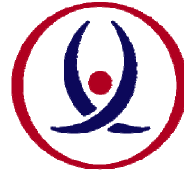


HEALTHWAYS

The Health/Care Trust Channel℠

Exchanging Health Information and Coordinating Care

Medicare Congress October 16, 2006

Dexter W. Shurney, MD, MBA, MPH

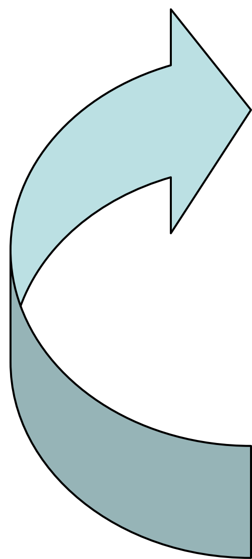
Senior Vice President and Chief Medical Officer

Exchanging Health Information and Coordinating Care

- The Need
- Challenges in Coordinating Care
- Some examples… "*Getting Closer*"

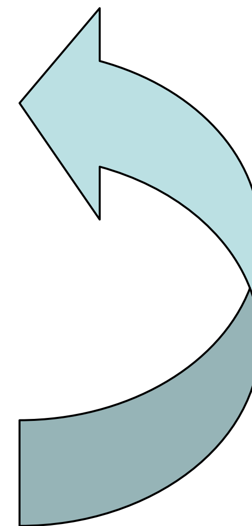
Healthways

- Largest provider of Health & Care Support, supporting 2+ million members
- Specific programs for wellness, disease management and high risk care management
- Over 45 million member months of proven experience
- Work with over 60 health plans and more than 600 employer groups
- Participating in 2 of 8 Medicare Health Support pilots

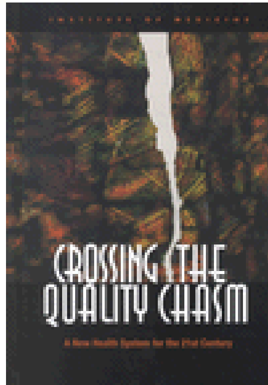


Care Coordination

DATA / Information



Care Coordination: A Growing Concern



The Robert Wood Johnson Foundation and the Institute for Healthcare Improvement partnered to establish Pursuing Perfection, a $20.9 million grant program, to support provider organizations committed to redesigning care systems and processes in accordance with IOM principles.

Following its "Crossing the Quality Chasm" report, the IOM identified care coordination as one of the top priorities in improving care, listing it among the Priority Areas for National Action.

- The current care system can't do the job
- Trying harder will not work…
- Changing care systems will…

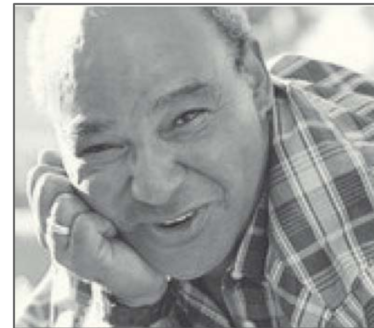
Seeing multiple physicians increases the need…

- Need for communication across providers is greater
- Greater risk for duplication
- Could increase health care costs
- Could increase potential for adverse events

Karen Milgate, Medicare, Payment Advisory Commission – 11.15.2005

Population Dynamics

- 2/3s of Medicare beneficiaries have 2 or more chronic conditions
- Patients with 2 chronic conditions see on average 7 physicians per year
- Utilization of multiple providers and sites often leads to fragmented health care and costly inefficiencies.

