



Art of the Possible Patient Journeys for COVID-19 and Beyond; Current and Future Steps to Fully Realize this Vision

Session LB11

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Panel Learning Objectives

After this session, the learner should be better able to describe:

- a highly desirable but not-yet-widely-realized patient journeys to address conditions such as COVID-19,
- knowledge ecosystem infrastructure needed to broadly deliver patient journeys like this for COVID-19 and beyond, and
- steps underway to realize the vision.

ACTS Initiative: A Consensus Healthcare Future Vision and Collaborative Steps to Achieve It

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Disclosure



Principal, TMIT Consulting LLC; no conflicts of interest in this presentation

Context: ACTS and the COVID Collaborative

ACTS = AHRQ evidence-based Care Transformation Support Initiative

- **Deliverable:** Roadmap and pilots to make AHRQ and other resources more FAIR, computable, and useful
 - **Goal:** Knowledge Ecosystem that support LHSs and broad realization of Quintuple Aim

ACTS COVID-19 Evidence to Guidance to Action Collaborative

- Open learning community supported by AHRQ to help participants respond to pandemic while piloting Roadmap execution
- Developed extensive 'art of the possible' [Concept Demonstration](#) for achieving goal:
 - Desirable but not yet widely realized '**patient journeys**' where **interoperable and computable evidence, guidance and data** drive **whole person care** for COVID-19, other conditions
 - **Enhancements to the national / global healthcare knowledge ecosystem** to widely realize these desirable healthcare experiences, processes, and results
- See Panel S60 for more details

Future Patient Experience (COVID-19 and Beyond)



During a patient's normal daily routines, they have convenient access to *evidence-based* resources and tools that:

- Support team-based, patient-focused, proactive care and **shared decision making** and **information sharing** with care team
- Enable **development and use of comprehensive shared care plans**
- Provide **guidance and tools for managing health issues** including links to social support systems and apps
- Enable them to find clinicians based on **transparent pricing and care quality metrics** that matter to them

