

# Planning to Improve the Health of a Diverse Population

## The Role of Information Technology

Dr. Mary-Lyn Fyfe

Chief Medical Information Officer

Island Health

June 2015



One Person. One Record. One Plan for *health* and *care*.

# Objectives

- Discuss One Approach to Planning *Population* Based Care
- Identify Key Considerations When Planning *Primary Care*
- Describe Effective Use of IT in Health System *Transformation*

# Agenda

- Introduction to Island Health
- Planning for Health of a Population
- Planning in Primary Care: Transformational Care Models
  - Supported by an Integrated E HR/EMR
- Technologies, Partnerships and Innovations
  - TeleHome Monitoring
  - Orcah – Island Health and Cerner Institute
    - Enabling the Best Possible Medication History
    - KnowMe

# Introduction to Island Health



# Vancouver Island, BC

Island Health Authority

~765,000 Vancouver Island Population

18,000 Health Care Professionals

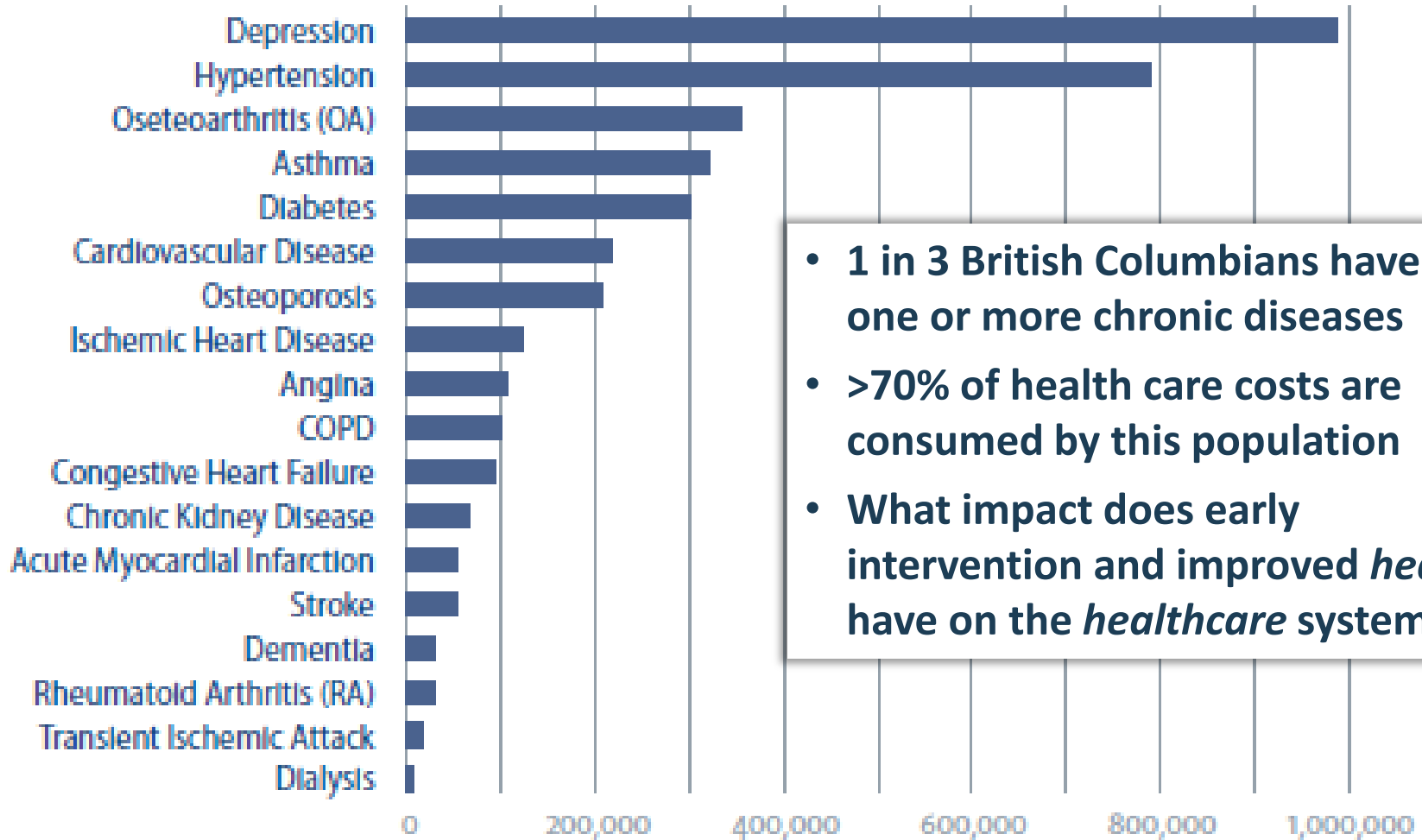
- 2,000 Physician Partners

150+ Facilities

- 6,370 Residential Care and Assisted Living beds
- 14,000 Home and Community patients (per year)
- 1,565 Acute Care & Rehab beds
- 1,075 Mental Health & Substance Abuse beds



