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The age of whole-person approach to health care delivery is dawning

BY TOM TEMIN

Health care organizations have long sought a whole-person approach to medical delivery. That is, care that takes into account the interconnectedness of peoples' various mental and physical systems, using data and measurable outcomes to drive care delivery. And one that vastly improves the customer experience people have when encountering the health care delivery system.

Efforts have fallen short. Now, the potential for whole-person – often called patient-centered – health care has advanced in recent years thanks to the maturing of several technologies that have enabled new thinking. In the federal health care domain, no less than in the private sector, the requirements of the pandemic coupled with updates to policy have accelerated that advance.

The Veterans Health Administration, for example, even has a title: chief connected care officer. Neil Evans, who holds that job, described the work this way: "It's caring for an individual in their entirety when it comes to thinking about health care. It goes beyond the more traditional medical aspects of health care of treating various diseases and moves into a paradigm where we're thinking about how to help individuals live their lives to the fullest."

PANEL OF EXPERTS



Neil C. Evans, M.D., Acting Assistant Secretary for Information and Technology and Chief Information Officer, Department of Veterans Affairs and Chief Officer, Connected Care, Veterans Health Administration



Colleen Hole, BSN, MHA, FACHE, Vice President, Atrium Health Hospital at Home Administrator, Chief Nurse Executive, Atrium Health Medical Group



Dr. Donald Kosiak, Senior Vice President and Chief Medical Officer, Leidos



Jonathan Merrell, Deputy Director for Quality Health Care, Indian Health Service



Chris Nichols, Program Manager/Chief, Enterprise Intelligence and Data Solutions, Defense Healthcare Management Systems (PEO DHMS), Defense Health Agency



Elizabeth Porter, Health Group President, Leidos



Dr. Eliot Siegel, Chief of Radiology, Veterans Affairs Maryland Healthcare System



Lance Scott, Solution Integration Director, Federal Electronic Health Record Modernization



That means more emphasis on preventive care “and building a plan around what matters to patients,” Evans added.

Evans spoke on a panel of federal health practitioners from both the civilian and military sides of the government. Convened by Federal News Network in conjunction with the Leidos Health Group, we discussed the state-of-the-art in health care delivery, including the thinking, workflows, and technologies required to bring it about.

Blocking and tackling

Genomics, artificial intelligence and machine learning, and a data-based approach to improving treatment are part of future whole-person approaches, panelists agreed. But what Dr. Donald Kosiak, senior vice president and chief medical officer at Leidos, called blocking and tackling can improve delivery immediately. Such strategies become apparent once the organization adopts a mindset toward whole-person health.

For example, information exists to give a longitudinal, and therefore more complete, picture of a patient. But in a practical sense that data isn't always available. Kosiak cited electrocardiograms taken over time.

“Wouldn't it be great,” Kosiak said, “if the system said, ‘Doctor, you ordered an EKG. I bet you might want to see an old one if it exists.’ And then be able to provide that for you without your having to go hunting for something. Simple from an AI perspective, but still not done today.”

The challenge, then, is not just locating the relevant data at machine speed, but also integrating it into the clinical workflow, Kosiak said.

The Indian Health Service, part of the Department of Health and Human Services, has adopted a whole-person approach. According to the deputy director for quality health care, Jonathan Merrell, the challenge is ensuring the supporting systems are “integrated,

coordinated, responsive to needs, preferences, and values of individuals served by our health system.”

Merrell said one success of the way health care is traditionally delivered is also an impediment to the whole-person approach.

“Historically we've had good outcomes specifically treating an illness like diabetes, like heart disease, say, with anti-coagulation type therapy,” Merrell said. “But that tends to reduce that individual to an illness. Our mission is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.”

Panelists also said that integrated systems and workflows, in the whole-person approach, must extend outside the walls of hospitals and clinics. The slow-rolling pandemic has greatly expanded options specifically in home-based telehealth.

Care where the patient is

Hospitals are great for many functions. But, said Colleen Hole, the chief nurse executive at Atrium Health Care Medical Group, “they're inherently risky in terms of falls and healthcare-acquired conditions, and delirium, and insomnia, and immobility and all of those things that keep the patient unwell.”

Hole said the pandemic prompted Atrium to innovate a program called hospital-at-home. The program was enabled thanks to a pandemic-induced rules waiver by the Centers for Medicare and Medicaid Services.

“[Hospital-at-home] really, truly is whole-person care. We're able to observe the patient in their own environment,” Hole said. She called hospital-at-home an “incredibly impactful, innovative model around truly delivering, and I mean, literally delivering, care to where patients are and prefer to be: in their home.”

She added that the idea dates back decades, but is only now taking hold in a widespread way.



Data is another axis, in addition to geography, on which the whole-person approach to health care delivery turns. Chris Nichols, the chief of enterprise intelligence and data solutions at the Defense Health Agency, said data for about 80% of health determinants for a given individual lie outside the systems operated by health delivery organizations.

