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by eccovia

MOVING TO A COMPREHENSIVE CARE PLAN

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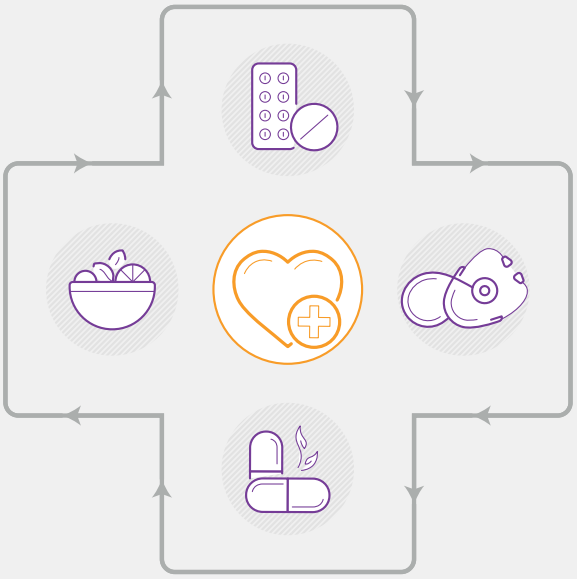
Today's challenge for Healthcare systems, insurance carriers, and providers is to better manage costs while improving outcomes for high-cost patients.

This is especially difficult when working with hard-to-reach populations, such as individuals who experience a combination of homelessness and other health-related needs such as mental illness or chronic disease. Providers struggle to address these concerns because they lack the patient data necessary to provide a 360° view of individual patients' needs.

Epic Systems CEO Judy Faulkner made waves in the healthcare industry when she announced that the solution to this problem is to transform the Electronic Health Record into a Comprehensive Health Record. Other EHR vendors scrambled to follow suit, claiming that they have already been discussing a Comprehensive Health Record concept which includes social determinants and other relevant types of data. Everyone appears to be talking about this idea, but what is actually being done to address all aspects of health for high-risk individuals? Let's start by providing a little background. High-cost patients are individuals who consume healthcare resources above the expected costs for the diagnoses and severity of their condition. Typically, high-cost patients have one or more barriers to obtaining care and maintaining health goals. These consumers challenge the ability of payer networks, health care systems, and providers to deliver effective care at an acceptable cost. As a result, almost half of the nation's health care spending is consumed by the 5% of patients at the top of the cost pyramid, while the top 1% accounts for more than 20% of the nation's total health care costs.[1] These high-cost patients bear the highest cost risk because they also bear the highest clinical risk. Payers and provider networks are trying to meet these challenges with new approaches, including expanding healthcare beyond the traditional walls of medicine, forming new partnerships, and directly addressing patient needs with respect to the social determinants of health.

1. Eapen Z., Jain S. "Redesigning Care for High-Cost, High-Risk Patients." *Harvard Business Review*, 2017 Feb 07.



The idea of the food pharmacy is simple.

Food is medicine.

AN UNDERSTANDING OF THE SOCIAL DETERMINANTS OF HEALTH IS REVOLUTIONIZING HEALTHCARE

Identifying at-risk populations based on social determinants of health and then tailoring healthcare delivery to them is a cornerstone of population health management. The aim is to reduce costs via care coordination and preventive care long before patients need an emergency room or enter the healthcare system for sick care.[2]

Some health systems have taken innovative approaches to combating local needs driven by the social determinants of health, expanding services far outside the bounds of traditional medical care.

WIDESPREAD SCREENING AND A FOOD PHARMACY

ProMedica, in Toledo, Ohio, had an epiphany. They realized that while the ProMedica medical system was thriving, the community they served was not as healthy, rating low on several health indicators such as obesity, infant mortality, and youth depression. As a result of this realization, ProMedica began screening all patients for needs among the social determinants of health, including education, employment, food security, housing, and transportation. For the initial 340 patients in the pilot program, 38 percent had needs in four or more of the assessed areas.