# Chronic Illness in British Columbia

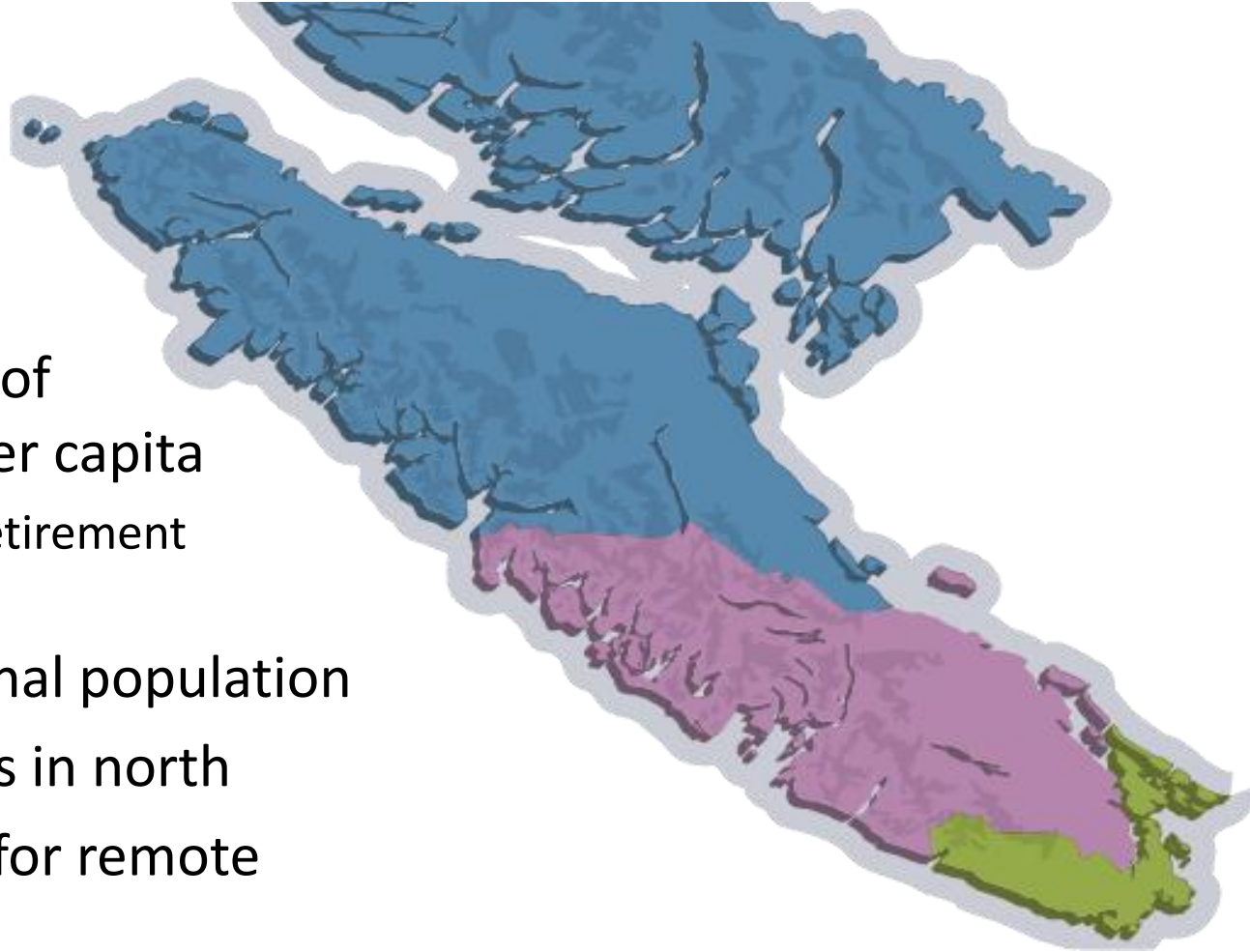


- 1 in 3 British Columbians have one or more chronic diseases
- >70% of health care costs are consumed by this population
- What impact does early intervention and improved *health* have on the *healthcare* system?




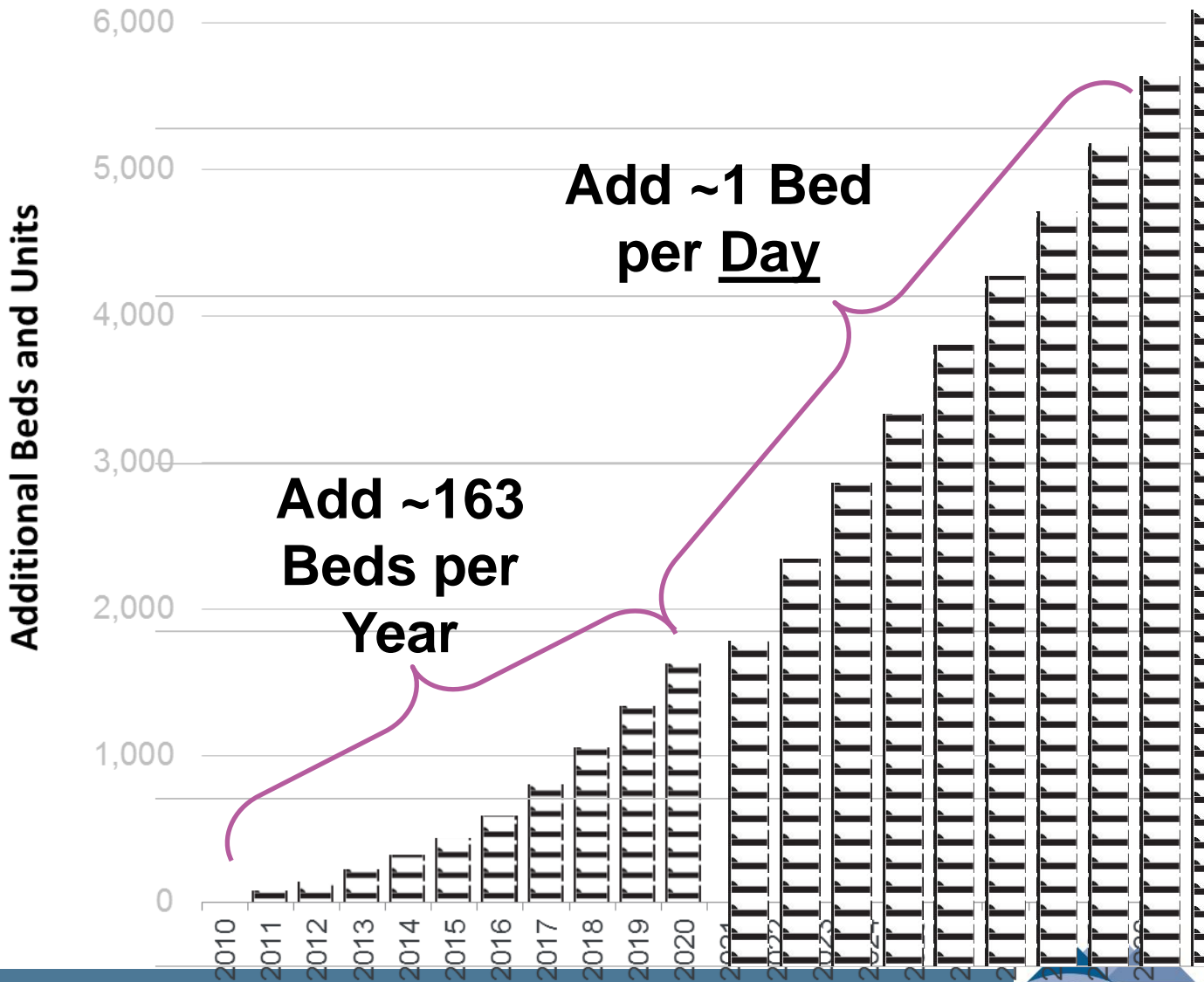
# Island Health's Population and Geography

