Briefing on Long-Term and Post-Acute Care

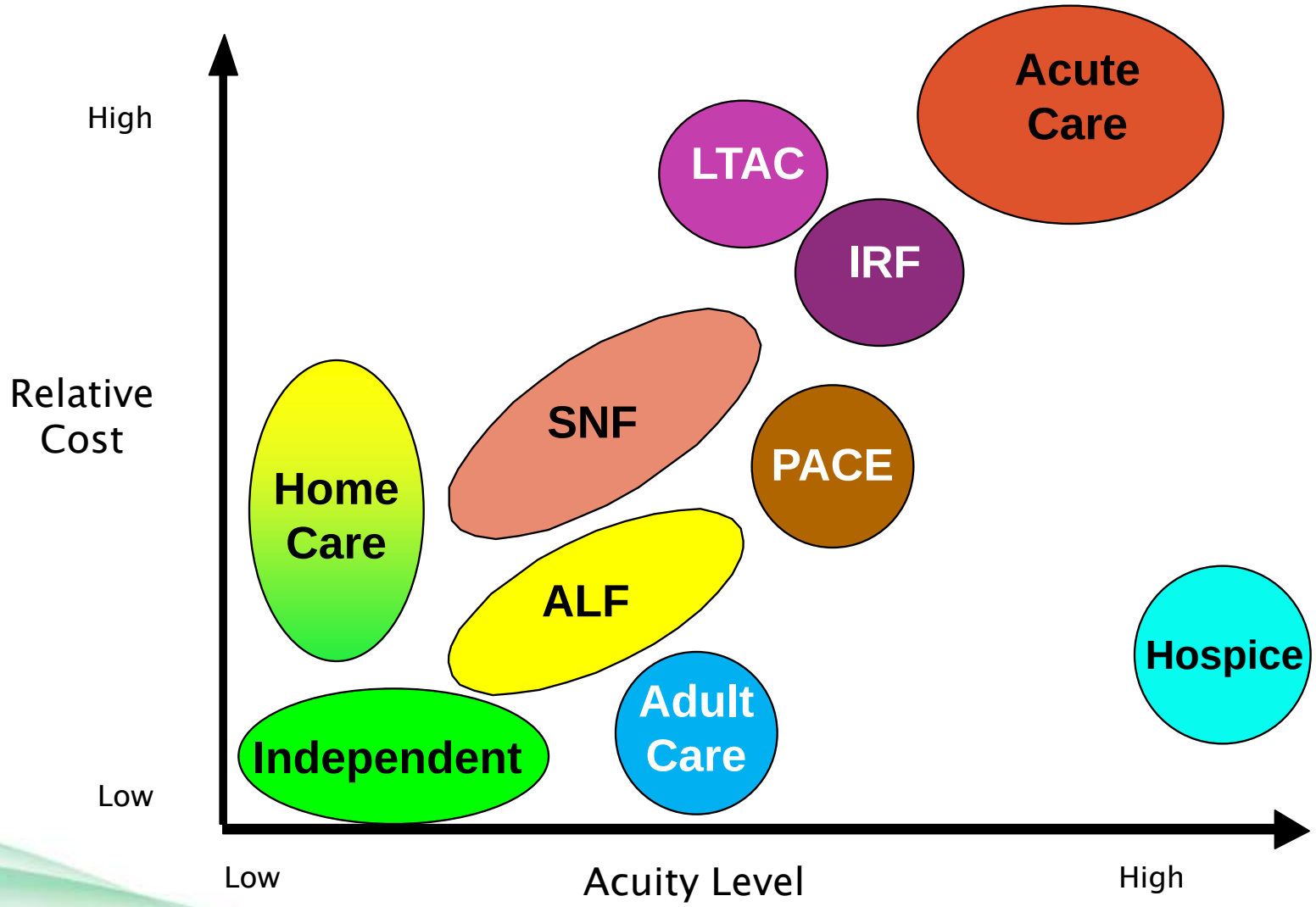
Health IT Standards Committee
June 20, 2012

John Derr, RPh, Golden Living,
Member Standards Committee

in collaboration with

Larry Wolf, Kindred Healthcare,
Alternate Member Policy Committee

LTPAC Silo Spectrum of Care



Briefing on Long-Term and Post-Acute Care (LTPAC)

- Essential to patient-centered coordinated care
  - Post-Acute Care: healing and rehabilitation after an acute event
  - Long-Term Care: people with disabilities or chronic care needs
  - Interdisciplinary care teams
- Increasingly able to participate
- Aligned with National Priorities for Quality Health Care
  1. Making Care Safer
  2. Ensuring Person- and Family-Centered Care
  3. Promoting Effective Communication and Coordination of Care
  4. Promoting the Most Effective Prevention and Treatment of the Leading Causes of Mortality, Starting With Cardiovascular Disease
  5. Working With Communities to Promote Wide Use of Best Practices to Enable Healthy Living
  6. Making Quality Care More Affordable

Federal Health IT Strategic Plan

OBJECTIVE C

Support health IT adoption and information exchange for public health and populations with unique needs

Strategy I.C.3: Support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings. Providers working in long-term and post-acute care (LTPAC) and behavioral health settings are essential partners in patient care coordination. ONC, CMS, and the Assistant Secretary for Planning and Evaluation (ASPE) will collaborate to address quality measures and evolving clinical decision support opportunities that will promote appropriate exchange of health information in LTPAC and behavioral health care settings for optimal coordination of care.

HHS will build on meaningful use to adopt electronic standards for the exchange of clinical data among facilities and community-based LTPAC settings, including, where available, standards for messaging and nomenclature. ONC will leverage the State HIE and Beacon Community grant programs in demonstrating methods for which the electronic exchange of information with LTPAC entities can improve care coordination. In addition, HHS will identify opportunities in the Affordable Care Act to support the use of health information exchange technologies by LTPAC and behavioral health providers to improve quality of care and care coordination.

Long Term and Post Acute Care

LTPAC HIT

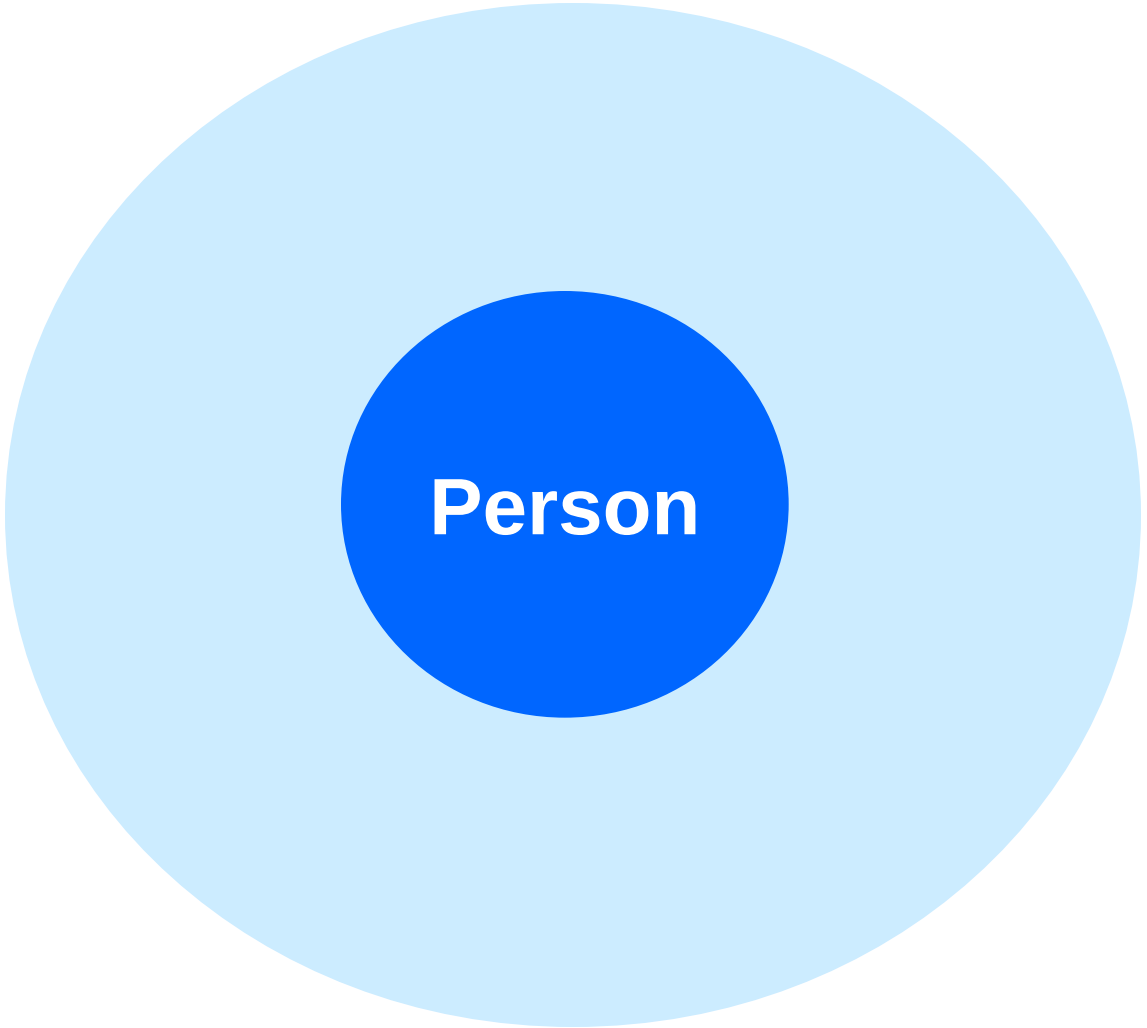
Health IT Collaborative ■ www.ltpachealthit.org