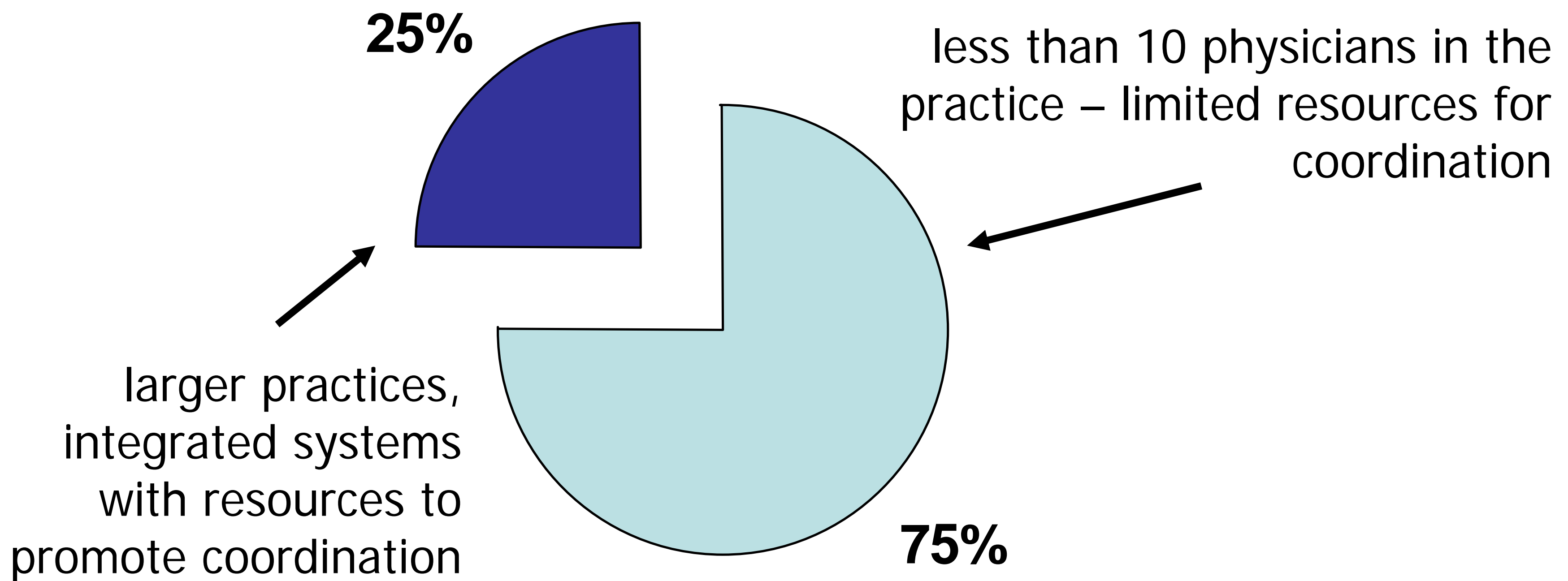


20 million+

With Diabetes and/or Heart Disease

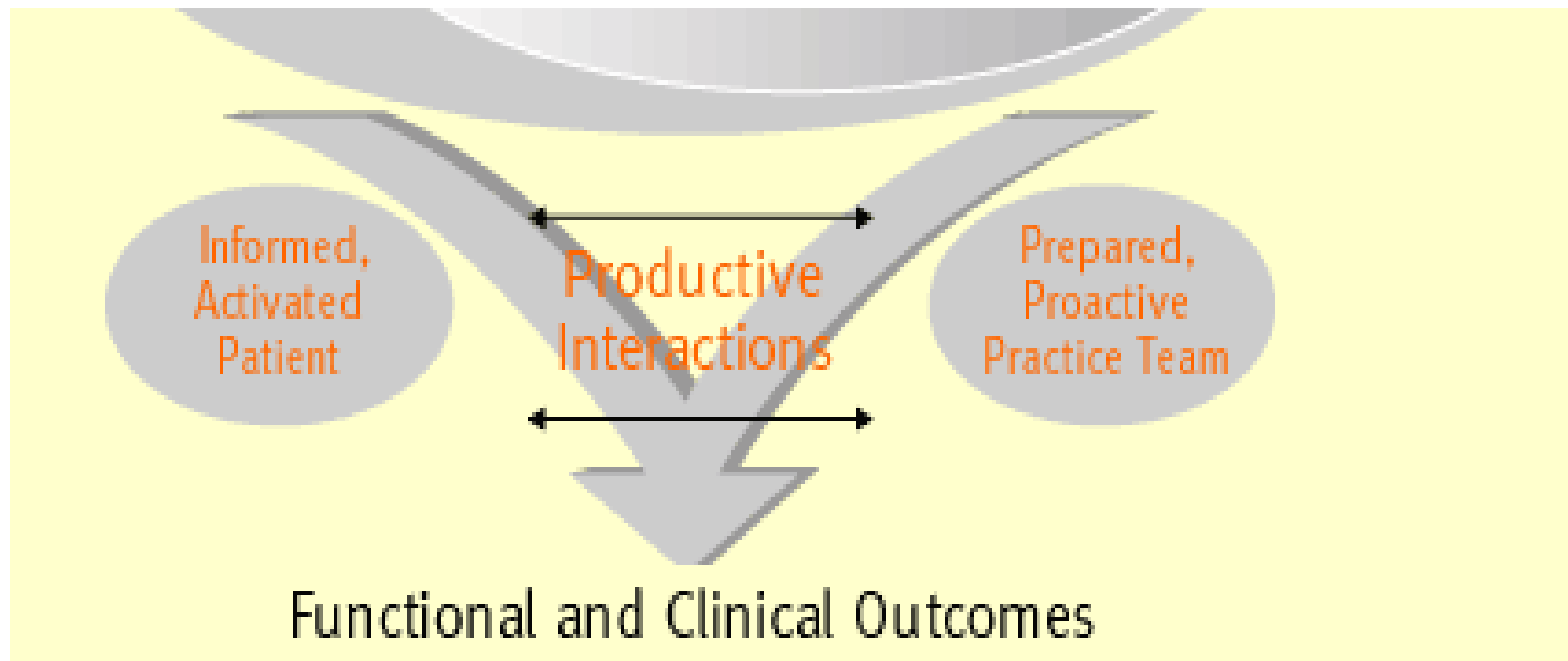
Delivery Dynamics

Physician Practices…



Kane C. (2004). Physician market place report: the practice arrangements of patient care physicians, 2001. Chicago, IL: Center of Health Policy Research, American Medical Association.

The Chronic Care Model

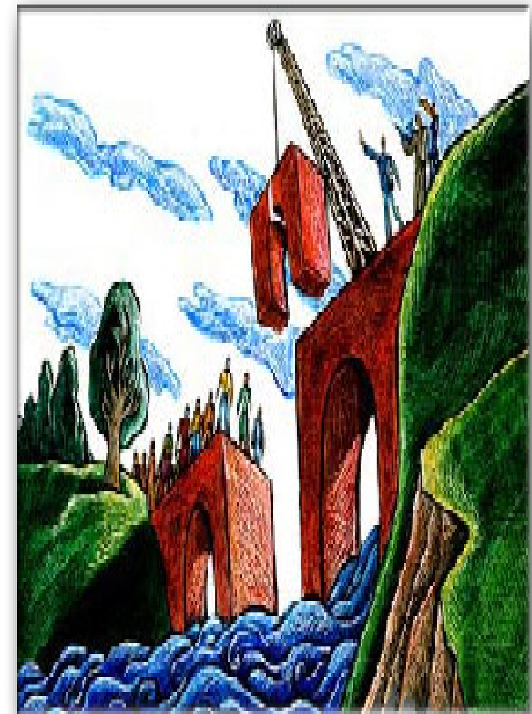


Source: Adapted from Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effect Clin Pract.*1998;1:2-4.

Key Challenges