- Highest proportion of confirmed chronic conditions per capita
- Highest proportion of elderly residents per capita
  - Fastest growth in retirement living in Canada
- 23% of BC's aboriginal population
- Poorer health status in north
- Challenging access for remote and rural clients



# The Case for Change

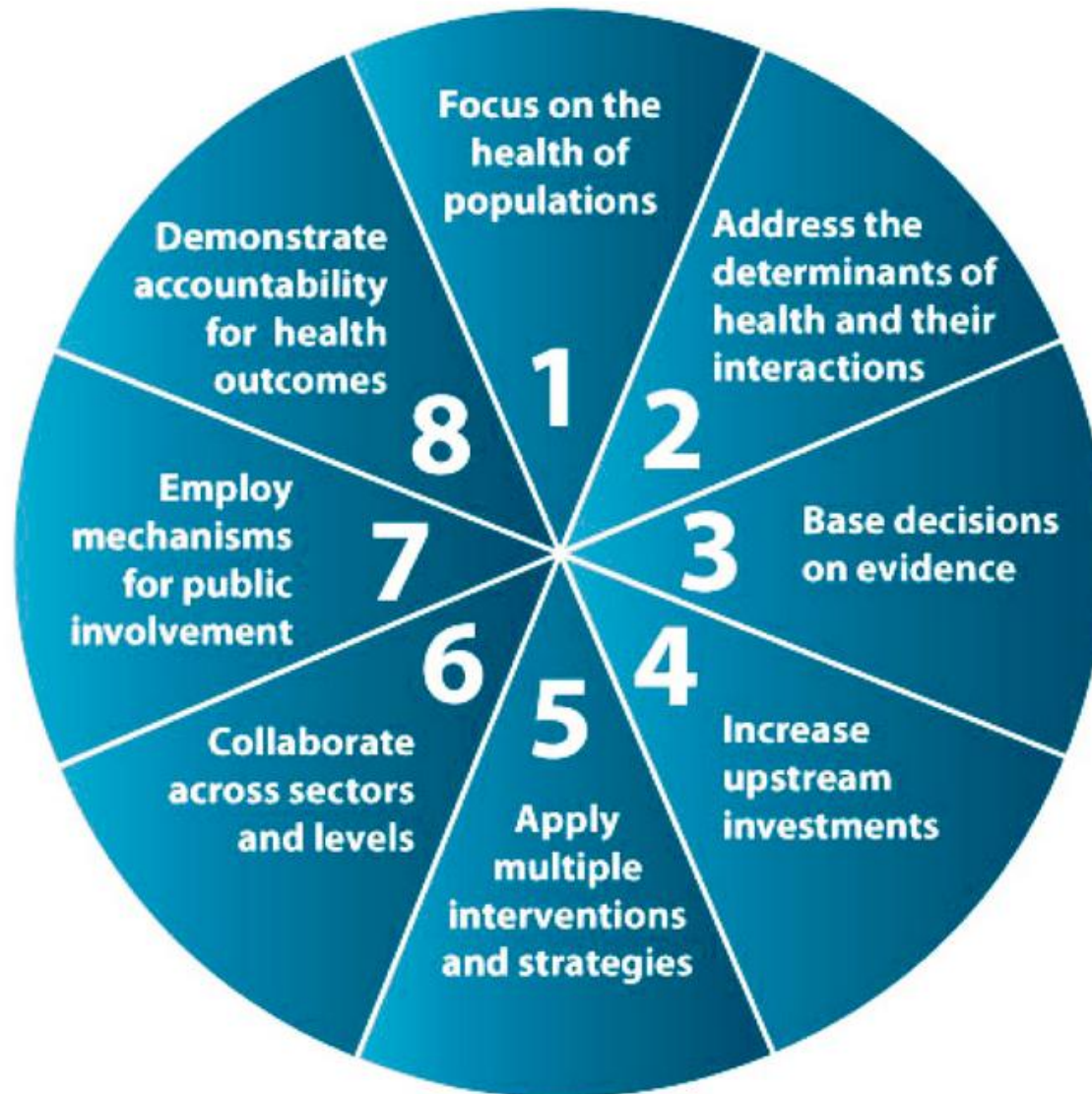
Maintain 92  
  
 Per 1,000  
 Population 75+



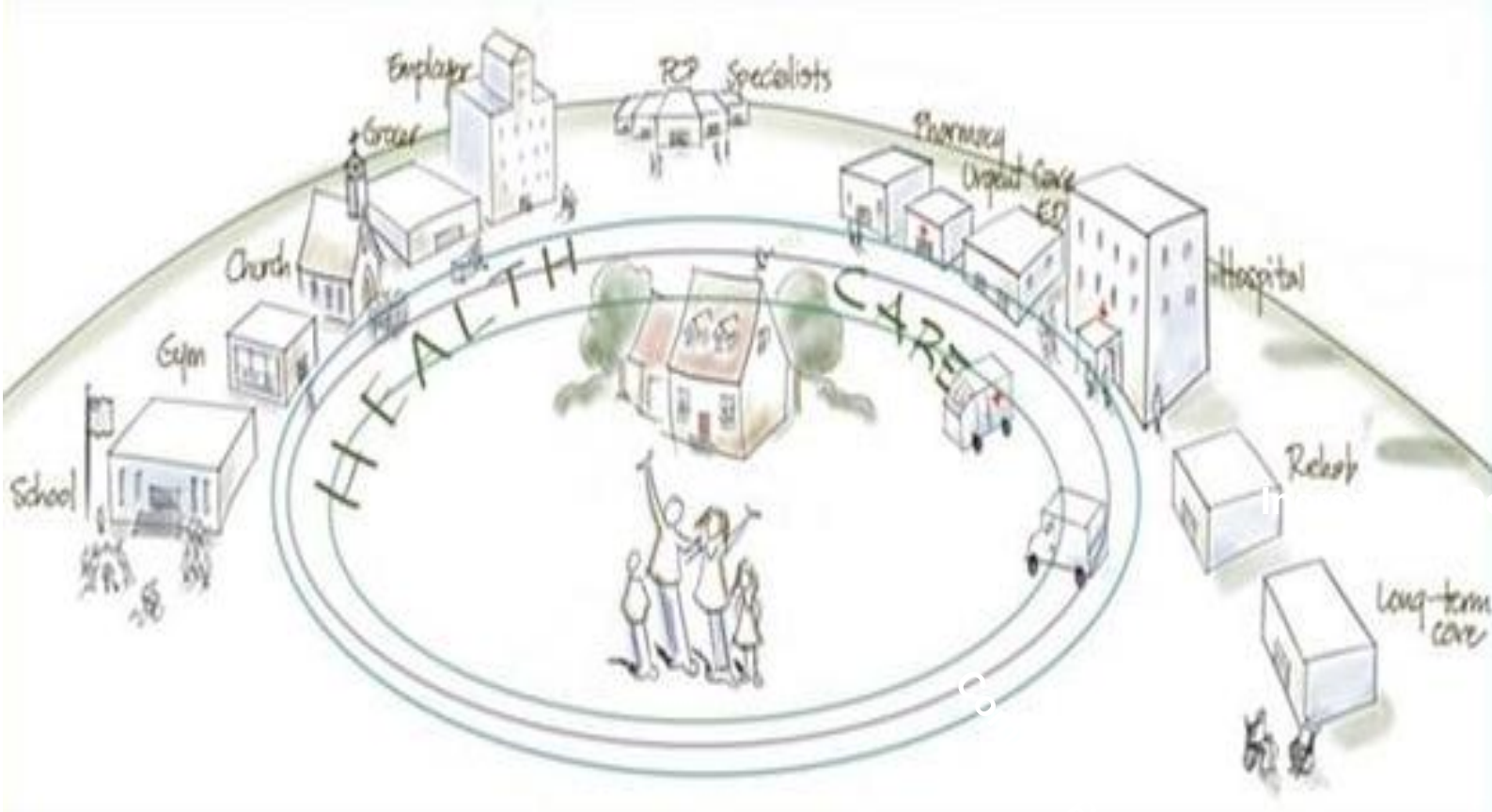