- Began 2005
- 8th Annual Summit
  - June 18-19, 2012
  - Baltimore, MD
- Roadmaps
  - 2005
  - 2008
  - 2010-2012
  - 2012 -2014

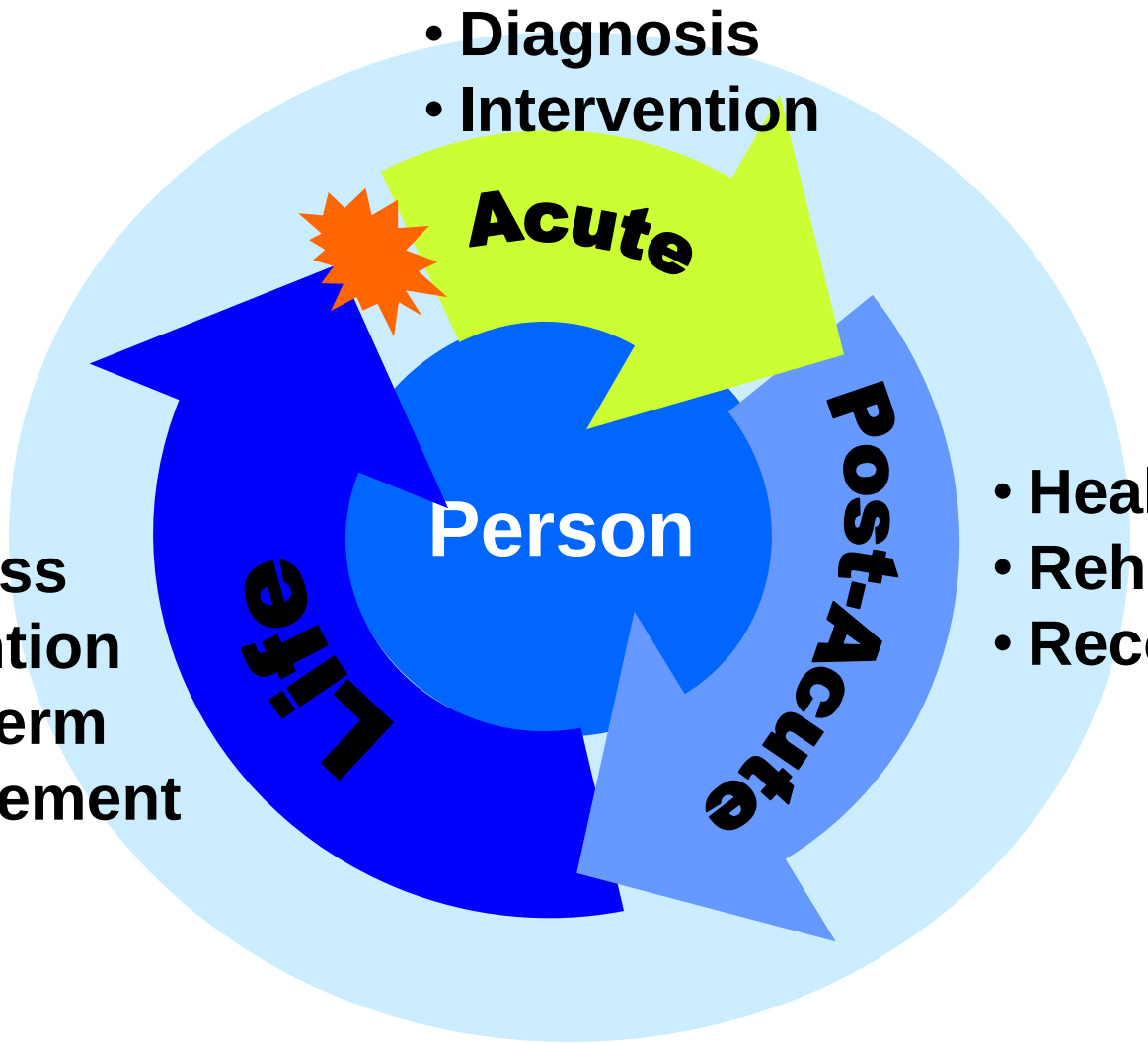
Government Representatives from ASPE, ONC, CMS, HRSA