One of the most pressing community needs was food insecurity. Beyond the humanitarian issues presented by this realization, research has shown that food insecurity is linked to health problems throughout a person's life, including higher-risk pregnancies; increased incidence of colds, chronic disease; behavioral health; a compromised immune system; and longer recovery from illnesses later in life.

These facts led ProMedica to pioneer the use of a food pharmacy—a service where food is prescribed as medicine—and invest in inner-city grocery stores with healthy food. As the ProMedica food security program description states, "the idea of the Food Pharmacy is simple: Food is medicine.

As such, a healthcare professional writes a referral to the food pharmacy for patients [who] are identified as food insecure. These patients are then able to visit the pharmacy to pick up a supplemental supply of healthy food for their family."Resolving food concerns yielded concrete health results. For the 4,000 patients who received a food pharmacy referral in 2016, emergency department usage dropped 3 percent, readmission rates dropped 53 percent, and primary care visit rates increased 4 percent.

ProMedica has also used its resources and influence in other areas to address the social determinants of health. For example, they have bought and sold a hotel property to keep jobs in the community, invested in real estate development initiatives, relocated ProMedica's headquarters as part of a downtown revitalization, and used their resources to secure loans and fund investments that have driven an estimated $500 million of new economic development in the Toledo area.[3]

2. Scherpbier, H., Smith, C. "The Importance of Social Determinants in Population Health." Philips Wellcentive White Paper, 2017.

3. Morrison, Ian. "Taking on the Social Determinants of Health." *Hospitals and Health Networks*, 2017 Oct 24.

TAKING HEALTHCARE BEYOND HOSPITAL WALLS

Just a few short years ago, Martin Luther King Jr. Community Hospital in South Central Los Angeles would have seemed like an unlikely candidate to demonstrate the future direction of healthcare. Previously known as the Martin Luther King Jr./Drew Medical Center, the hospital was closed in 2007 due to patient neglect, mismanagement, and preventable patient deaths and injuries.

Determined not to repeat the mistakes of the past, LA County built a brand-new facility with a new purpose and vision. The new hospital sees itself as part of a larger system to improve the lives and protect the health of its residents—a mission that extends beyond traditional medical care to address needs in housing, food, jobs, and other services. For example, the new hospital partnered with a farmer's market—an effort sponsored by the county to combat the neighborhood's lack of fresh fruits and vegetables. A new behavioral health center will soon open, and a senior center, library, and transportation hub are planned.

"That larger vision of trying to take care of the community, not just treating patients in the hospital, is what puts Martin Luther King Jr. Community Hospital at the forefront of the future of U.S. healthcare," said Bruce Leff, professor of medicine at Johns Hopkins University School of Medicine.

> "Although our mission is to provide acute care for the community, we are continually finding ourselves saying, to do it well, we have to go beyond the walls and into social determinants of health and population health."
>
> Ian Morrison, *board of directors for Martin Luther King, Jr. Community Hospital*

Increasingly, public health experts are convinced that addressing the social determinants of health is crucial both for patients' wellbeing and for building a cost-effective healthcare system. Rather than just treating the illnesses that result from all these factors, they're looking for new models of care that can confront the roots of those problems. These models free up resources and enable providers to deliver traditional medical services to more people.

In the new paradigm of addressing the social determinants of health alongside traditional medical needs, the area surrounding Martin Luther King Jr. Community Hospital is as good a place to start as any. Health outcomes are below average, with mortality rates for stroke and coronary heart disease about 30 percent higher than the county overall. The area lacks many of the features needed for healthy living, such as access to healthy foods, and safe spaces for walking and exercise Instead, there are too many liquor stores, high rates of crime, and other factors that contribute to stress and disease. In other words, it is an environment that stands to benefit a great deal from a community hospital's efforts to address needs far beyond the walls of the medical facility.