# Planning for Health of a Population

# Canadian Population Health Approach: Organizing Framework



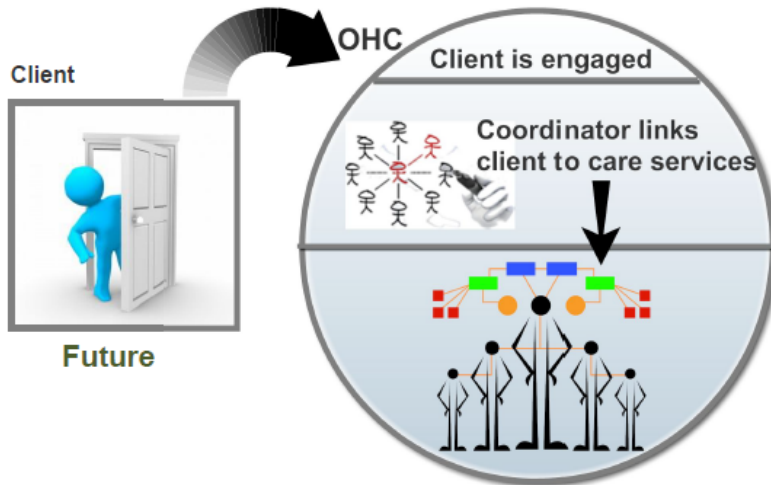
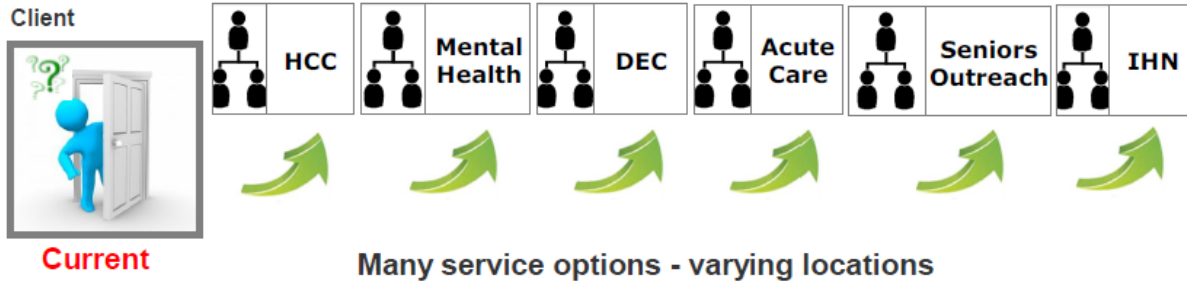
# Cerner/Island Health Shared Vision



# **Planning in Primary Care Transformational Care Models**

**Collaborating Across Sectors and Levels  
Base Decisions on Evidence**

# Patient Experience: Now and Future



An integrated care model makes engagement for health services easier for the client.