Fragmentation (Delivery of Care and Data)

- No definition of roles and responsibilities for different parties
- Difficulty in aligning incentives
- Health providers not specifically trained in care coordination
- Systems not widely available to support coordination
- Disagreement between patients and physicians on defining success



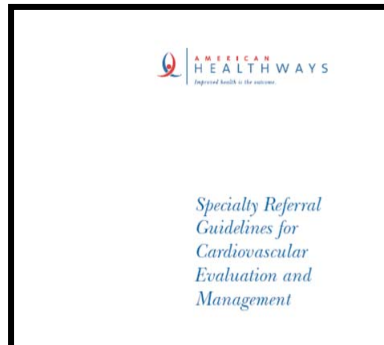
Engagement

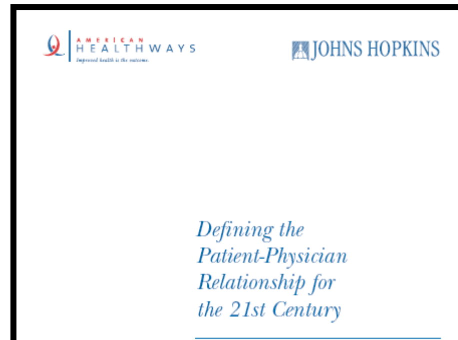
- Some patients lack motivation or capacity to take responsibility
- Insulation from the true economic impact of decisions