www.ltpachealthit.org

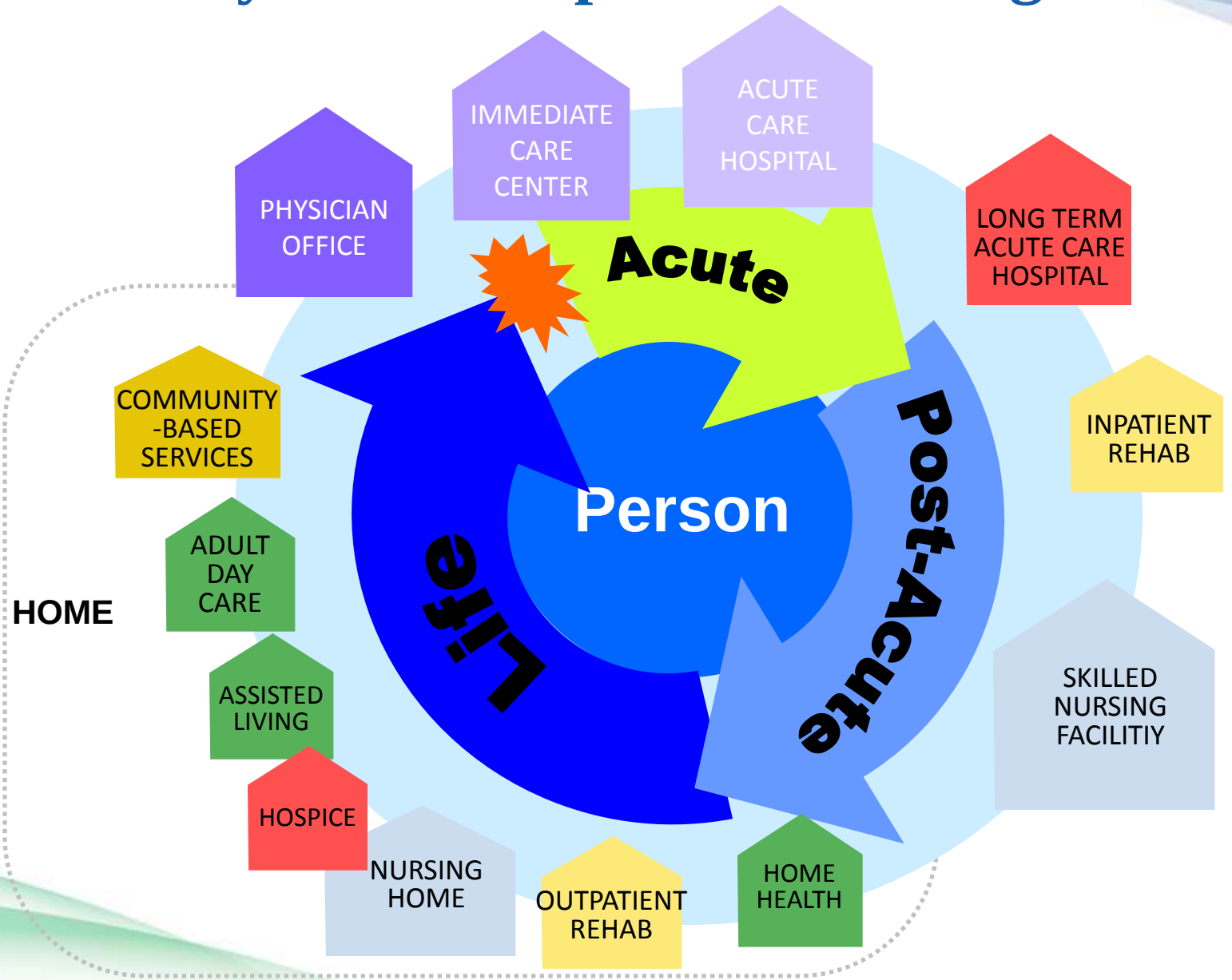
Individual Health



Life Cycle / Care Cycle



Care Cycle / Example Care Settings



Transformation of Healthcare

STATIC, REACTIVE, EPISODIC HEALTHCARE SYSTEM

TO

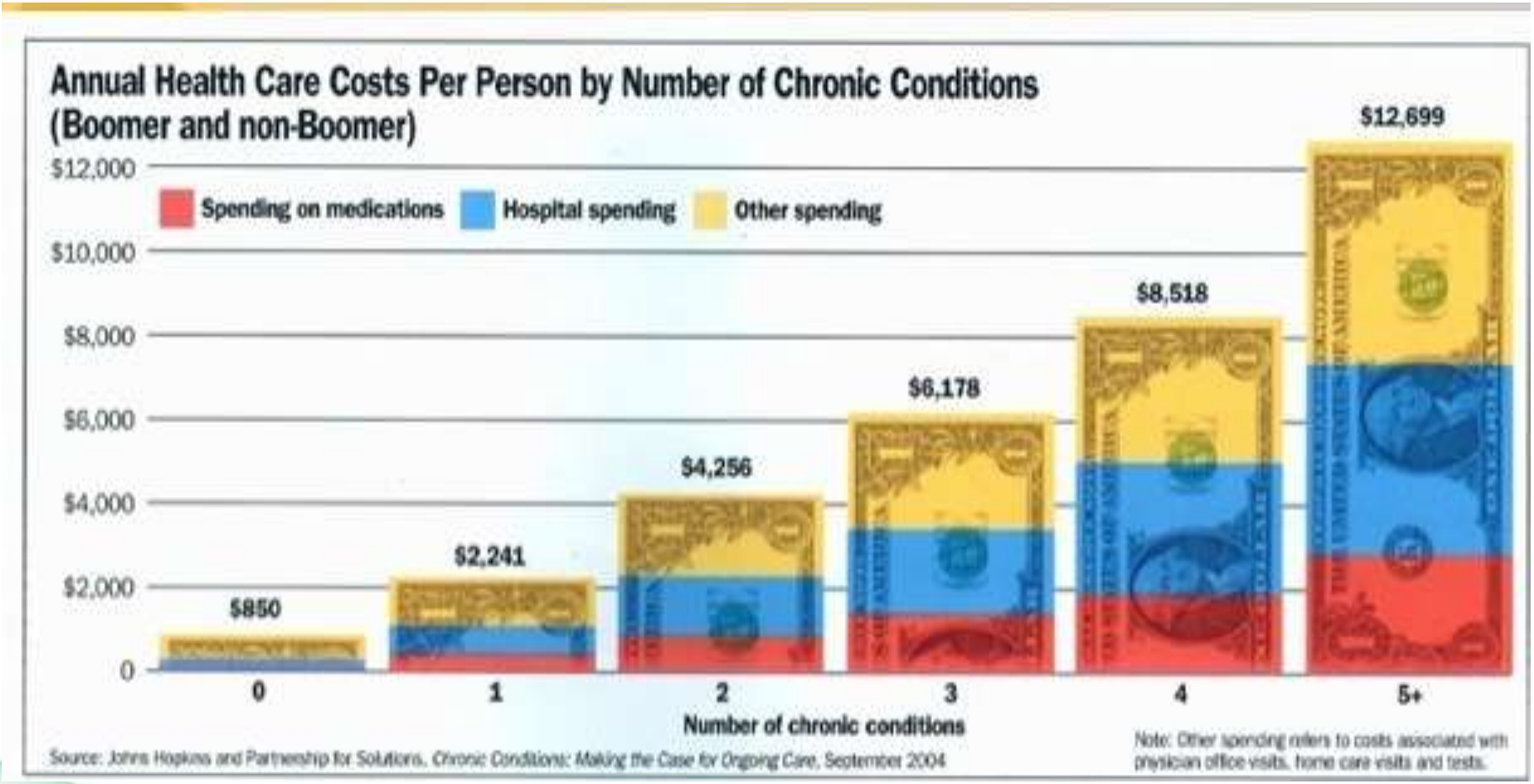
DYNAMIC, PROACTIVE, WELLNESS HEALTHCARE SYSTEM

HOW

An Integrated, dynamic, longitudinal Person Centric Electronic Health Record Empowering Personal Health Accountability, Wellness, and Proactive Care through transitions of care interoperability based on standards.

June 2012, Baltimore, MD

High Cost of Chronic Care



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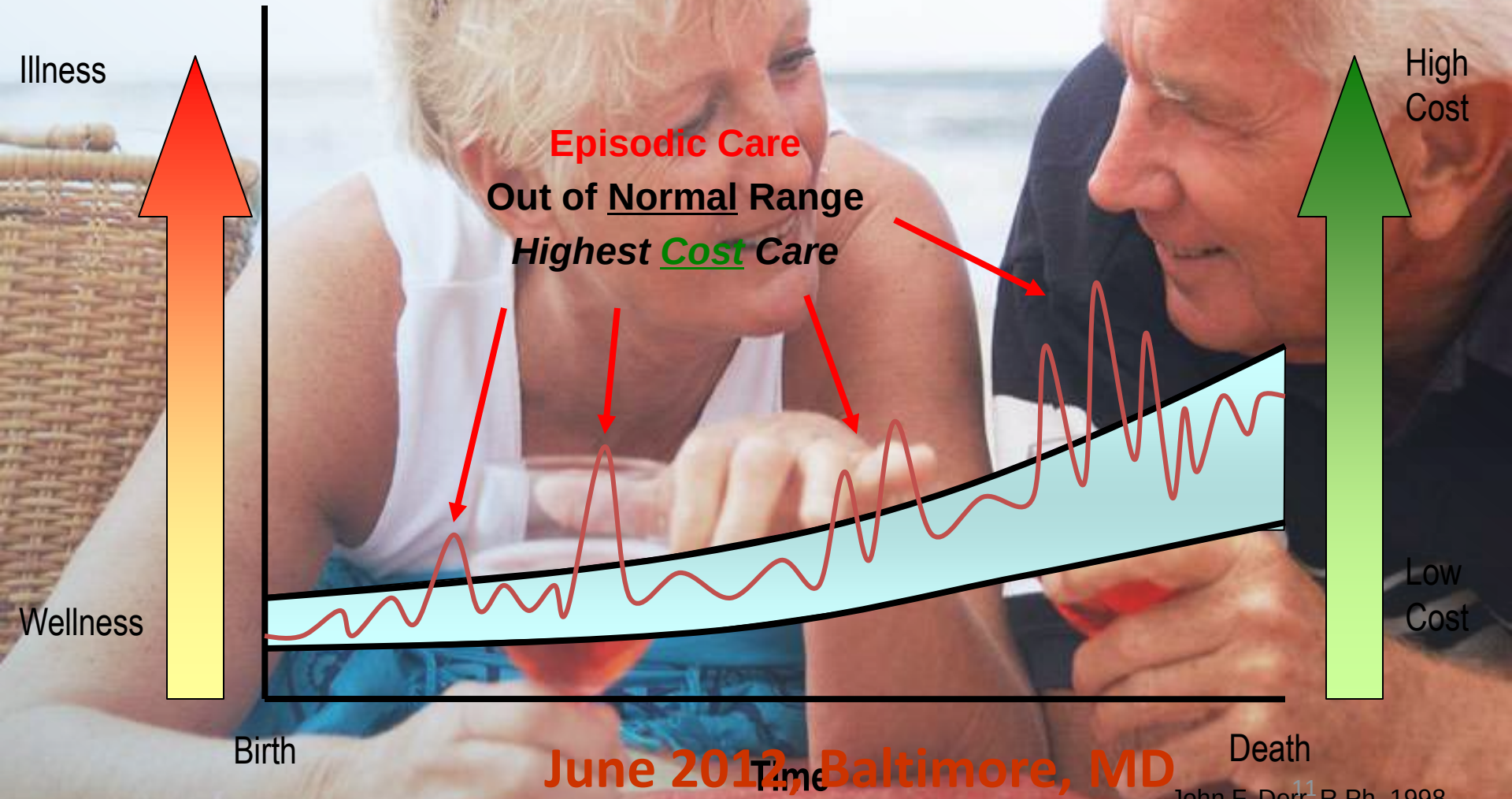
Person Centric Longitudinal Healthcare