November 7, 2012 v.4

# Inspiration for Change: Integrated Health and Care

## Nuka Model – summary

1. Relationships – trusting personal partnerships
2. Customer Driven – Alaska Native values
3. Same Day Access
4. Max Packing
5. Working at the top of your license in team
6. Service Agreements
7. Job Progressions, Career Ladders, Mentoring
8. Giving Story, Receiving Story
9. Accountable Performance
10. Putting services into culture
11. Asset Based positive approaches
12. Operational Principles

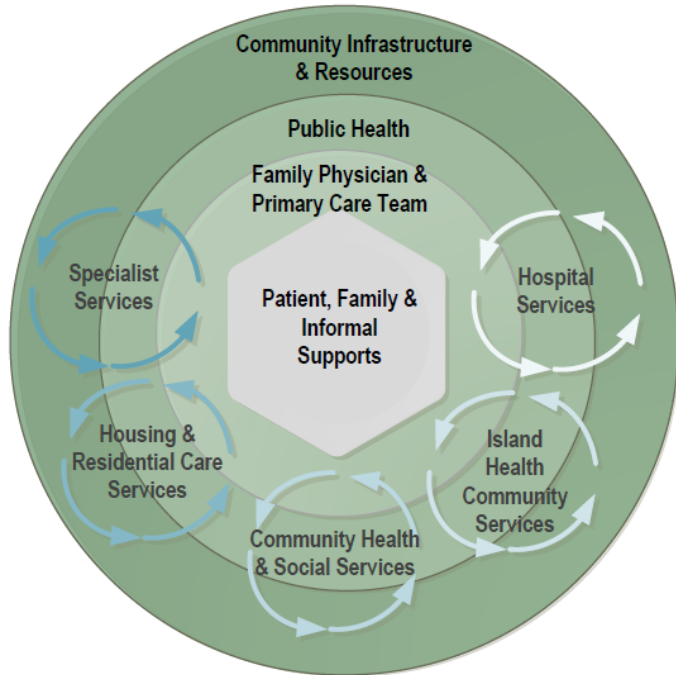


<http://www.southcentralfoundation.com/>



# Flipping the Balance of Care

AIM: Population Health & Wellness



**Care** – from hospital to community

**Delivery** – from individual care providers to care teams

**Power** – from provider to patient and family

**Costs** – from treatment to prevention and co-production

**Emphasis** from volume to value; and from health care to health

Flipping Health Care. Bisognano. Aug 2014

# Health Centred Around the Individual

Nutritionist

Care Navigator

Family

Primary Care  
Provider



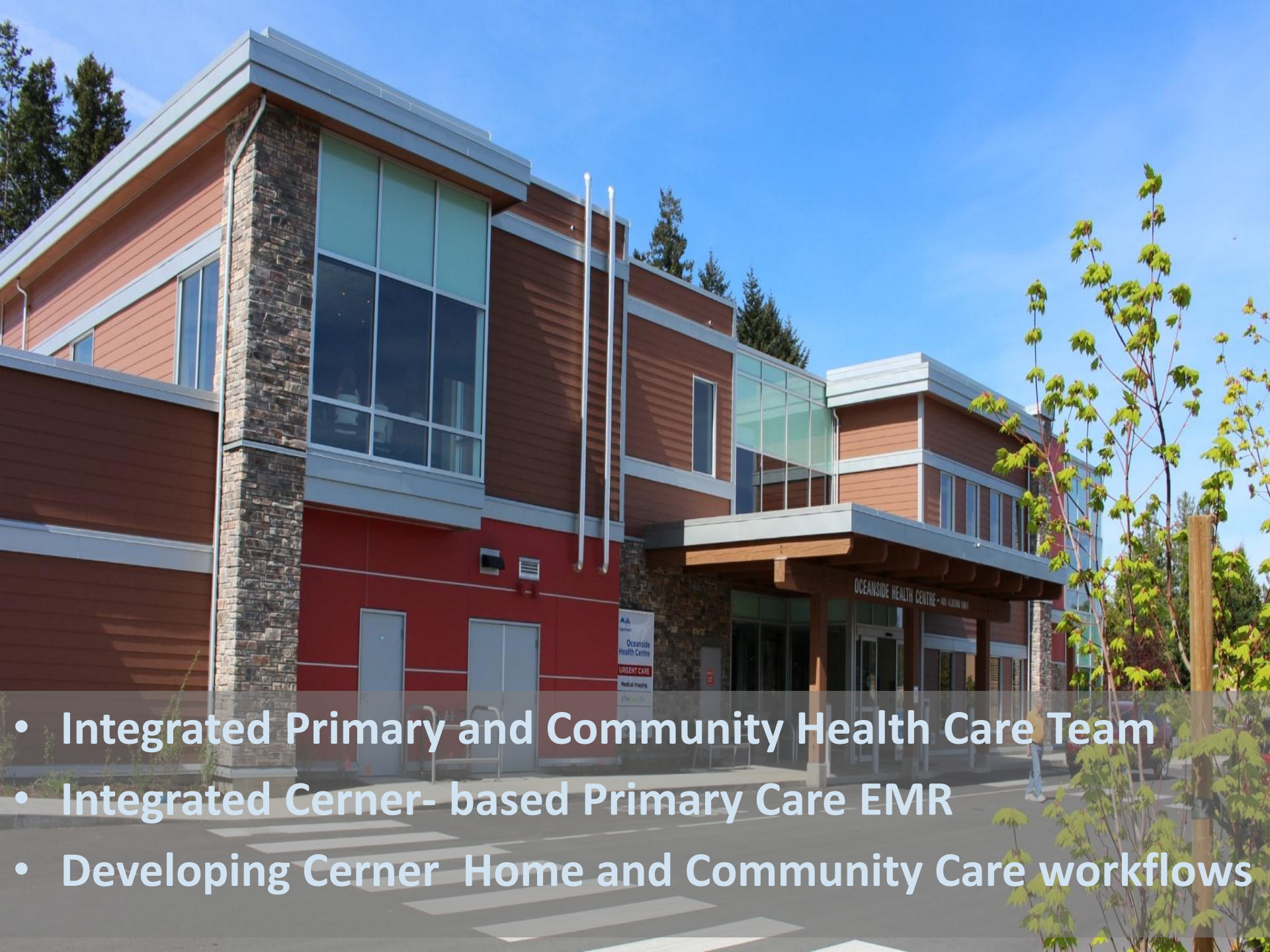
Medical Office  
Assistant

Community-  
Based Providers

Pharmacist

Behavioural Specialist





Oceanside Health Centre  
URGENT CARE  
Medical Imaging

OCEANSIDE HEALTH CENTRE - 400 ALBERTA HWY

- Integrated Primary and Community Health Care Team
- Integrated Cerner- based Primary Care EMR
- Developing Cerner Home and Community Care workflows