"Although our mission is to provide acute care for the community, we are continually finding ourselves saying, to do it well, we have to go beyond the walls and into social determinants of health and population health," said Ian Morrison, a member of the hospital's board of directors.[4]

AN ESSENTIAL TOOL: THE COMPREHENSIVE CARE PLAN

Medical, behavioral health, and social support providers are joining forces to build coordinated systems of care to serve high-risk populations. A big challenge for systems of care is a lack of data sharing and real-time communication among providers. The 21st Century Cures Act focuses on establishing an interoperable health system that empowers individuals to use their Electronic Health Information to the fullest extent and enables providers and communities to deliver smarter, safer, and more efficient care. The Office of the National Coordinator for Health Information Technology (ONC) recently released a draft of their new Trusted Exchange Framework. According to the framework, the vision they seek to achieve "is a system to securely access and use health information from different sources. A system where an individual's health information is not limited to what is stored in electronic health records, but includes information from many different sources and provides a longitudinal picture of their health."

Most healthcare organizations have an Electronic Health Record (EHR) to collect medical data, but they have no way to share data with other providers, such as social services or substance abuse treatment programs. Epic's smartphone-based Share Everywhere solution—which, as Epic vice president of patient engagement Janet Campbell put it, enables patients everywhere "to easily share their health information with anyone they choose, no matter where they are"—encompasses a good idea, but it falls short of the mark of providing a longitudinal picture of patient health.

Apple's Personal Health Records app that allows users to "view medical records easily and securely on [their] iPhone."

4. Colliver, Victoria. "How 'Killer King' Became the Hospital of the Future." *Politico*, 2017 Nov 08. https://catalyst.nejm.org/making-the comprehensive-shared-care-plan-a-reality/

The ability to view health information is a great step in the right direction. However, there is still a lack of data sharing between health and social service providers. What organizations really need is a Comprehensive Care Plan.

A Comprehensive Care Plan is a living document that is built from customized social and physical health assessments and is accessible to all members of a multi-disciplinary care team. Shared assessments, intake and enrollment, care plans, and progress notes must be accessible at the point of care so providers are fully informed of all aspects of the patient's condition. For example, data recorded as part of an intake for homelessness would be available to a medical provider treating a chronic condition. The availability of this data can then help the medical provider choose an appropriate treatment plan and tailor it to the unique needs of the patient. Likewise, a community support provider benefits from seeing a patient's health history prior to recommending a care plan that may be unsuited to the patient.

HOW SHOULD A COMPREHENSIVE CARE PLAN LOOK?

According to NEJM Catalyst, "People need a plan that anticipates changes in health status, links them to services early in their care trajectories, and helps them manage key transition periods in their lives." A Comprehensive Care Plan should:

- Integrate data from primary care, mental health, and social services
- Allow all participating care team members to electronically view information that is directly relevant to his or her role in the care of the person
- Enable real-time communication with members of an interdisciplinary team
- Place the person's goals at the center of decision-making and give them direct access to their information
- Track a person through high-need episodes (e.g., acute illness), as well as coordinate preventative care during periods of health improvement and maintenance

CONCLUSION

Uncertainty around healthcare reform and rising healthcare costs will continue to place additional responsibility on providers to be accountable for improving patient outcomes while managing costs. This pressure will most likely accelerate as the Federal Government pushes more responsibility for healthcare down to the States. Expanding patient records to include social determinants is an important first step, but to truly take medicine outside of the clinic walls, providers and communities must continue to implement innovative models of collaboration that connect health and social service providers and enable whole person care coordination.

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Bruce Leff, *professor of medicine at Johns Hopkins University School of Medicine*

A Comprehensive Care Plan is the key to this collaboration. ClientTrack empowers medical, behavioral health, and social support providers to collaborate on evidence-based, coordinated systems of care to serve high-risk populations.

For more information about how our ClientTrack case management platform can help your organization create and execute a Comprehensive Care Plan, feel free to reach out to us at sales@eccovia.com.

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