OBJECTIVE TO KEEP A PATIENT WITHIN HIS/HER NORMAL QUALITY OF LIFE RANGE



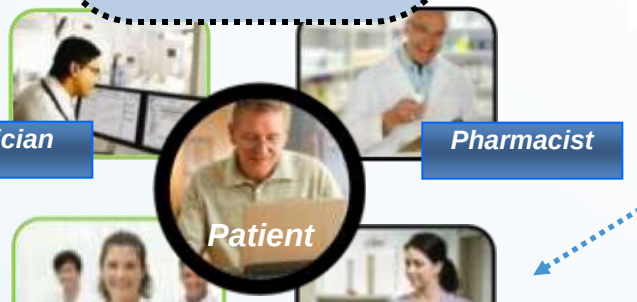
John F. Derr, R.Ph. 1998

Physician-Led Based | Patient-Centric | Outcome-Integrated Care

ACO Medical Home

Referring Hospital, Discharge Planner

Physician Office



Longitudinal Health Record

SNF/ALF

Home Health

Therapy

Laboratory

Imaging

Pharmacy

Hospice

DME

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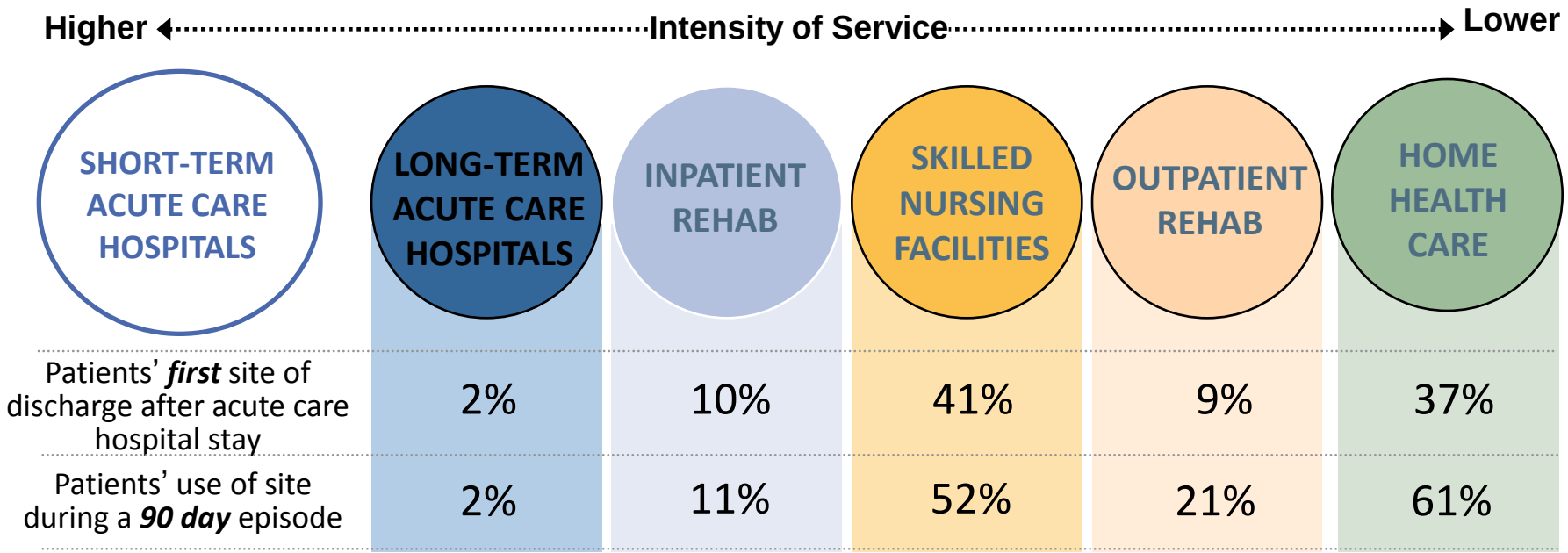
Patients Discharged to Post-Acute Care

35% of Medicare beneficiaries discharged from short-term acute hospitals receive post-acute care

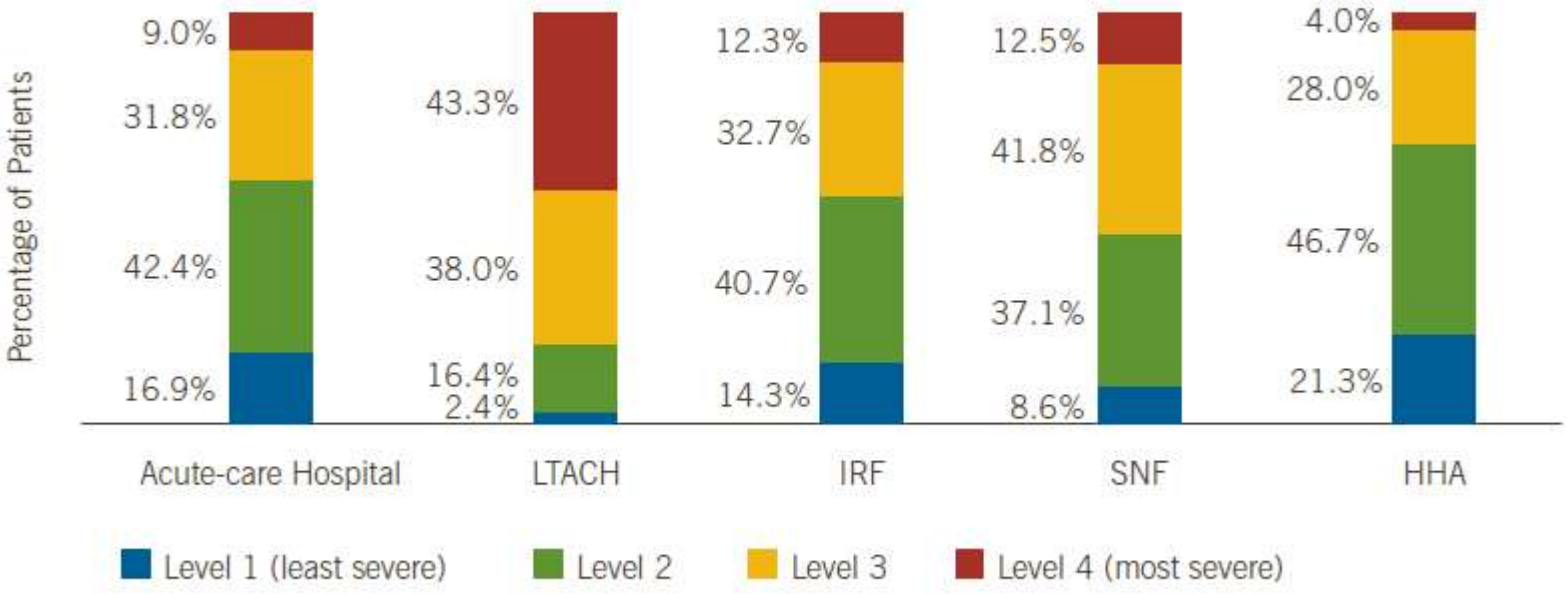


Medicare Patients' Use of Post-Acute Services Throughout an "Episode of Care"

Source: RTI, 2009:
Examining Post Acute Care Relationships in an Integrated Hospital System

LTPAC - Acuity

Chart 1: Short Term Acute-care Hospital (STACH) and PAC Severity of Illness (SOI), in Prior STACH Stay



Source: Analysis of the 2008 100% Medicare Standard Analytical Files by The Moran Company.
Note: SOI is measured by the 3M APR-DRG Grouper.

TrendWatch: Maximizing the Value of Post-acute Care
American Hospital Association, November 2010
http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf

Medication Related Problem Costs

- $76.6 billion - ambulatory care[1]
- $20.0 billion - acute care[2]
- $4.0 billion - nursing home care[3]

$100.6 billion direct medical costs of MRPs

Sources: 1 - Bootman L, et al, Arch Internal Med, 1995
2 - Bates, et al, JAMA, 1995
3 - Bootman L, et al, Arch Internal Med, 1997

LTPAC – Settings and Medicare Beneficiaries

Chart 2: Medicare Patient Volume and Spending for Fee-for-Service Beneficiaries, by PAC Provider Type

Facility Type	Number of Facilities (2009)	Number of Beneficiaries Treated (2008)*	Estimated Medicare Spending (2009)
Long-term Acute Care Hospital	432	115,000	$4.9 billion
Inpatient Rehabilitation Facility	1,196	332,000	$5.7 billion
Skilled Nursing Facility	15,053	1.6 million	$25.5 billion
Home Health Agency	10,422	3.2 million	$18.3 billion

Post-acute care accounted for approximately 12% of all Medicare spending in 2008.

Source: Medicare Payment Advisory Commission. (June 2010). *Data Book: Healthcare Spending and the Medicare Program.* Washington, DC.
*Data from Medicare Payment Advisory Commission. (March 2010). *Report to the Congress: Chapter 3.* Washington, DC.
Includes fee-for-service beneficiaries only.

TrendWatch: Maximizing the Value of Post-acute Care
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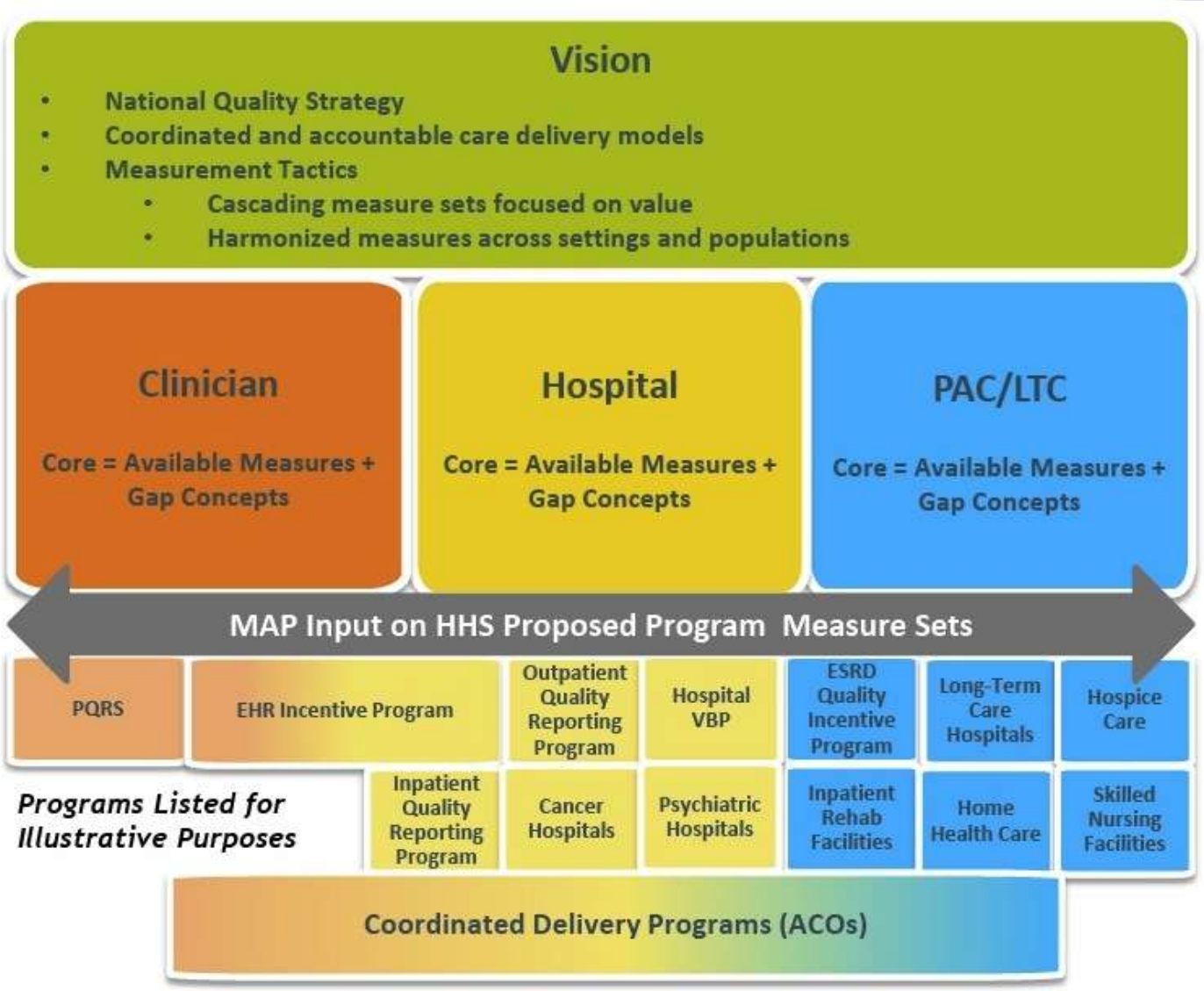
http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf