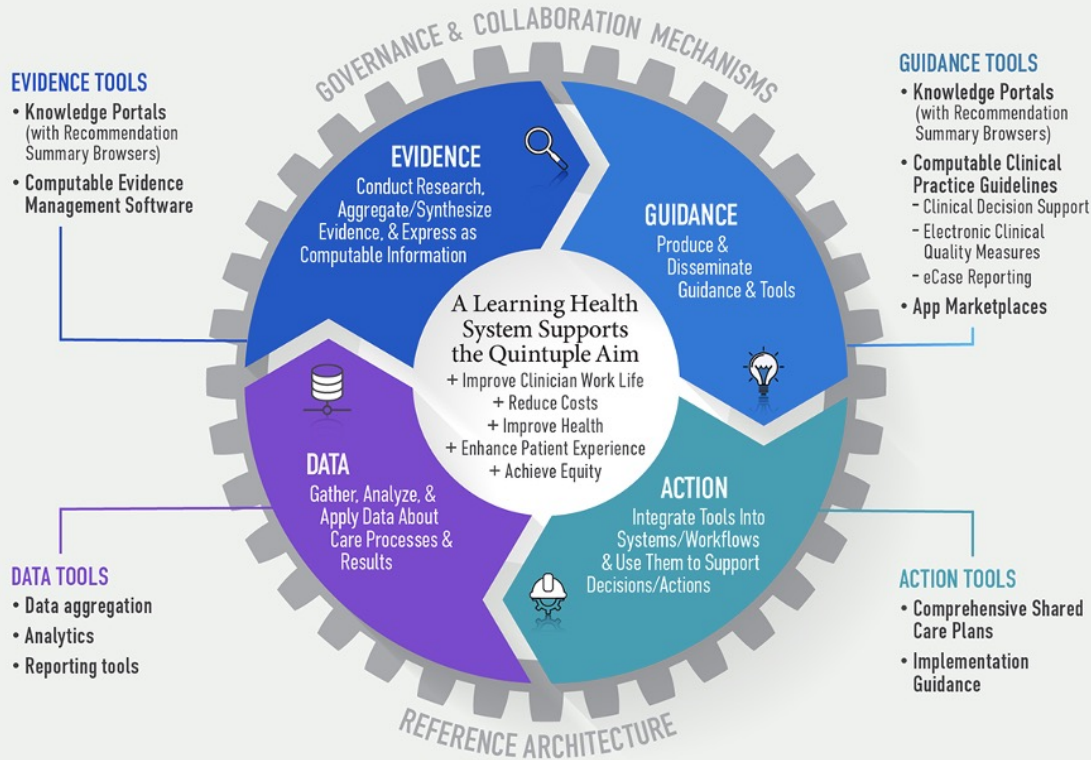
Future Care Team Experience



During a professional care team's normal daily routines, they have convenient access to evidence-based resources and tools to improve work satisfaction and care processes / results that:

- Help them **gather, integrate, prioritize, review critical patient data** to enable proactive healthcare
- Make the **right shared decision-making processes, actions, and documentation** the *easy* thing to do
- Provide clinical information and **guidance** via portals and other **workflow-friendly tools** that deliver vetted, evidence-informed information responsive to the need
- Streamline and **optimize communications and collaboration** with patients and others on their care team
- **Optimize care for individual patients / populations** through approaches that help identify and close care gaps

Vision Requires Digital Knowledge Ecosystem to Foster LHSs and Realize Quintuple Aim



Concept Demo also has extensive knowledge ecosystem details, resources

- Ecosystem gaps and steps to close
- Tool mockups (e.g., for processing computable evidence / guidance)
- LHS Case Study (Univ MN)
- Care transformation tools (next slides)
- much more...

Targets Used to Illustrate Improved Cycle:

- COVID Anticoagulation
- Preventive Care (cancer screening)
- Pain Management / Opioid Use
- Blood Pressure Control
- others

Tool: QI Checklist* for Target-Focused Quality Improvement Efforts

Excerpt from QI Checklist Tool:

IV. The QI SOP / Checklist

1. Intake/Prioritization: Is this engagement appropriate for the QI program? If yes, then:
2. Ensure shared understanding among QI Team of problem/issue scope
 - a. Current state of issue (both inside and outside the CDO; see prioritization scheme from HIMSS guidebook [see slide below])
 - i. Number of individuals affected
 - ii. How those individuals are affected
 - iii. Outcomes for affected individuals
 - iv. Implications for provider workflow and patient journey
 - b. Current projects/programs/tools being used to address this (both inside and outside CDO)
 - c. Known best practices and guidelines (both inside and outside the CDO)
 - d. Current pilots/proofs of concept for targeted clinical outcome
 - e. Synthesis of desired state for CDO
 - f. Gaps between current state and best practices or ideal, desired state¹
3. Make a plan to close the gap¹
 - a. Are new workflows that are needed? (details)
 - b. Do processes need to change? (details)

¹ see service blueprint template for desired activities and tools at each step the patient journey

Tool: Patient Journey Template* for Target-Focused Quality Improvement Efforts

improving health and the healthcare journey

LIVING LIFE

"Most of my health journey occurs outside of my interactions with the healthcare team"



before the healthcare encounter

INDIVIDUAL JOURNEY

Maintain Health

Activities Between

Trigger for Event

Pre-Activities



ENCOUNTER

PATIENT & CARE TEAM INTERACTIONS

DISCHARGE

during the healthcare encounter

after

Arrive at Location

Check In Process

Rooming Process

In Room Process

Wrap Up Process

Post Encounter

Population Health
Encounter

*Developed via Collaboration between ACTS and VA Human Factors Engineering Team: tool and more info [here](#)

Health / Health Care Activities at “In Room Process” Phase of Patient Journey

FRONT STAGE HEALTH & HEALTHCARE activities

actors

{ lay foundation for productive visit }

Negotiate

Encounter Goals

within the context of broader patient health goals, preferences, current circumstances (e.g., SDOH), etc., leveraging the comprehensive shared care plan (CSCP)

GOALS

Lay the foundation to ensure all patient concerns are addressed.

