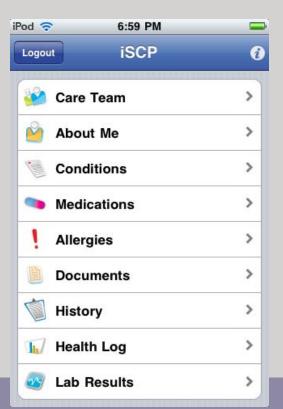
Shared Care Plan -- Connected After Discharge

- Shared Care Plan—a Community-Based Personal Health Management System
 - Initial introduction before leaving hospital
 - Access by patient and any caregiver
- Electronic interface to discharge instructions
 - Calendar entries, Medications, Symptoms, F/U Appointments
- Monitoring
 - Personal and professional
 - Electronic symptom tracking of patient
 - Home devices
 - On-line messaging capability

Shared Care Plan — A Community-wide Personal Health Management System on MS HealthVault

Currently interoperable with EMRs, HealthVault, Labs, State Immunization Data Base, Home Devices, and rules driven community care coordination software.





A Formula for a Successful eCommunity Health Management

Patients

- Labs, Medications,
 Immunizations, CCR
- Decision support relevant information
- Messaging and alerts
- Family care management

Doctors / Providers

- Clipboard information
- Closing communication loops of all sorts with patients and providers

Hospitals

- Transitions of care
- Home care management if at risk for costs

Employers

- Wellness
- Payers
 - Lower cost, higher quality

Schools

- Immunizations
- Medications

Integrating a New Vital Sign

- Stepping Stones --Qualis & Whatcom County
 - A community-wide care transitions project at the halfway point (of phase one)
- Redesigned the work in the hospital
- Spreading throughout the hospital
- Creating agreements between clinics and hospital
- We are designing the processes for integrating the PAM as a useful vital sign

PAM 13 Survey and Results -- Inside our PHR

Shared Care Plan Your Health Record Bank





James M Pierson 12/18/1949, 60 years old, male

Health Summary View Connections Care Te Medications | Allergies | History | Documents

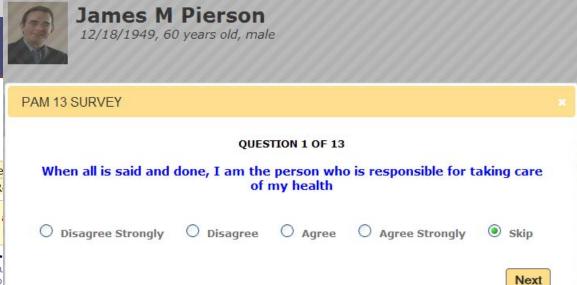
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I want the person working with me to know.

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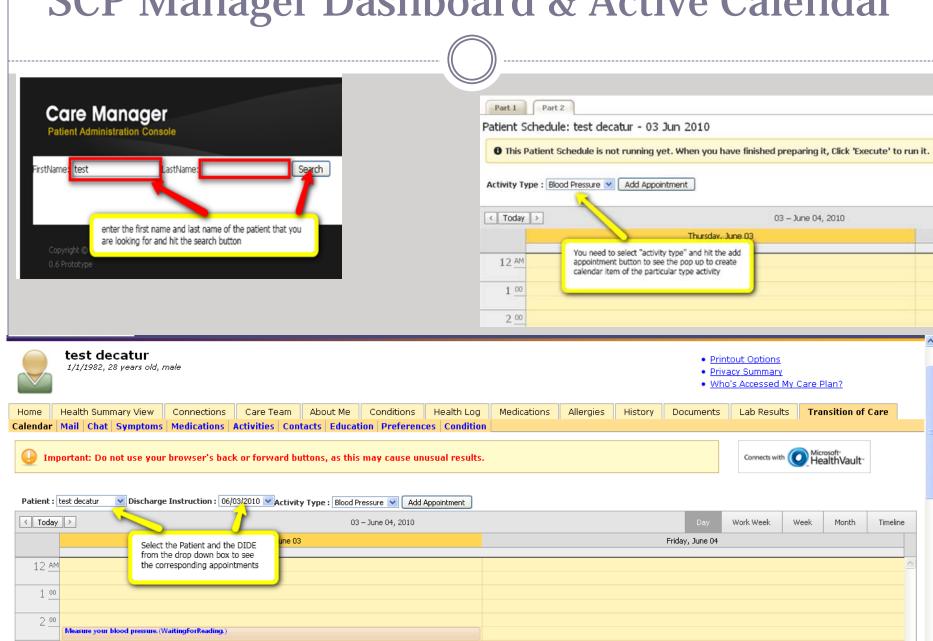
PAM 13 SURVEY