Required Electronic Assessments

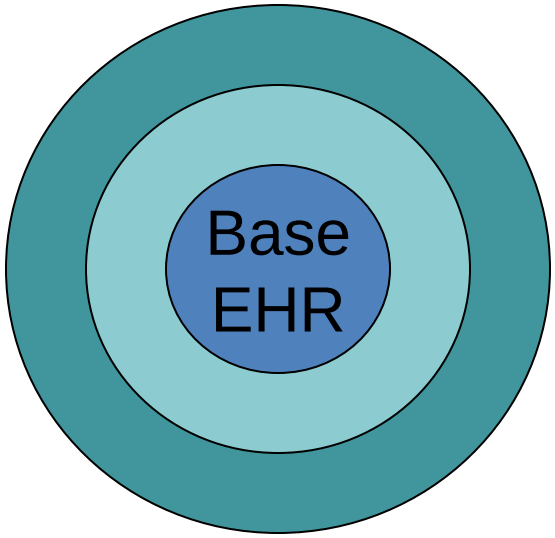
- **Nursing Facility:** Minimum Data Set (MDS 3.0)
- **Home Health:** Outcome and Assessment Information Set (OASIS-C)
- **Rehab Hospitals:** Inpatient Rehab Facility-Patient Assessment Instrument (IRF-PAI) / Functional Improvement Measure (FIM)

- **Prototype Multi-Setting:** Continuity Assessment Record and Evaluation (C.A.R.E.)

NQF – MAP (Measure Applications Partnership) Harmonize Measures



Certified EHR Technology



1. Includes patient demographic and clinical health information, such as medical history and problem lists; and
2. Has the capacity:
   i. To provide clinical decision support;
   ii. To support physician order entry;
   iii. To capture and query information relevant to health care quality;
   iv. To exchange electronic health information with, and integrate such information from other sources; and
   v. To protect the confidentiality, integrity, and availability of health information stored and exchanged

Micro Kernel

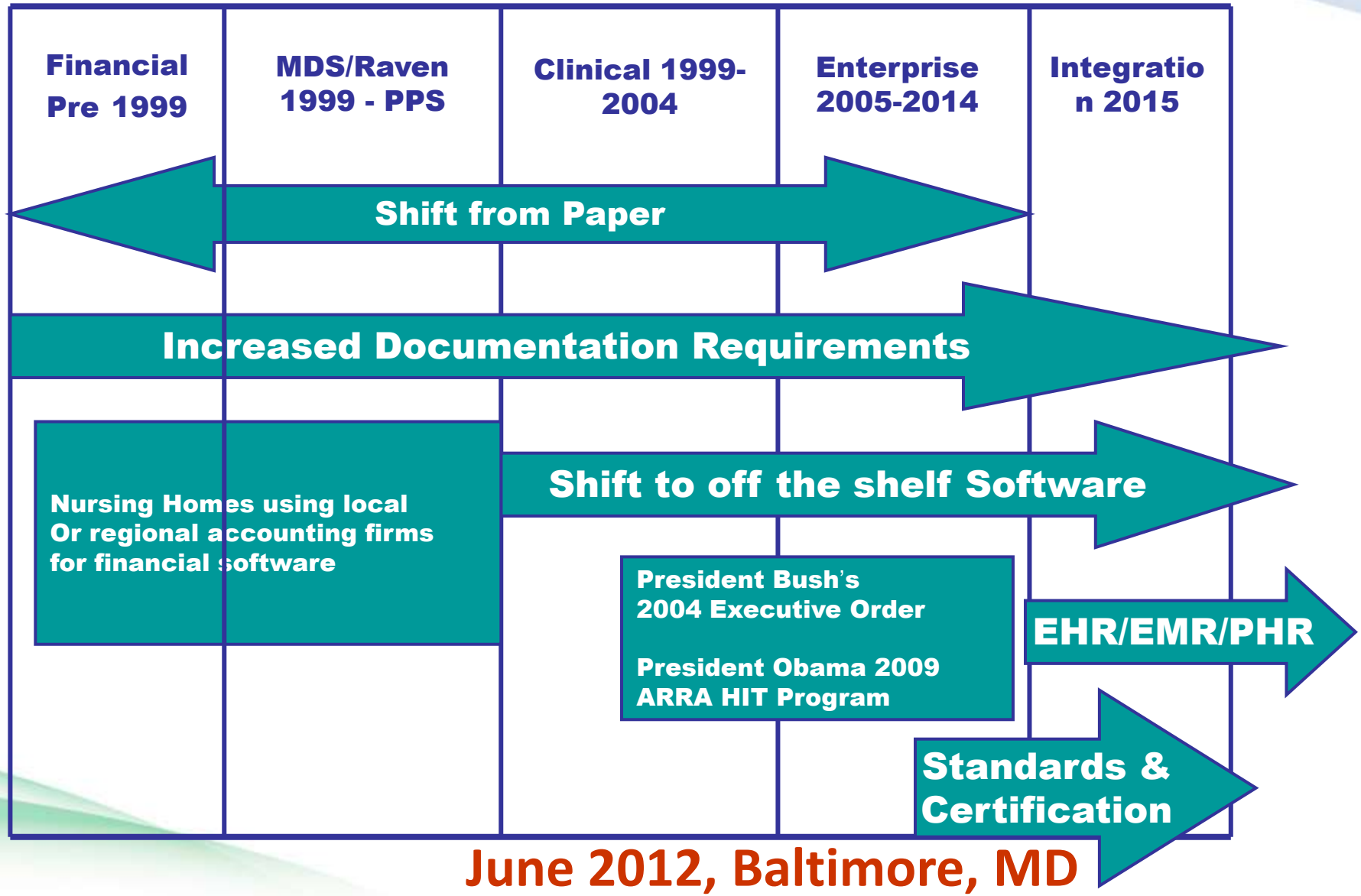
What is the minimum necessary for all settings to

- **Provide a base for process and quality improvement?**
- **Ensure a legal medical record?**
- **Improve care coordination? Standards and Interoperability?**
- **Enable a Learning Healthcare System?**

Software, Certification

- ONC-ATCB – Modular Certification
  - Potential for a common core
- CCHIT – LTPAC Certification
  - Specialized needs of these settings