Develop a shared understanding of patient's current concerns, overall health goals, and how the care team can help.

{ gather and review data }

Review Existing Data

gathered prior to visit (PROM, PGHD, etc.) using CSCP (and other sources as appropriate)

GOAL

Examine pertinent existing data needed to achieve goals in this visit and beyond.

{ make and document shared evidence based decisions and begin executing }

Review Evidence Based Guidance/ Pathway(s)

in light of patient's goals and data to identify paths to achieving health/encounter goals

GOAL

Access, review, and discuss evidence and guidance in order to help achieve patient's targeted health goals.

Make Shared Decisions

about specific actions to achieve health/encounter goals

GOALS

Ensure patient, caregivers, and care team align on the actions needed for the patient to reach overall health goals.

Address encounter, ongoing, and/or new health conditions.

Use shared decision making to evaluate risks and determine management plan.

Execute Shared Decisions

take initial actions, such as prescriptions, referrals and tee up support for after encounter actions

GOAL

Begin treatment plan activities to set the patient up for success in reaching targeted health goals.

Document

GOALS

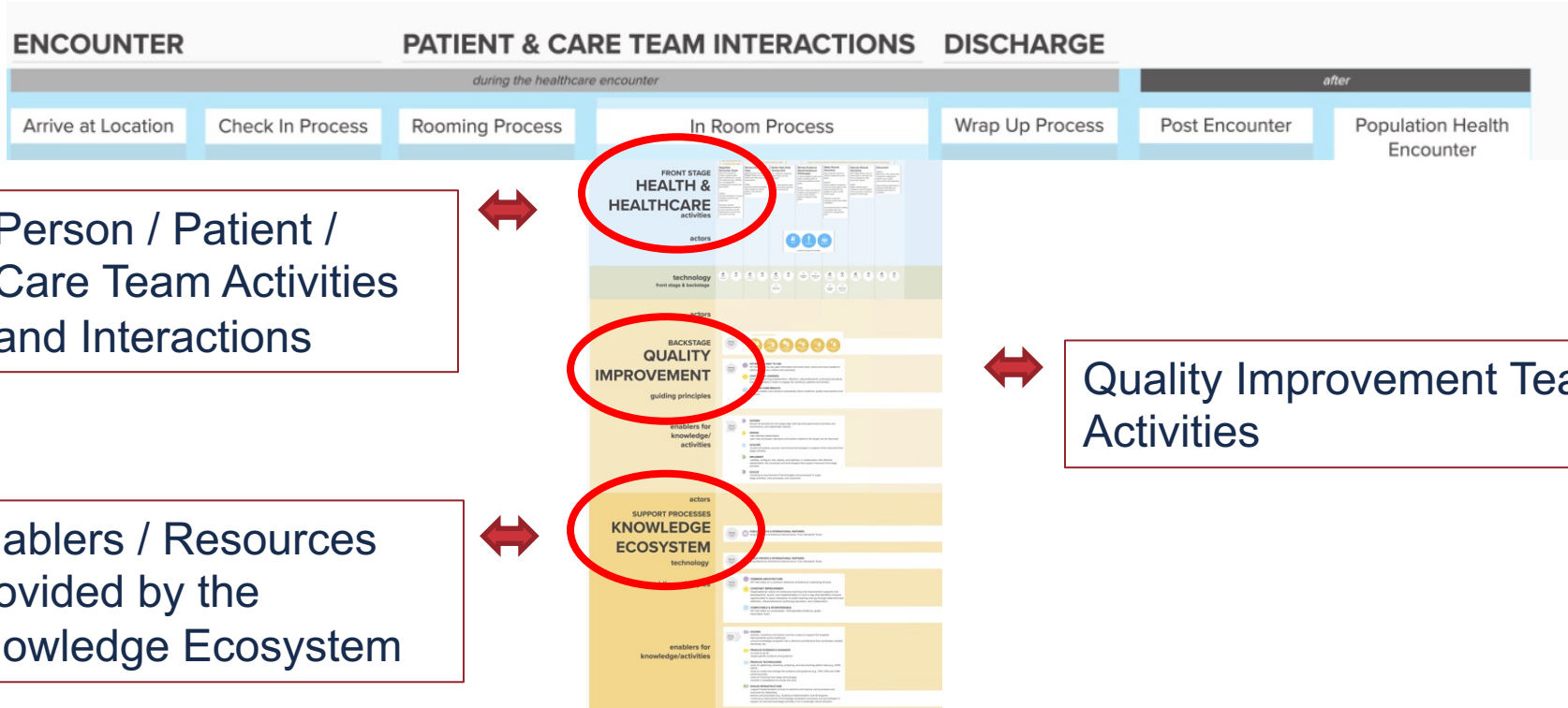
Record all visit related data needed for subsequent patient care, quality improvement and reporting