# **Technologies, Partnerships and Innovations**

# **TeleHome Monitoring**

**Focus on the Health of Populations**

**Base Decisions on Evidence**

**Apply Multiple Strategies and Interventions**



# TeleHome Monitoring: Innovating Care Delivery



*“Telehomemonitoring provides me the ability to remotely ‘see’ how my patients are doing every day and to deliver care more proactively. This helps me to identify potential health problems before they arise.”*

Christine Gotzman, HCC Nurse



# TeleHome Monitoring for Chronic Heart Failure

<b>Results</b> ( <i>n=87</i> )	<b>Pre</b>	<b>Post</b>	<b>Change</b>
Hospital Admissions (#)	36	14	↓ 61%
Length of Stay (days)	426	106	↓ 75%
Emergency Dept Visits (#)	57	20	↓ 65%

## **Client Experience and Satisfaction**

Client Compliance with Daily Measurements	<b>98%</b>
% Reported “Easy to Use”	<b>92%</b>
% “Strongly Agreed” that monitoring helped to manage CHF	<b>87%</b>

# Understanding the Possibilities: Bending the Curve



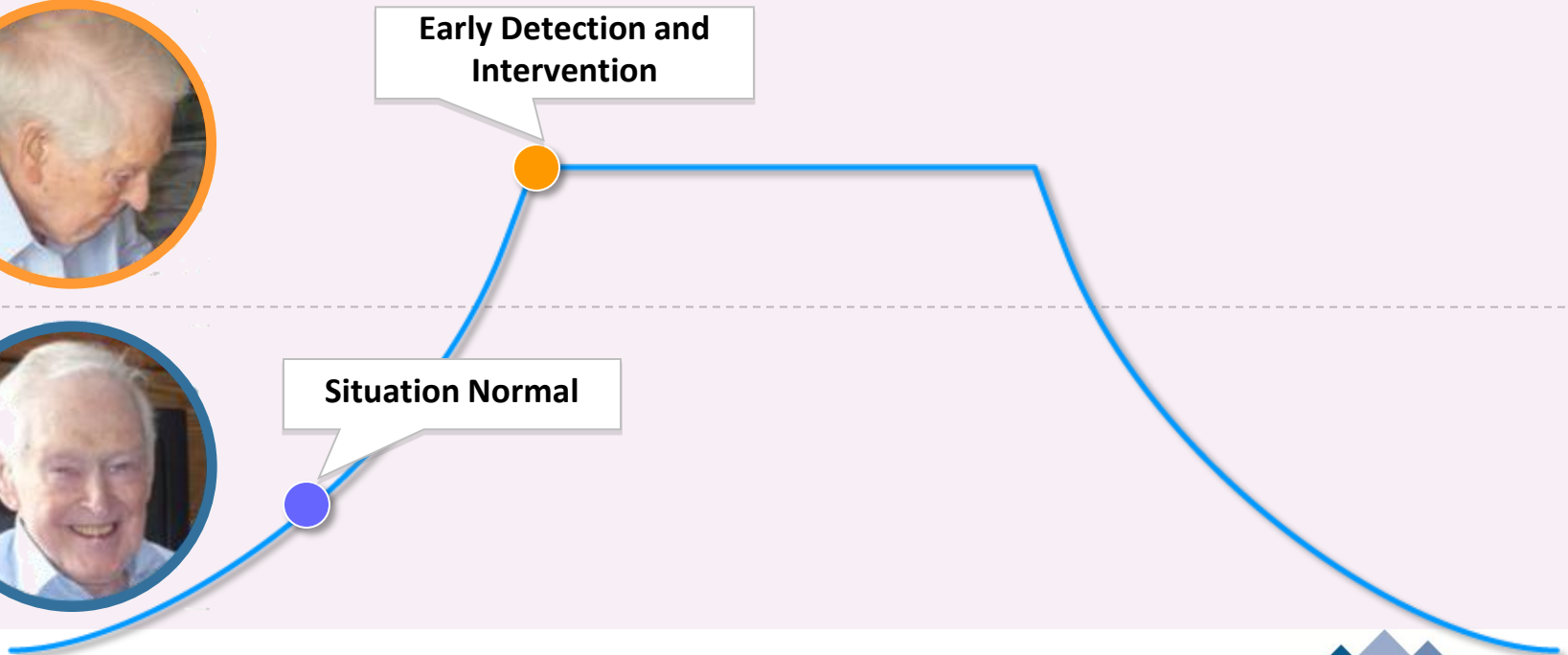
*Telehome monitoring helps avoid acute incidents*



**Early Detection and Intervention**



**Situation Normal**



# New Conditions, Integration and New Care Models



## 2015/16 (600+ clients)

- One new condition
- Introduce Personal Health Records
  - Oceanside
- **Data integrated into Cerner EHR**



## 2016/17 (1,000+ clients)

- Expansion of integrated care teams
- Extend multi-condition monitoring

## 2014/15 (200+ clients)

- Expand CHF monitoring
- Broaden referral process
- Optimize care pathway
- New Models of Care i.e. Oceanside