History of LTPAC HIT



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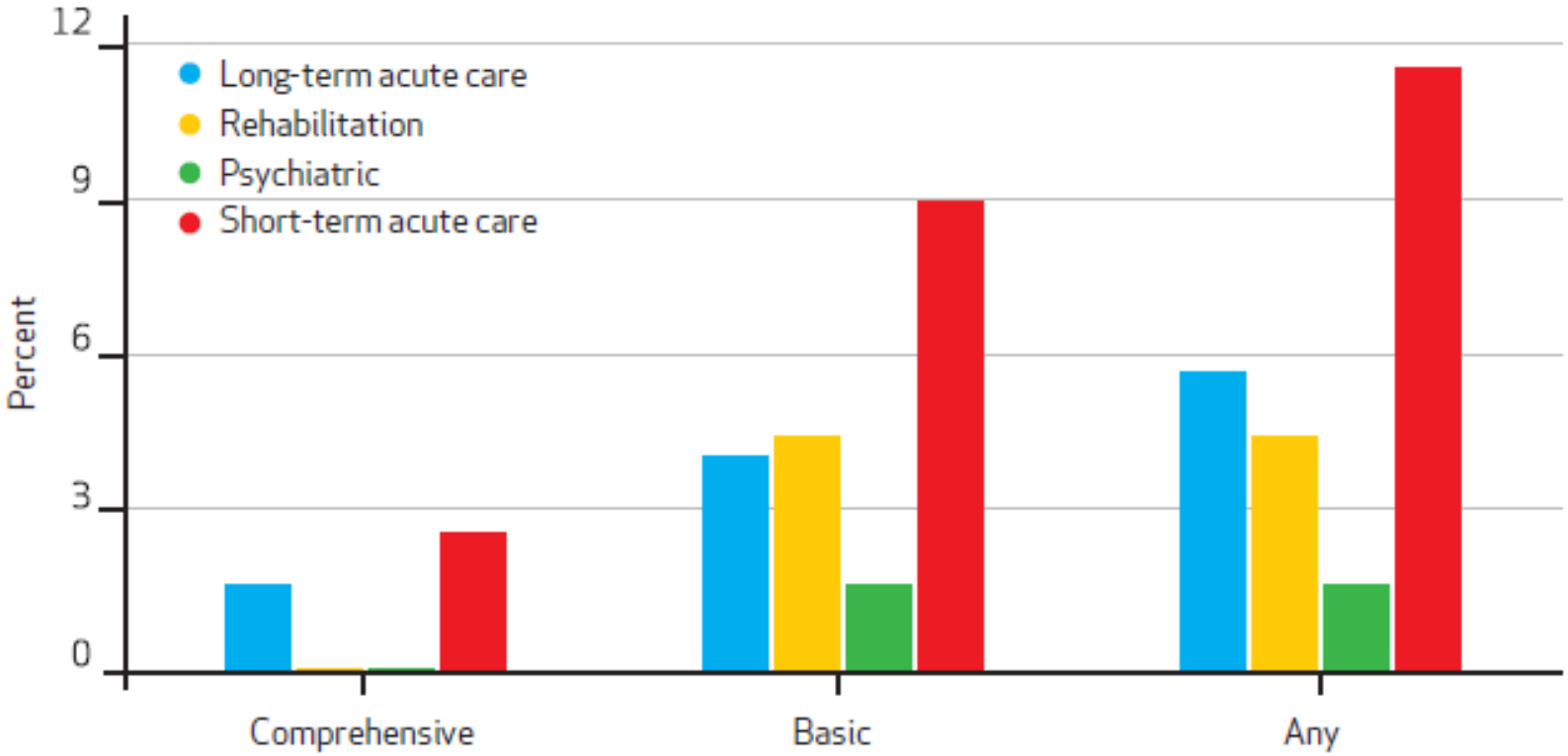
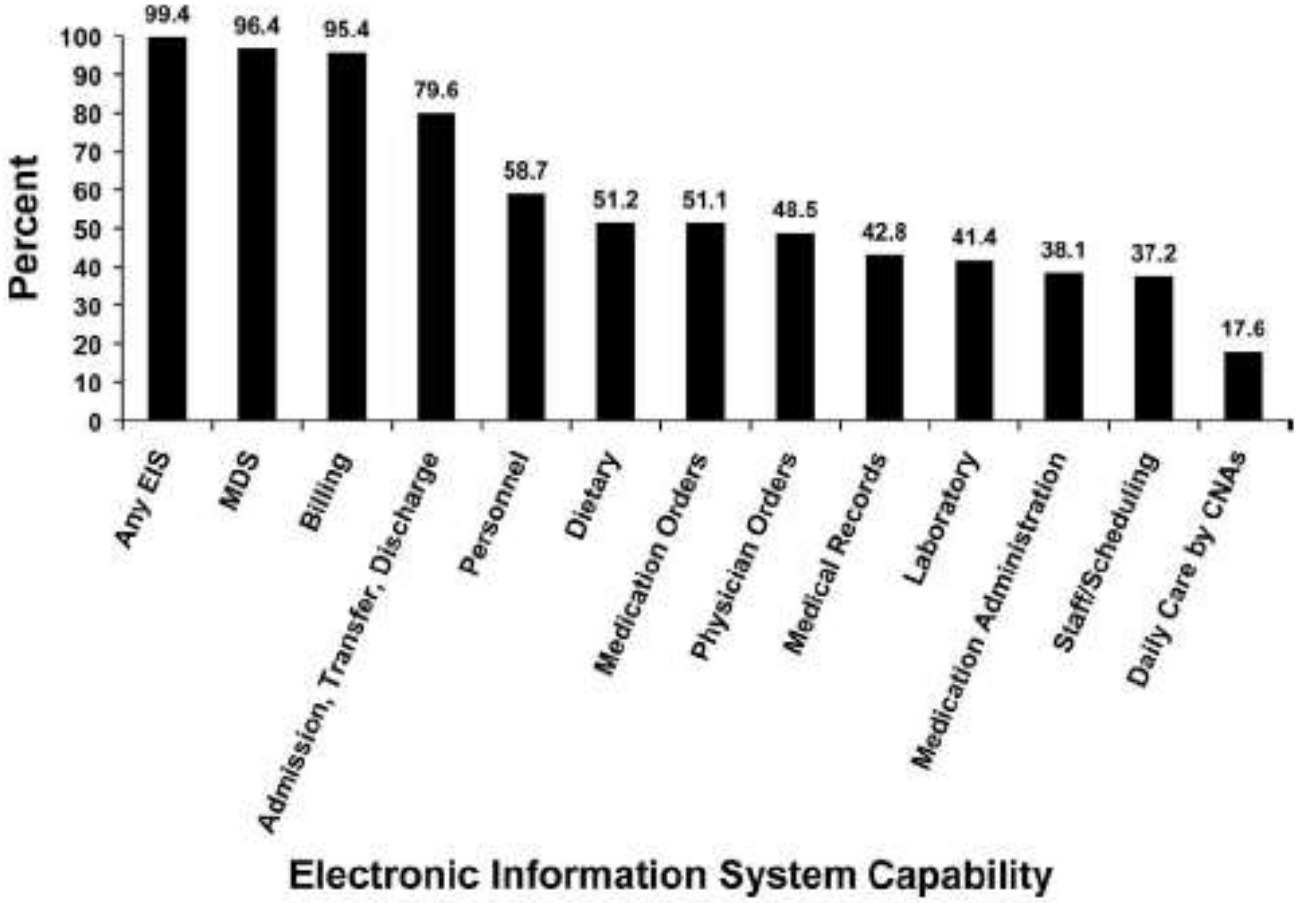
HIT Adoption – LTACH, IRF, Psych (2009)

Electronic Health Record (EHR) System Adoption Rate Among Hospitals, By Type Of Hospital And EHR System Capability, 2009



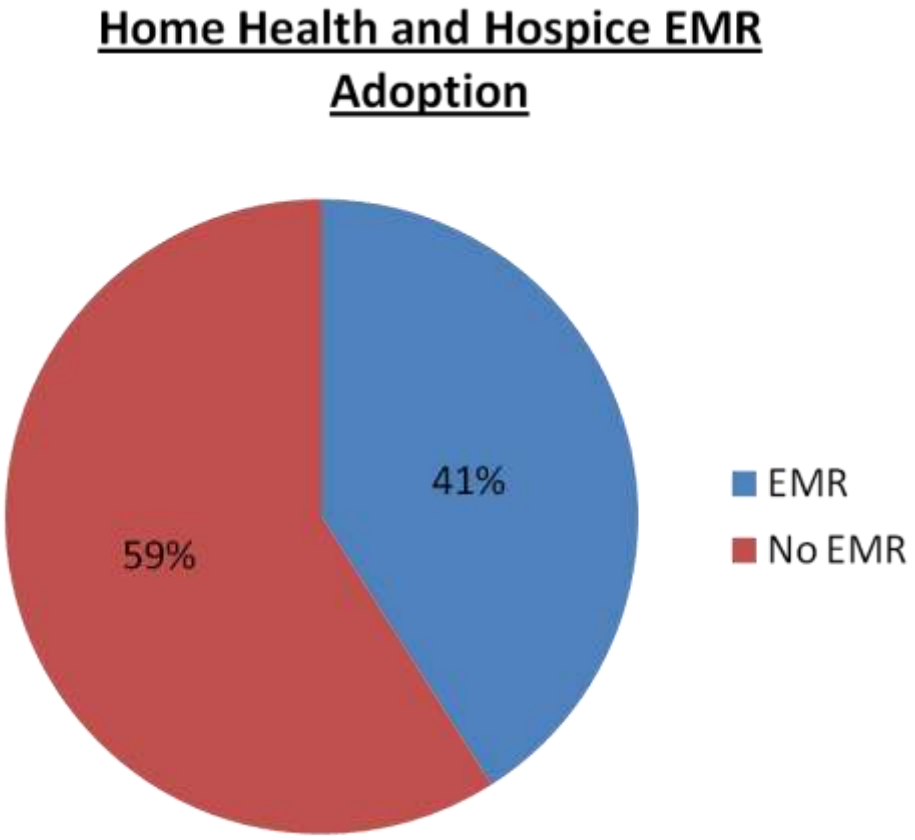
Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates Of Adoption Of Electronic Health Records
Larry Wolf, Jennie Harvell, Ashish K. Jha
Health Affairs, Vol 31, No 3 (2012)

HIT Adoption – Nursing Facilities (2004)