New evidence generation is gathered efficiently as a seamless byproduct of workflow.



present through all activities

Tool: Service Blueprint Template Defines Steps, Activities to Optimize Targeted Patient Journey*



*Developed via Collaboration between ACTS and VA Human Factors Engineering Team: tool and more info [here](#)

AHRQ evidence-based Care Transformation Support (ACTS) Roadmap

ACTS Roadmap: Overview, Initial Steps



A Stakeholder-Driven Plan for Enhancing Evidence-based Care Delivery and Improving Outcomes

Aim: By 2031, realize a mature healthcare knowledge ecosystem that supports Learning Health Systems (LHSs) and delivers measurable improvements in health, costs, and provider and patient experience.



Create/Use Governance & Collaboration



Enhance/Leverage Infrastructure



Enhance/Develop Living Computable Guidance



Enhance Guidance Implementation & Assessment



Evaluate/Plan Roadmap Execution

Phase 1:
Concept Demonstrations
2021-2024

Phase 2:
Pilots
2024-2027

Phase 3:
Scaling
2027-2030

Phase 4:
LHS/Quintuple Aim
2030-2031

Growing group of stakeholders is beginning to execute Roadmap, including using QI Checklist, Patient Journey / Service Blueprint Template

Initial Targets Being Explored:

- Long COVID, COVID Anticoagulation
- Preventive Care (cancer screening)
- Pain Management / Opioid Use
- Blood Pressure Control
- Sepsis

AHRQ Next Steps Under Advisement

Stakeholder Engagement Towards Future Vision



Forty-one organizations provided support letters indicating plans to collaborate and align efforts / investments to achieve the Future Vision.

Federal Agencies: 1

[VHA](#) (Nebeker)

Care Delivery Organizations: 8

[VCU/ACORN](#) (Krist)

[UM Health Fairview](#) (Melton-Meaux/Tignanelli)

[U Chicago Medicine](#) (Umscheid),

Rutgers [RWJBarnabas Health](#) (Sonnenberg)

[MUSC](#) (Lenert)

[Hennepin Healthcare](#) (Pandita)

[AAACHC-CVN](#) (Frick)

[VUMC](#) (Johnson)

Professional Societies/Accrediting

Bodies/Institutes: 7

[American Medical Association](#) (Rakotz)

[AMIA](#) (Dykes)

[ACMQ](#) (Casey)

[ACCME](#) (Singer)

[NCQA](#) (Barr)

[RTI](#) (Richardson)

[ACP](#) (Qaseem)

Health IT Vendors/Initiatives: 11

[Epic](#) (Little)

[Cognitive Medical Systems](#) (Burke/Bormel)

[Health Catalyst](#) (Rimmasch)

[Apervita](#) (Middleton)

[U Mich/MCBK](#) (Friedman/Richesson/Flynn)

[Logica Health](#) (Hu)

[EBM on FHIR/COKA/Computable](#)

[Publishing](#) (Alper)

[BPM+ Health](#) (Rubin)

[HL7](#) (Jaffe)

[PICOPortal](#) (Agai)

[ZeaMed](#) (Bondugula)

Patient Advocates: 4

[Hassanah Consulting](#) (Tuftte)

[Rosie Bartel](#) (Bartel)