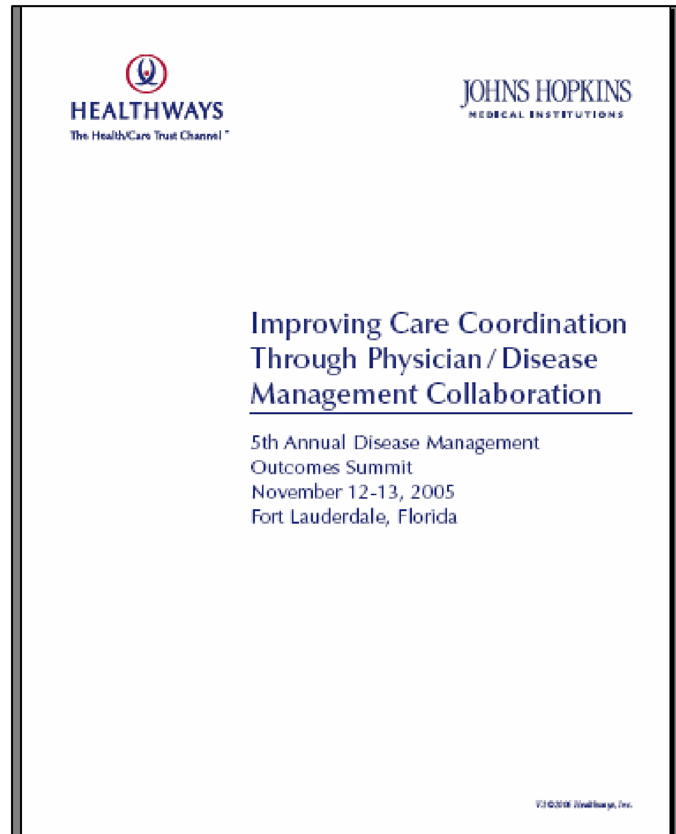
The Johns Hopkins/ Healthways Summit

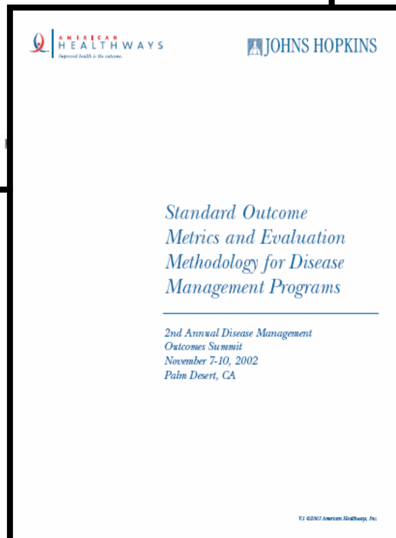
- First held in 2001
- Brings together more than 200 practicing physicians, physician executives, thought leaders and subject matter experts from across the country
- Engages participants in intensive discussions on critical issues and produces consensus report of recommendations
- Past topics include pay-for-performance, the patient-physician relationship and measuring disease management outcomes

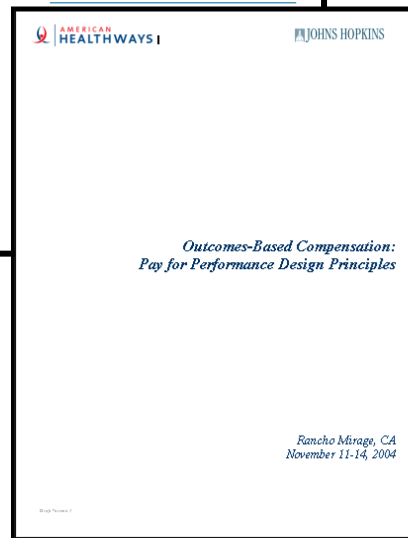
Consensus Conference on Care Coordination











http://www.healthways.com/articles/outcomes/SummitBooklet.pdf

Key Attributes of Care Coordination

1. Puts patients at the center of the care process and supports their engagement in their care, as well as their responsibility for their health and well being.

2. Requires organized and integrated care by health care teams.

3. Emphasizes positive healing relationships and ensures continuity of care.

4. Is an ongoing process that requires investment in comprehensive health information technology for data sharing, tracking and analysis of outcomes.

5. Requires aligned incentives and payment methodologies.

Defining Care Coordination

The health care team (includes the patient) supported by the integration of all necessary information and resources, chooses and implements the most appropriate course of action at any point in the continuum of care in order to achieve optimal outcomes for patients.