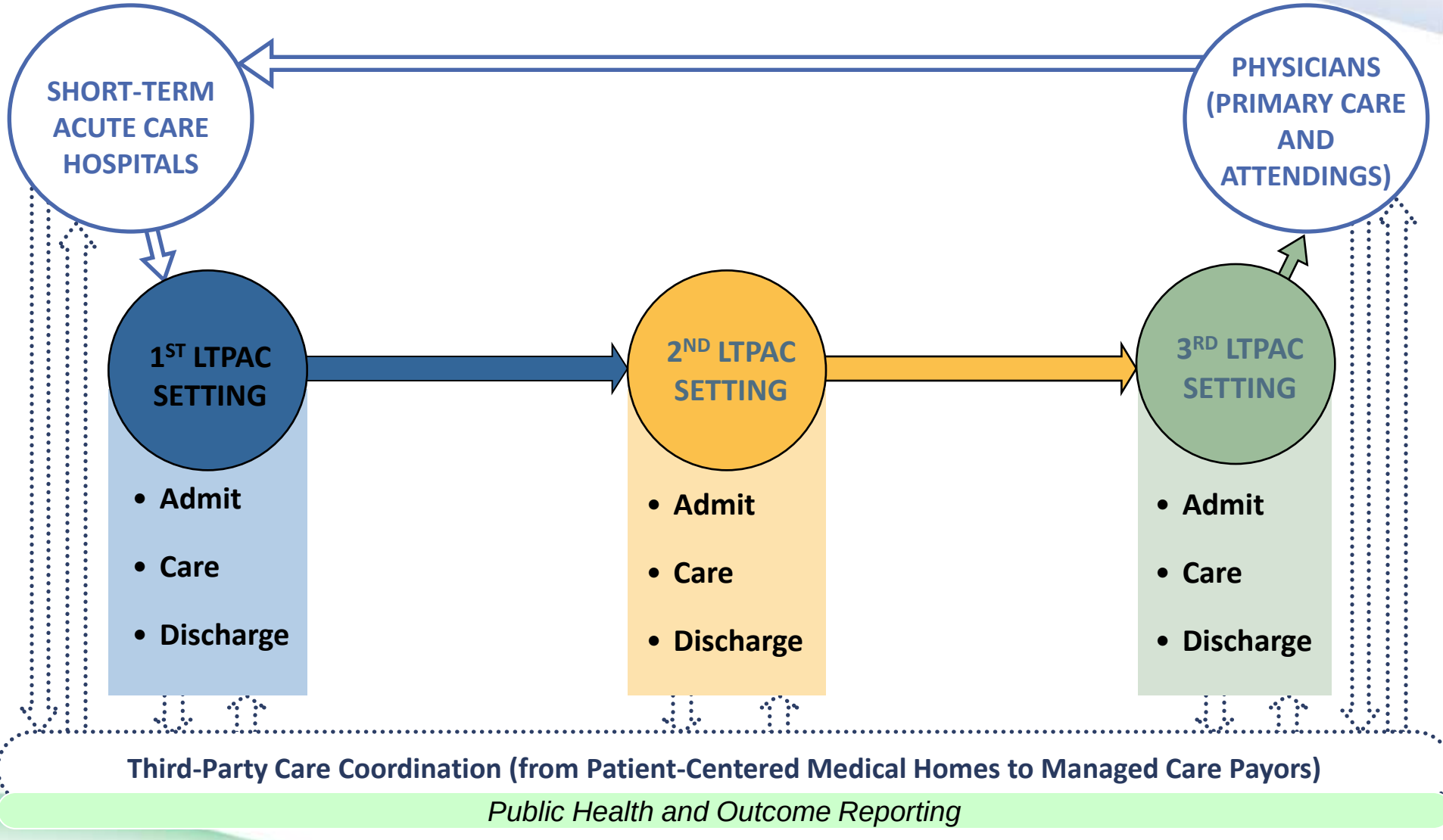
Use of Electronic Information Systems in Nursing Homes, United States, 2004
Helaine E. Resnick, Barbara B. Manard, Robyn I. Stone, Majd Alwan
Journal of the American Medical Informatics Association, Vol 16, No 2, March/April 2009

HIT Adoption – Home Heath & Hospice Agencies (2010)



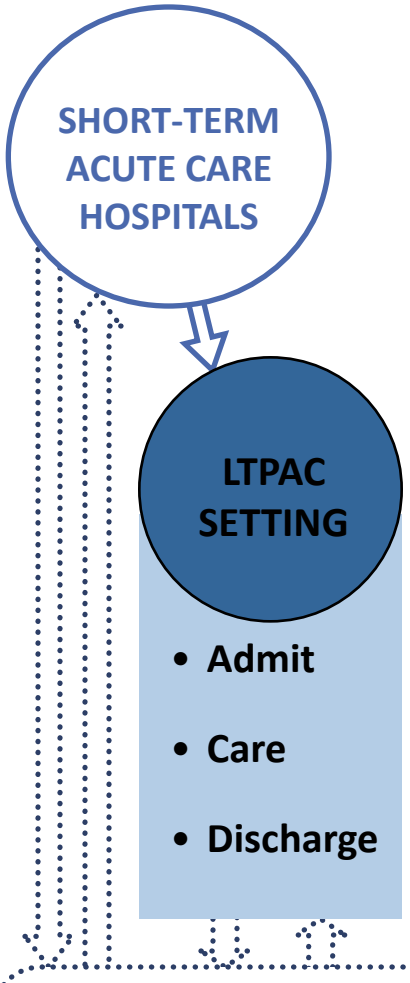
EMR Adoption and Use in Home Health and Hospice
CDC National Center for Health Statistics, September 2010.

Care in Multiple Settings



Note: Often physician, pharmacy, laboratory and other services are fragmented among the settings and care may bounce back to an earlier setting.

Care Coordination Is Multi-Step



- At Referral / Discharge Planning
  - Admission Decision
- At Discharge
  - Current Status
- At Admission
  - Physician: Admission Orders, Admission History and Physical
  - Nursing/Therapy: Initial Assessments
  - Reconciliation processes

Third-Party Care Coordination (from Patient-Centered Medical Homes to Managed Care Payors)

Public Health and Outcome Reporting

Note: Each setting has its own perspective, payor and regulatory requirements. The needs of sender and receiver are different.

HIE Challenge Grants: Improving Long-Term and Post-Acute Care Transitions

- Colorado
  - Community-based care management with focus on reducing hospital readmissions
  - Address developmentally disabled populations
  - 160 organizations in four communities to use results delivery, community record, CCD
- Massachusetts
  - Learning Collaborative to improve care transitions
  - Universal Transfer Form
  - Hybrid tools to bridge different technology levels
- Maryland
  - Building on work of three early adopter LTPAC providers
  - Portal access for those with limited technology
  - Registry of Advance Directive documents
- Oklahoma
  - Two-way communication between nursing facilities and hospitals
  - Include information from INTERACT (Interventions to Reduce Acute Care Transfers) http://www.interact2.net/
  - Also Advance Directives, ADLs, MDS
- National Governors' Association workshops on HIE and LTPAC:

  Alaska, Arkansas, Indiana, Michigan, North Dakota, Pennsylvania, Rhode Island and Washington + HIE Challenge Grantees for LTPAC
- Delaware HIN
  - 100% of acute hospitals, 100% of SNFs and other LTC providers
  - 88% of medical providers

Reusing Existing Assessments

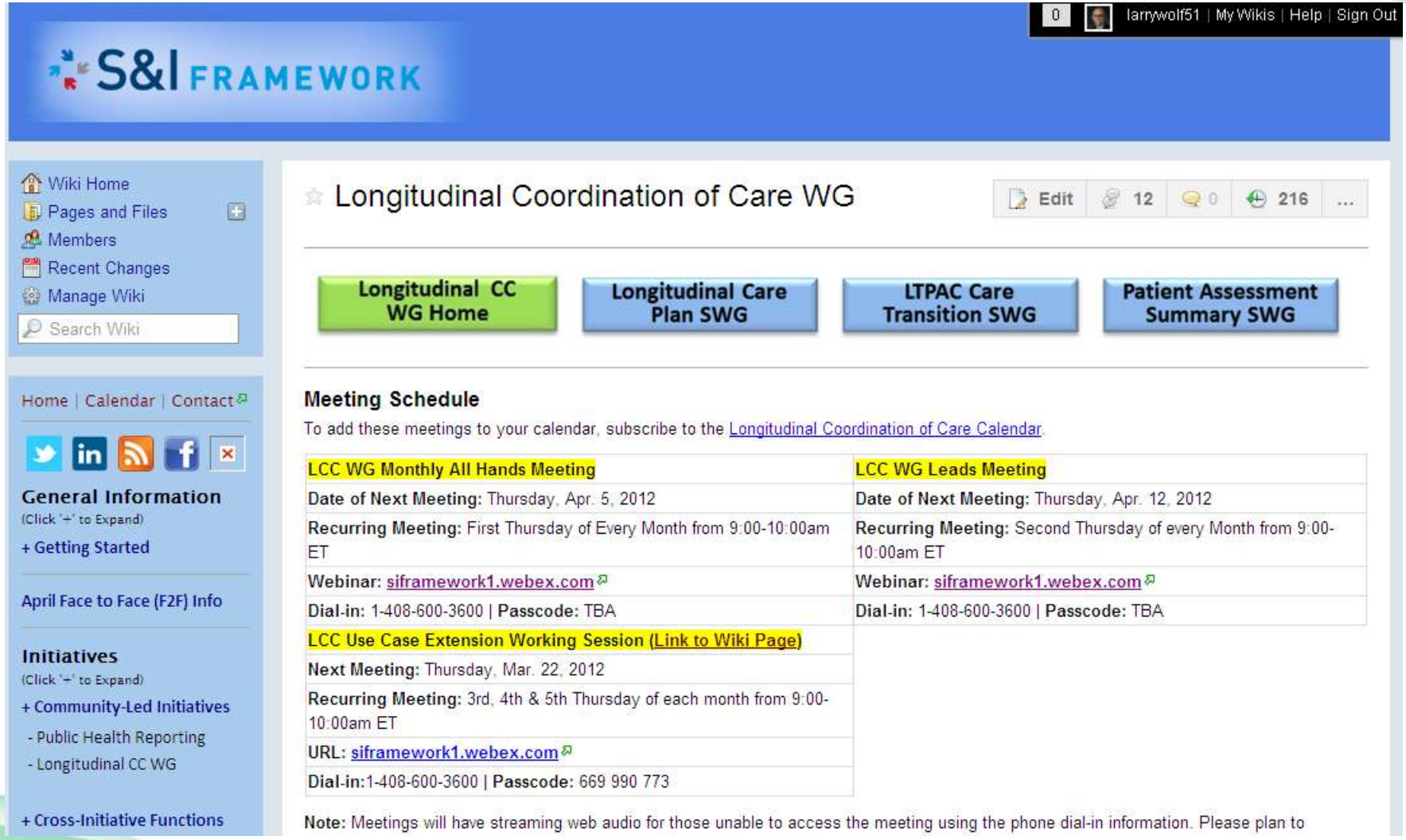
- Transform MDS and OASIS to CCD/C-CDA
  - Select components for inclusion
  - Re-code and format for CCD