[Society for Participatory Medicine](#) (Hennings)

[Maureen Smith](#) (Smith)

Clinical Evidence/Guidance Organizations: 10

[Cochrane](#) (Soares-Weiser)

[COVID-END](#) (Grimshaw)

[GIN](#) (Harrow)

[JBI](#) (Jordan)

[Epistemonikos](#) (Rada)

[MAGIC Evidence Ecosystem](#)

[Foundation](#) (Vandvik/Brandt)

[McMaster University](#) (Iorio)

[University of MN EPC](#), School of Public Health,

Division of Health Policy and Management

(Butler/Beebe)

[Brown University EPC – SRDR](#) (Saldanha)

[Penn Medicine Center for Evidence-based](#)

[Practice](#) (Mull)

14+ Already Collaborating on Stakeholder-driven Phase 1 Plan Execution specifics

LHS Plan Component	Activity
Provide Governance Support Coordination / Synergy Scaling Targets & Settings	<ul style="list-style-type: none"> Form Steering Committee, WGs; Conduct working meetings / convenings: Set up and manage collaboration infrastructure / website (see Coordination Support Needs below for more details) Cultivate synergies with offerings / initiatives from AHRQ and many other interdependent stakeholders Leverage and enhance the National (Global) LHS future vision
Deliver Care and Conduct QI Focused on Specific Targets (in Care Delivery Organizations)	<ul style="list-style-type: none"> Care for targeted patients / populations as part of QI initiative <ul style="list-style-type: none"> Leverage patient journey / service blueprint template / QI Checklist (see section below) as appropriate Adapt guidance to local needs and integrate into systems and workflows, e.g., via CDS interventions Leverage and enhance the care delivery and organizational LHS future visions Adapt / integrate target-focused guidance into system and workflows (e.g., via CDS interventions and QI efforts) Gather (using eCQMs) / analyze target-focused care process and outcome data - e.g., for regulatory reporting and local QI efforts; share data for public health, new evidence generation Collaborate to leverage, enhance, and synthesize best QI practices in general and for the target (e.g., as outlined here)
Create / Maintain / Aggregate Living, Computable Evidence, Guidance, CDS, eCQMs for Targets	<ul style="list-style-type: none"> Collaborate to leverage, enhance, and synthesize best practices for creating living, computable evidence and guidance in general and for the targets
Create / Enhance Ecosystem Tooling	<p>Tools related to the 'resource developer future vision' (leverage ACTS Standards & Infrastructure WG report)</p> <ul style="list-style-type: none"> Knowledge Portal Computable Clinical Practice Guideline Authoring App Marketplace (leverage ACTS Marketplace WG report) Comprehensive Shared Care Plan (CSCP) Digital Quality Measurement Registry for Care Process and Results Data
Aggregate / Leverage Clinical Measures & Outcomes Across Organizations	<ul style="list-style-type: none"> Gather and harmonize care results data Use data for public health improvement and cross-organizational QI efforts

Emerging Stakeholder-Driven Roadmap Execution Activities



- Working version of this **early draft stakeholder activities table** is [here](#)
- Includes stakeholders already beginning these activities, and other potential candidates to engage
- Undergoing vetting, refinement, and expansion with participants
- To be adapted into tool to help engage additional stakeholders and coordinate efforts

Collaborate With Us to Enhance Your Efforts and Progress Toward the Future Vision!



Review [LHS Concept Demonstration](#), [Phase 1 Plan](#), [Plan Execution Efforts](#)

Consider how what you're doing can help others & vice versa

Use / Enhance / Share: [QI Checklist](#), [Journey / Blueprint Template](#)

Join meetings of Phase 1 Plan participants

Reach out: josheroff@tmitconsulting.com

Discussion (for After Last Panel Presenter)



Questions for presenters?

What areas of the LHS cycle are you working on?

- Targets?
- Successes? Needs?

Mutually beneficial synergies between your efforts and the ACTS vision, tools (QI Checklist, Journey / Blueprint), and Stakeholder-driven LHS Plan activities?

- What does that alignment look like?