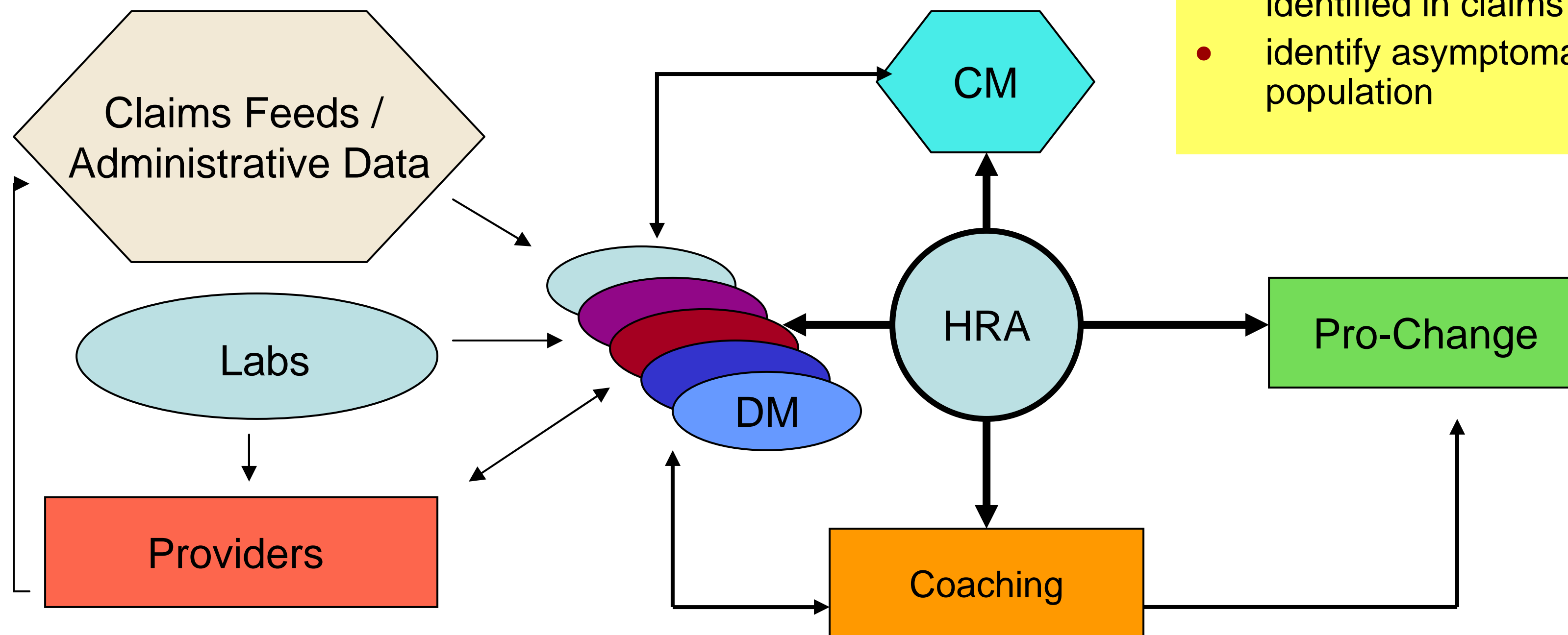
- Outcomes Summit Participants 2005

Integration

Information Exchange at the Service Level

HRA as Referral Source

- real time identification
- no claims run out issue
- find the population not identified in claims
- identify asymptomatic population

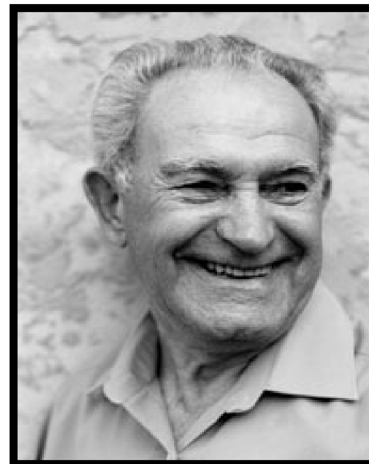


Information and Understanding

Consumption, and Costs and Benefit

Self-Efficacy

Develop Discrepancy



Effective Team Member and Satisfied Customer

Care Coordination: Guiding Principles

- Relationships among individuals on the health care team should be characterized by trust, open communication and mutual respect.
- Entire health care team shares responsibility for the management and care of the patient over time and across care settings.
- Health care teams include all members participating in the delivery of health care services under the leadership of a physician.
- Effective teams are characterized by clearly defined roles and responsibilities, coordination of activities and clear communication processes.

***"Coming together is a beginning.
Keeping together is progress.
Working together is success."***

— Henry Ford

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