MDS 3.0

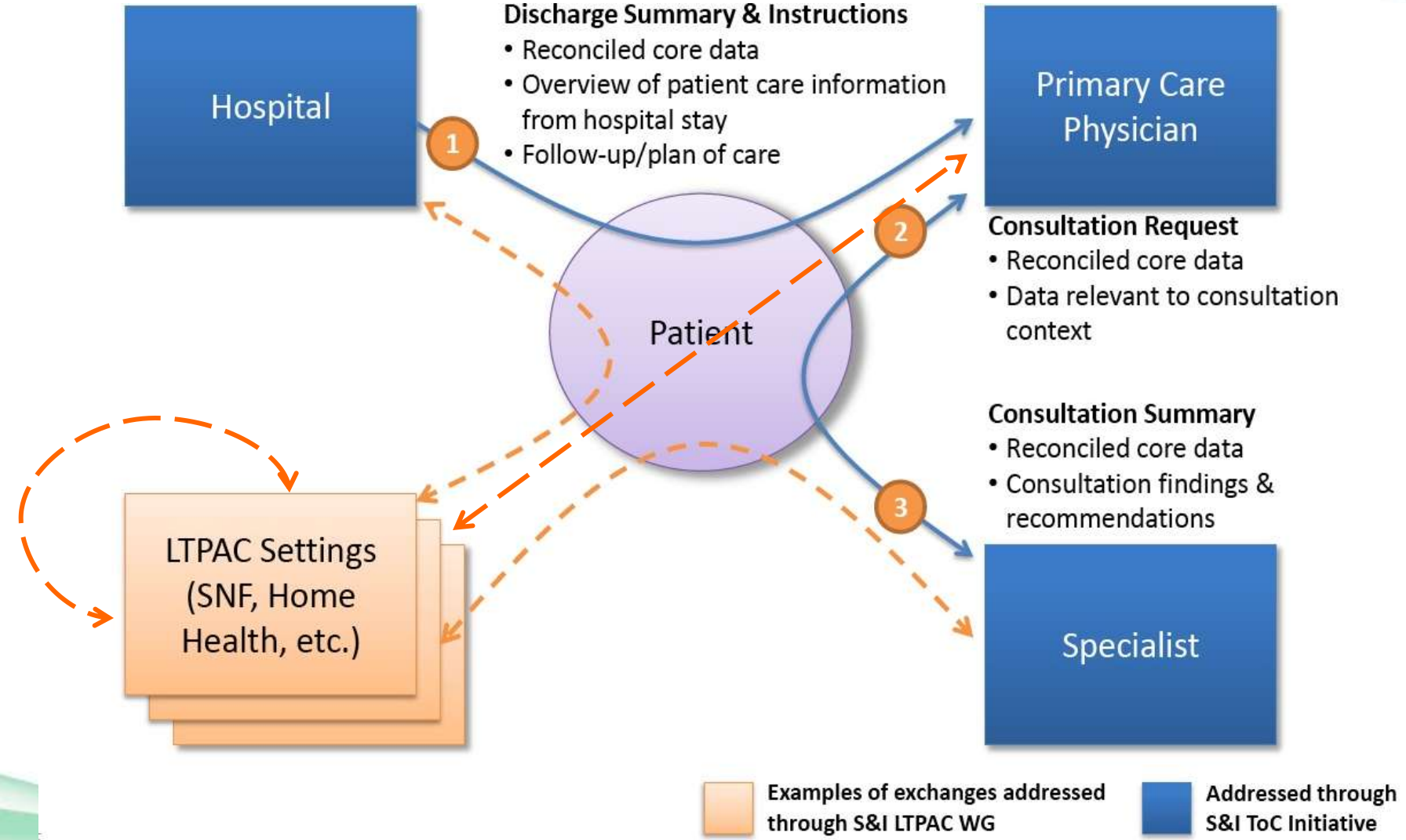
KEYSTONE BEACON COMMUNITY

CCD (C32)

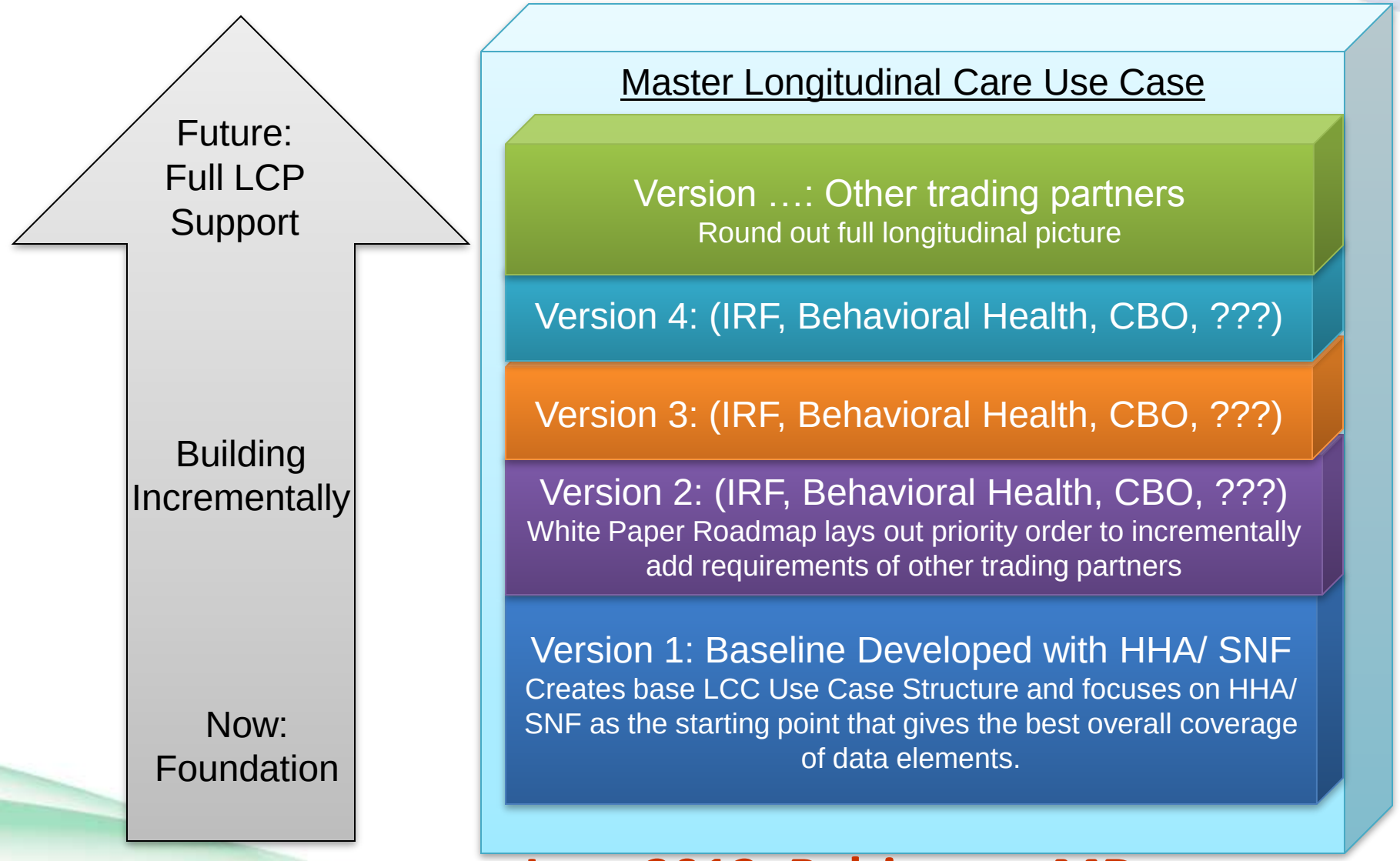
S&I Framework: Community-Led Initiative



Building on the S&I ToC Framework



Baseline Transaction and Build



8th LTPAC HIT Summit Summary

- New Approaches to Care Coordination
- Patient Engagement
- Quality Outcomes
- Getting Ready for Meaningful Use
- Interoperability & Interconnectivity Showcase
- Re-Hospitalization & Telemedicine
- Clinical Decision Support
- S&I Framework LCC
- Project Direct
- HITECH and HIPAA
- Medication Management
- Workforce Challenges

Helping people live their lives