

GETTING TO PATIENT-CENTERED CARE: How Health IT Can Meet the Needs of Patients and their Families

Effective, meaningful use of HIT is an essential element of a health care system that is designed to meet the patient’s needs and preferences at the right time, in the right setting, for the right reason, and at the right cost. But the success of ARRA and broader health care reform will require a fundamental shift from a delivery system that is centered on the needs of providers and payers, to one that emphasizes active consumer participation and meaningful partnerships between patients and providers to support health improvement – a patient-centered health care system.

As a general matter, the meaningful use of health IT in ARRA should motivate information use and health IT adoption to achieve clear and demonstrable goals for improved patient health and consumer experience with care. Improving care coordination and medication management are two good starting places, and can be effectively pursued and supported by the patient-centered model described below. As technology advances, more innovative approaches to patient-centered care – some of which cannot be imagined today – should be considered in the evolution of the definition of “meaningful use.”

Below, we offer a comprehensive set of expectations for patient-centered care, and an overview of meaningful use of health IT from a consumer perspective that:

- Is phased, consistent with the evolution of “meaningful use” in ARRA.
- Focuses on key “patient-facing” information uses enabled by health IT.
- Charts a path for using health IT to support care redesign that is patient-centered and information-rich.¹

| EXPECTATIONS FOR PATIENT-CENTERED CARE | MEANINGFUL USE OF HEALTH IT FOR CONSUMERS |
|--|---|
| <p><i>Care is comprehensive, coordinated, personalized and planned.</i></p> <ul style="list-style-type: none"> - Providers have ready access to accurate information and up-to-date medical history and information about patient health, treatment and preferences - Communication and coordination occurs between patients, caregivers and providers, and across providers, settings and services, including outside the health sector. - Providers use technology to track referrals, tests, and prescriptions, reconcile medications and provide patients/caregivers with reminders for | <p>2011</p> <ul style="list-style-type: none"> - A care summary is generated and shared with the patient (by paper, electronic or with PHR depending on preferences) and other authorized providers and family caregivers after every visit or discharge. Includes: <ul style="list-style-type: none"> ▪ Problem list ▪ Care plan ▪ Referrals ▪ Lab results ▪ Medication history - Reminders about preventive services, medications, necessary/routine tests, and follow-up care are sent to patients via their preferred medium (email, PHR |

¹ Additional activities and redesign of processes that do not involve direct patient/consumer generation or use of information are required for care to be patient-centered. For example, ePrescribing should be required as part of meaningful use to ensure the safety of individual patients, but the information in this case is generated and used more by physicians and pharmacists than patients. For more information, please see the document, “Achieving the Health IT Objectives of the American Recovery and Reinvestment Act: A Framework for ‘Meaningful Use’ and ‘Certified or Qualified’ EHR” by the Markle Foundation at www.markle.org.

preventive services.

- Personalized care plans are developed in collaboration with the patient/caregiver. Care plans take into account patients' needs and preferences, based on comprehensive assessments of both patients and their caregivers including physical, emotional, social, and functional status. These plans are monitored on an ongoing basis and routinely updated.
- Care team connects the patient and caregiver with community-based support services.

Patients and their caregivers are partners, making informed, shared decisions.

- Patients and clinicians work together to proactively plan care, manage chronic conditions and support healthy behaviors based on patient needs and preferences
- Patient decision tools support informed medical decision-making based on evidence, health goals and preferences
- Patients and providers collaborate to effectively manage chronic conditions, including education about healthy behaviors and engagement of caregivers, where appropriate.
- Patients have access to unbiased, evidence-based information on all treatment options so that they can make an informed choice that reflects their personal preferences.

Transitions between settings of care are smooth, safe, effective and efficient

- At each care transition (office visit, discharge) patients and the care team will understand what care was provided, diagnoses, key health information and what follow-up is needed
- Providers facilitate patient coaching to build their confidence, skills and tools for managing their care and conditions.

or other electronic tool, paper, etc).

2013

- **Prompts and key information** (patient preferences, health goals, functional status, preferred language, advance directives and social situation) are used to individualize and customize care.
- **Patient generated data** is incorporated into the clinical context for individualized care.
- **Connections** are made to community resources (online and offline groups, support programs, community services, social services, etc.).

2011

- Patients have **electronic access** to the lab results, medication lists and problem lists.
- A **care summary** is generated and shared with the patient and other authorized providers and family caregivers after every visit/discharge. (see above)
- Patients are connected to **resources** that help them understand their medical information in the context of their specific health needs (Medline, etc.).
- Providers make available **shared decision making tools** to promote partnership in care and treatment decisions.

2013

- Patients have real-time **electronic access** to their medical record along with linkages to tools that make the information meaningful and useful to them.
- Patients have access to evidence-based **decision support tools** that enable informed choices tailored to their preferences

2011

- A **care summary** is generated and shared with the patient and other authorized providers and family caregivers after an episode of care. (see above)

2013

- Referrals are made to **online patient coaching** and/or other self-care management tools.

Patients can get care when, where, and how they need it

- Clinicians are available nights, weekends, and on holidays, with ready access to the patient's information
- Alternative care delivery methods and communication tools (phone, email, secure messaging) are available to meet patients' needs and preferences for care (after hours, without traveling to office, etc.).
- Clinicians accommodate the needs of patients with disabilities, limited English proficiency, cultural differences or other issues that can impede access to needed care.
- Patients and authorized family caregivers can access their information when they need it and have the ability to move and use information according to their choosing.

Patients and their caregivers are participants in continuous quality improvement

- Patients and caregivers have a means to give clinicians feedback about their experience of care.
- Automated, aggregate data collection enables timely data for public reporting of consumer-friendly, meaningful information about cost and quality of care.
- Quality and cost information is used by consumers to choose their care providers, as well as to inform patients about standards of care.
- Patients are involved in the redesign of care delivery processes.

2011

- Patients are able to use **secure messaging or email** for more timely and beneficial communication with their providers.
- **Personal health records or other consumer tools** are populated by providers and are easily portable.

2013

- Patients are able to use **online scheduling** for more convenient access to their care providers.
- Providers use **remote monitoring** to manage patients with chronic illnesses in the least restrictive way.
- **Electronic tools** provided by the health care team are accessible to people with visual, hearing, mobility, cognitive, and other impairments. They are also available in multiple languages.

2011

- Information about patients' experience of care is collected electronically and used to improve.*
- Quality data are electronically generated, aggregated and publicly reported in ways that are meaningful for consumer use.
- Information about race, ethnicity, primary language, and gender is collected and used in ongoing efforts to reduce disparities.

2013

- Data regarding cost and the clinical quality of care are electronically collected and publicly reported for consumer use.
- Outcomes measures are reported stratified by race, ethnicity, primary language, and gender to spur disparities reduction.

For more information, contact Eva Powell at 202-986-2600 or epowell@nationalpartnership.org

*Information about a patient's experience of care is a critical part of validating whether HIT is being used in ways that are truly meaningful for patients and consumers. While best practices for collecting and using this information electronically are not yet agreed upon, it is critical that health professionals find effective ways for doing so. Any definition of meaningful use must require providers to collect and use patient experience information to improve care. The methods for collecting, using and reporting this data will evolve over time with the definition itself.