Nichols cited behavioral, biological, physical, social and access to care among the factors for which data might exist. That presents the challenge of “how do we get to that information to drive better outcomes for our patients?”

Integration and visibility of patient data is the whole point of development of the new electronic health record (EHR), now ongoing by the departments of Defense and Veterans Affairs. VA is working directly with technology vendor Cerner with Leidos as a team member, while the Defense Department is using Leidos as its prime system integrator for the Cerner base product. The goal is an interoperable EHR established for a service member upon induction, and lasting through his or her status as a veteran.

The projects will result in a sort of data and records roundup, pursuant to the whole-person delivery approach.

“DOD starts out basically scattering records everywhere in commercial facilities around the country, around the world, and within military facilities,” said Lance Scott, the solution integration director for the Federal Electronic Health Record Modernization office, a joint DOD-VA activity. “And then you add on the element of a deployment, you’ve got records out there, you’ve got records everywhere.”

The initial task of the office was establishment of what Scott called the joint longitudinal viewer to gather the scattered data and bridge it to both VA and DOD. The result? “The most complete comprehensive picture

I can put in front of a clinician about that patient’s history. To me, that’s a better holistic-person view that I give to the clinician,” Scott said.

He cautions, good outcomes won’t result from simply dumping terabytes of data on practitioners. If anything, practitioners across the board already struggle to spend sufficient time with patients, as opposed to peering into screens.

As things stand now, Scott said, lots of data in an on-screen “outside records tab” makes all the information available in a sense. “But the clinician has to do another step, while they’re seeing the patient. They must go out and look at that data. They can manually reconcile some of that data into the record. But they have to think to do that, and they have to have time to do that,” he said.

“It is my job, it is our jobs, to try to make sense of all this data and put the right data in front of the clinician at the right time,” Scott said. The program office is working on a couple of strategies to ease the data overload problem. One involves natural language processing, and one gives DOD and VA practitioners certain trusted data sources that automatically become reconciled in the EHR.

Liz Porter, president of the Health Group at Leidos, said that in working with the Defense Department, she’s discovered a disconnect even between systems that store physical fitness records and those that store service members’ health care records.

As an active duty military spouse, she said, “I know that my record is in 20,000 different places. If anybody wanted my medical history, it’d be really hard to find.” She added that the health record itself is only one element of person’s total health picture. Hence the need for both data integration and interoperability.



Prevention, not cure

Still another element in establishment of true patient-centered, whole-person health care is the set of policies concerning reimbursement. That is, the incentives driving health care organizations. And here, the Veterans Health Administration is a leader in how it emphasizes delivery of preventive services that can prevent physical or mental problems that will be more difficult and expensive to treat.

Dr. Elliott Siegel, the chief of radiology at the VHA Maryland Healthcare System, underscored this point. The system, he said, “has a major emphasis on reimbursement just for diseases. If you’re outside of a system, such as the Department of Veterans Affairs, it’s really difficult to get reimbursement for things that, for example, are offered within the VA as part of the whole health system.” These include preventive and wellness measures such as stress reduction, yoga, tai chi, mindfulness, nutrition counseling and acupuncture.

He and others noted that patients must be active participants in their own care.

“The other thing that’s really important about whole-person health,” Siegel said, “is empowering patients to be not just passive recipients of care – which I think to a large extent is the case within the U.S. – and make them essentially co-partners in their healthcare.”

Merrell of IHS noted that one way to bring in patients as whole people, and not merely as cases with this or that disease, is by understanding and accounting for their varying background and cultural norms.

“For IHS,” he said, “this also means integration of cultural practice, and traditional ways of knowing and healing into our healthcare delivery. Many of our facilities have developed both formal and informal ways of integrating traditional healing and culture into care.” He said IHS has, over the years, evolved to a team-

based approach to health care, with the patient as a key team member.

The team approach to whole-person healthcare delivery means organizations have to pay attention to the vitality of the teams themselves. This is especially true when the health care profession as a whole is under stress thanks in part to the pandemic and thanks in part to a shortage of certain practitioners in certain areas.

Faster and more intuitive access to relevant data will help. Hole of Atrium added that rethinking roles and responsibilities can also help. She described a multidisciplinary team approach in which the physician is not necessarily at the center of the care model.

Of physicians, Hole said, “One, we can’t afford them. And two, we’re not gonna be able to find them. We’re not making enough of them.” She envisions registered nurses “as the non-provider care team lead, aggregating resources of social workers, care managers, health coaches, all of those who really touch a patient before the patient is in trouble.” She said such an approach would reduce physician burnout by taking them out of the model of constantly responding to acute situations in 15-minute intervals or fly-by morning rounds.

Equally helpful to the health care profession itself would be greater portability of licenses from one geographical area to another. Payers have allowed portability at least temporarily in some instances because of the pandemic.

Porter of Leidos said that’s exactly what has enabled specialists to do telehealth sessions with remote veterans, and enabled mobile clinics to deliver overdue examinations on Indian reservations.

“License portability, certainly in the mental health space, it’s an area where there just aren’t enough providers,” Porter said. 🤖

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