# Electronic Health Record Partnerships and Innovations



**Cerner**<sup>TM</sup>

**o r c a h**  
INSTITUTE



**island health**

# The Orcah Institute for Innovation in Population Health

- **The Drivers and Opportunity**

- In 2011, both Island Health and Cerner had a need to respond to the emerging focus on accountable care and population health
- Both parties recognized Island Health's unique positioning as an end-to-end micro-system with an aging population demographic

- **The Orcah\* Institute**

- One of four Cerner 'Institute' relationships focused on developing future-oriented solutions with broad applicability

- **IHealth – 'the Beginning'**

- The foundational infrastructure for advanced clinical analytics, quality improvement and health innovation



**Cerner Client Institute Relationships**

# **Enabling an Electronic Best Possible Medication History through Data Integration**

**Collaborating Across Sectors and Levels**

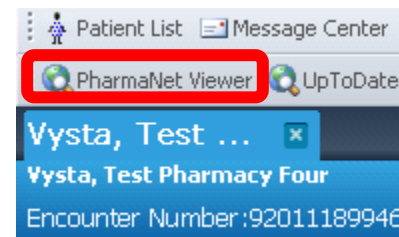


# Towards Medication Safety – An Integrated PharmaNet View

## A Canadian First in 2008

### Provincial Drug Database Integration within a Regional Electronic Health Record

- Cerner configured to pass physician's credential (CPSID) and patient's Personal Health Number (PHN) seamlessly; no further log in required
- View Access to patient's 15 most recent dispensed prescriptions and/or last 14 months of dispensed prescriptions from PharmaNet



**Divoky, A** MMale 70 Y CERNER: Divoky, A DOB:1937-FEB-14 PHN#:9147081439 MRN:34-27-37  
PharmaNet: DIVOKY, A DOB:1937-FEB-14 PHN#:0009147081439

#### Recent Medications

Medications	Adverse Reactions
2023-APR-18 R 1000 COMPOUNDED MIXTURE UNKNOWN To be taken as directed. LEVIS	ERYTHROMYCIN STEARATE ABBOTT LABS 125MG/5ML ORAL SUSP (302)
2022-MAR-14 F 300 METHADONE HCL PHARMASCIENCE 100% POWDER TAKE AS DIRECTED CULLEN	WARFARIN SODIUM UNKNOWN 5MG TABLET (10308)
2022-MAR-12 F 10 CHLORPROMAZINE HCL UNKNOWN 100MG SUPP.RECT TESTUBG LABELS AND THIS IS A SIG CODE FOR TES DOCTOR CULLEN	PENICILLIN G POTASSIUM NOVOPHARM LTD 312.5MG TABLET (151432)
2022-MAR-12 F 300 TEMAZEPAM APOTEX INC 15MG CAPSULE TAKE AS DIRECTED CULLEN	SULFAMETHOXAZOLE/TRIMETHOPRIM HOFFMANN-LAROC 400-80MG TABLET (272469)
2022-MAR-12 F 70 BUPROPION HCL UNKNOWN 100MG TABLET SA TAKE AS DIRECTED CULLEN	DIAZEPAM APOTEX INC 5MG TABLET (36215)
2022-MAR-12 F 300 WARFARIN SODIUM APOTEX INC 1MG TABLET TAKE AS DIRECTED CULLEN	
2022-MAR-12 F 300 LABETALOL HCL APOTEX INC 200MG TABLET TAKE AS DIRECTED CULLEN	

#### Adverse Reactions

ERYTHROMYCIN STEARATE ABBOTT LABS 125MG/5ML ORAL SUSP (302)

WARFARIN SODIUM UNKNOWN 5MG TABLET (10308)

PENICILLIN G POTASSIUM NOVOPHARM LTD 312.5MG TABLET (151432)

SULFAMETHOXAZOLE/TRIMETHOPRIM HOFFMANN-LAROC 400-80MG TABLET (272469)

DIAZEPAM APOTEX INC 5MG TABLET (36215)

#### Conditions

GOUT C

ALLERGY - PENICILLAMINE

# Towards Medication Safety: An Electronic Best Possible Medication History (BPMH)

## A BPMH is a Medication History Created Using:

- A systematic process of interviewing the patient, family and/or caregiver
- A review of at least one other reliable source of information to obtain and verify a patient's medication use
  - Prescription, non-prescription, traditional, holistic, herbal, vitamins, supplements and office samples
- Complete documentation of medications including name, dose, route and frequency

BPMH is a snapshot of a patient's actual medication use, which may be different than what is contained in their records!

Data Sources: Safer Health Care Now! presentation: A Novel Tool to Assess the Quality of Admission MedRec Processes  
Accreditation Canada <http://www.accreditation.ca/sites/default/files/rop-handbook-en.pdf>

# Towards Medication Safety: Integrated PharmaNet Data BPMH Pilot at Oceanside Health Centre

- Joint initiative between BC Ministry of Health Pharmaceutical Services Division, Cerner Corporation and Island Health Authority to pilot ***another first in Canada***
  - Direct PharmaNet access via Cerner for Nurses (RNs) and Nurse Practitioners (NPs)
  - Cerner/PharmaNet **data** integration to support BPMH documentation
    - PharmaNet medication profile accessed via External Rx History button in Medication List
    - Ability to import directly into Cerner
- BPMH documentation in Urgent Care, Primary Care and Medical Day Care

The screenshot displays the Cerner Medication List interface. At the top, a yellow header bar shows 'PHN:BC 9029817037' on the left and 'Encounter Number:92012880286' on the right. Below this is a dark blue navigation bar with a home icon and the text 'Medication List'. A secondary navigation bar contains several buttons: '+ Add', 'Document Medication by Hx', 'Check Interactions', and 'External Rx History'. The 'External Rx History' button, which features a pill icon, is highlighted with a red rectangular border. On the left side, a dark grey sidebar menu lists options: 'Patient Summary', 'MAR', 'Interactive View', 'Orders + Add', and 'Medication List + Add'. The main content area shows a 'Medication List' tab selected, with a 'View' button and a status indicator that reads 'Displayed: All Inactive Orders | Completed Medications'.