Activation Score	Activation Level	Date
56.4	3	6/7/2010 6:48:06 AM
70.8	4	6/3/2010 1:24:52 PM
75.3	4	6/2/2010 9:45:04 PM

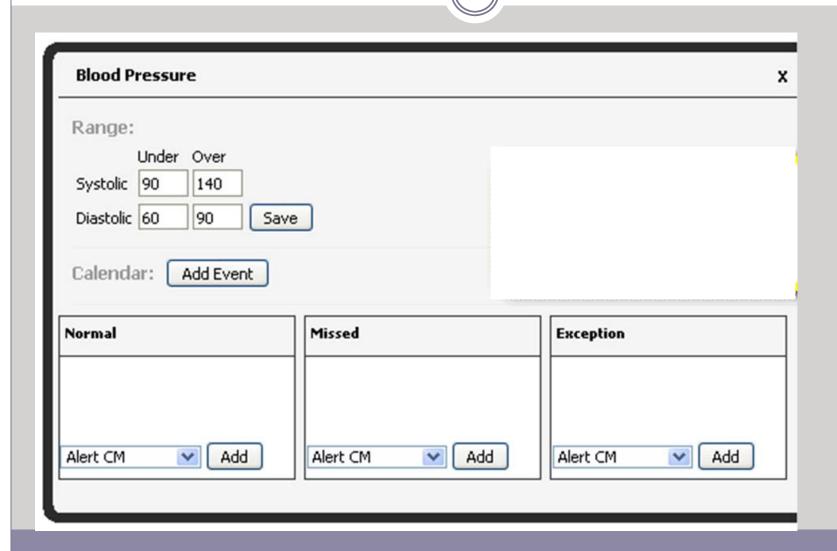


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SCP Manager Dashboard & Active Calendar



Automated Alerts with Messaging to Anyone



PAM Nursing Guide

Low Activation (Levels 1 and 2)

Characteristic	Implications
People low in activation feel overwhelmed by both the details of life and (especially) dealing with their health.	If you try to get them to understand more than one or two self management elements you will contribute to them being overwhelmed and they will not remember or do anything. You have to make a clinically informed choice as to what the one thing (two if level 2) is they need to understand.
In life in general, and with regard to health in particular, people at high levels experience far	The key for low activation patients is to help them break this negative emotions – poor self

High Activation (Levels 3 and 4)

Characteristic	Implications
Levels 3 and 4 are not overwhelmed (especially level 4) and have a clear goal focus. This is especially true for Level 4	With a strong goal focus and not being overwhelmed high activation patients can handle more information and more complicated information.
Level 4 patients in particular evaluate their return on investment. They tend to already have clear	Ask high activation patients what their health goals are (they are important to them and play a major

We have just begun to develop the patient and family PAM guide--how to interpret your PAM score and what to do next.

NEXT

- Collect PAM at time of admission and after discharge
- Train staff, coaches, patients and family to use PAM
- Use PAM to recommend coaching support
- Integrate PAM into post-discharge rules:
 - E.g., with a low PAM score we might engage family care givers or care managers earlier when a patient does not take a suggested action, such as weight themselves or indicate that they have made a follow up appointment.

SHARED CARE PLAN A Community Health Record Bank

ACKNOWLEDGEMENTS

- Came from Pursuing Perfection
 - o RWJF IHI
- Inspired creation of Microsoft HealthVault
- Developer/Vender Congral, Inc
 - Synched with MS HealthVault
- Washington State Health Record Bank Pilots
 - Ongoing