# Enhanced BPMH Oceanside Health Centre Pilot – Phase 2 (Apr 2015)

thnet, Lawrence Gender:Female Age:39 years Loc:MDC-OHC  
 N:BC 9030146411 Encounter Number:92013541732 MRN:19618420 DOB:01-Jan-1976 \*\* Allergies Not Recorded \*\*

Add External Rx History Medication History  
 No Known Home Medications  Unable To Obtain Information  Use Last Compliance

Reconciliati  
 Meds Hi

**External Rx History**

Display: Last 12 Months  Show Individual Instances Disclaimer: ▲

This Rx history contains prescription records provided by community pharmacies and pharmacy benefits managers (PBM's). Such Rx history may be incomplete and prescriber should not rely solely on this Rx history data to make any clinical decisions. It is the responsibility of the prescriber to validate and verify the information directly with the patient or via other appropriate means.

PharmaNet Profile

Order Name/Details	Last Fill	Add As
✓ Rx history as of: 23-Apr-2015 15:06		
METHADONE (METHADONE) 10MG/ML UNKNOWN		
(3) WARFARIN SODIUM 2.5 MG TABLET APOTEX INC	15-Feb-2015	

To be taken once daily(1) at approx. the same time each day.

Document Medication by Hx

Order Name/Details	Last Dose Date/Time	Information Source	Compliance Status	Compl
Last Documented On 23-Apr-2015 15:22 (Test , P2 RN)				
<b>4 Home Medications</b>				
acetaminophen (acetaminophen extra strength) 1,000 mg, oral, Q8H, PRN: Pain				
<b>4 Pending Home Medications</b>				
amoxicillin (Amoxil) 500 mg, oral, Q8H				
ALPRAZolam (Xanax 0.25 mg oral tablet) 2 tab oral DAILY PRN: anxiety		Patient	Still taking, as prescribed	Family tabs d

Cerner Profile

▼ Details for **warfarin (warfarin 2.5 mg oral tablet)**

Cerner Order Details Entry

Details  Order Comments  Compliance

Dose	Route of Administration	Frequency	Duration	Dispense	Refill
1 tab	<input type="checkbox"/> oral	<input type="checkbox"/> DAILY		30 tab	

Drug Form: Tab  PRN:  Samples:  Requested Refill Date:

Requested Start Date/Time: 23-Apr-2015 1526 Performing Location:  Special Instructions:

Type Of Therapy:  Acute  Maintenance

# **KnowMe**

## **Changing the Conversation**

**Employ Mechanisms for Public Involvement**  
**Address the Determinants of Health and Their Interactions**



# See me as a **P**erson not just another **p**atient

my **S**tory

my **G**oals

my **L**ife Plan

my **C**are Team

my **F**amily

my **V**alues

my **D**aily Living

my **F**ears

my **H**obbies

What's Important to **M**E regardless of where I am





# KnowMe Possibilities

- Additional Patient Identified Information
  - Personal care team
  - Problems (symptoms)
  - Hobbies
  - Mood
  - Stressors
  - Housing/Education/Work
  - Daily living habits
  - Advance directives
  - Life events
  - Goals
- Additional Clinical information (TBD)
  - Home treatments and assistive devices
- Professional and community services
- Additional views
  - Timelines (i.e. visits and life events)
- Engagement via Patient Portal

# KnowMe at the Beginning: Know My Story

Smith, Katherine - Opened by Carter MD, Jan

Task Edit View Patient Chart Links Notifications (Loading) Options Current Add Help


Home Links New Sticky Note View Sticky Notes Tear Off Attach Charges Charge Entry Exit Calculator Message Sender AdHoc Communicate

Smith, Katherine

Smith, Katherine DOB: 12/21/1955 Age: 65years Sex: Female Allergies: Penicillin, Shellfish  
Weight: 167 lbs. MRN: 200365448 PHN: 1005-63251

KnowMe Print 5 minutes ago

Menu - Ambulatory



VIP

I am a happily married positive person who lives with chronic pain and fatigue everyday. I want to work with my health team to find solutions that will improve the quality of my life. I am passionate about taking care of my health to the best of my ability.


## Know my story

### Kathy Smith

I am a 65 year old white female. Speaks English as a primary language. Observes Methodist


Home: 250-858-1234  
Mobile: 250-858-5678

#### Emergency Contact...




John Smith, Husband  
250-858-5678...  
Same address as Kathy

#### Next of Kin...



Sally Woods, Daughter  
250-858-1267  
Victoria, BC...



Derick Woods, Son  
255-858-6534  
Toronto, ONT...

#### Retired 5 years

High School Teacher - Desk/Office **Loud noises**  
Graduate Degree complete

After a long career as a Teacher I retired at age 60. After completing my English Literature Masters program from University of Victoria in 2009 I have begun volunteering for a

#### Emergency

**Cigarettes, Wine**  
3 Cigarettes per day, Wine 1 glass per day

I have been a long time smoker and continue trying quit. I enjoy going to a Foxtrot dance group weekly and volunteer at the community kitchen. I love reading novels and writing poetry


#### Diabetic and Exercise 3-4 times/w...

1500 calories goal **Restrictions:** gluten free and fish  
Walking, Running, Weight lifting - 45 minutes

Eating as healthy as possible to stay active. I have found that limiting gluten from my diet has helped. Walking regularly at the community gym keeps me active.


#### Home

1813 Crescent Rd. Victoria, BC



#### Vacation Home

5454 Lake Shore Dr. Vancouver, BC



#### Family and Living Environment

Home independently, in Apartment

Daughter is in Ontario. 67 hours of home support per week. Lives with husband John. Kathy is having a hard time getting around the apartment as it has multiple steps into the home and up to the bathrooms and bedroom.

# Discussion