



IMPACT

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Clinical Documentation Hearing
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Summary

1. Documentation for the purpose of care coordination needs to support the needs of the rest of the care team, including the patient and their caregivers.
2. Standard datasets to support care coordination across the continuum of care will be balloted in the HL7 August/September 2013 ballot cycle for incorporation into the Consolidated CDA. We encourage broad participation in this effort by joining for free at <http://wiki.siframework.org/Longitudinal+Coordination+of+Care>
3. Use of clinical decision support within documentation tools can facilitate capturing and recording the needed information.
4. Future EHR functionality should include the ability for “receivers” of patient data to use their EHR to instantly and efficiently provide feedback to the standards organizations for new data element requirements that are not part of the current datasets.

Clinical Documentation for Care Coordination

I define this as the timely **capture and recording** of information that will be **needed** by other members of the care team, including the patient and their caregivers, in a **standardized format**, to facilitate coordinated “shared care” as well as transitions of care. While this is a broad and complex topic, I will focus on three areas:

1. What clinical information is needed by other members of the care team?
2. What is the status of standards required for recording and conveying clinical data for care coordination?
3. How does one know what to capture and record to support coordinated care?

Clinical Information Needs of the Care Team

Traditionally, when clinicians or patients document and send information to other members of the care team, they send what they believe the other team members need. Dr. Terry O'Malley, Medical Director Non Acute Care Services at Partners HealthCare System, had the revelation that the best way to determine what to document and send is to ask the receivers of this information what they need! So in 2011, as part of the \$1.7 Million ONC's Health Information Exchange Challenger Grant known as IMPACT (Improving **M**assachusetts **P**ost-**A**cute **C**are **T**ransfers), Dr. O'Malley and I conducted a survey of 46 healthcare organizations, as well as some patients, asking what information they needed for their specific roles when receiving patient information from other "sending" healthcare organizations. Eleven types of healthcare entities were surveyed, including hospitals, emergency departments, nursing facilities, home health agencies, physician offices, community-based organizations, patients/families, etc... Surveys were completed by 12 types of team members, including physicians, nurses, therapists, social workers, case managers, secretaries, patients, etc... We received 1135 survey responses for specific transitions, identifying which data elements were required, optional, or not needed for each sender/receiver pair. In all, we identified 325 data elements required for one or more sender/receiver pairs. To put this number into perspective, the Continuity of Care Document (CCD) which is currently used as the standard document to electronically convey patient information during care transitions, only has approximately 175 data elements.

It also became clear after reviewing these surveys, that many of the transitions did not require all 325 data elements. After further analysis, we found that there were really 5 datasets representing 5 categories of sender/receiver pairs, in order of increasing size:

1. **Report from Outpatient testing**, treatment, or procedure
2. **Referral to Outpatient testing**, treatment, or procedure (including for transport)
3. **Shared Care Encounter Summary** (Office Visit, Consultation Summary, Return from the ED to the referring entity)
4. **Consultation Request** Clinical Summary (Referral to a consultant or the ED)
5. Permanent or long-term **Transfer of Care** to a different facility or care team or Home Health Agency

These datasets were then reviewed and/or supplemented both locally as well as nationally through the following forums:

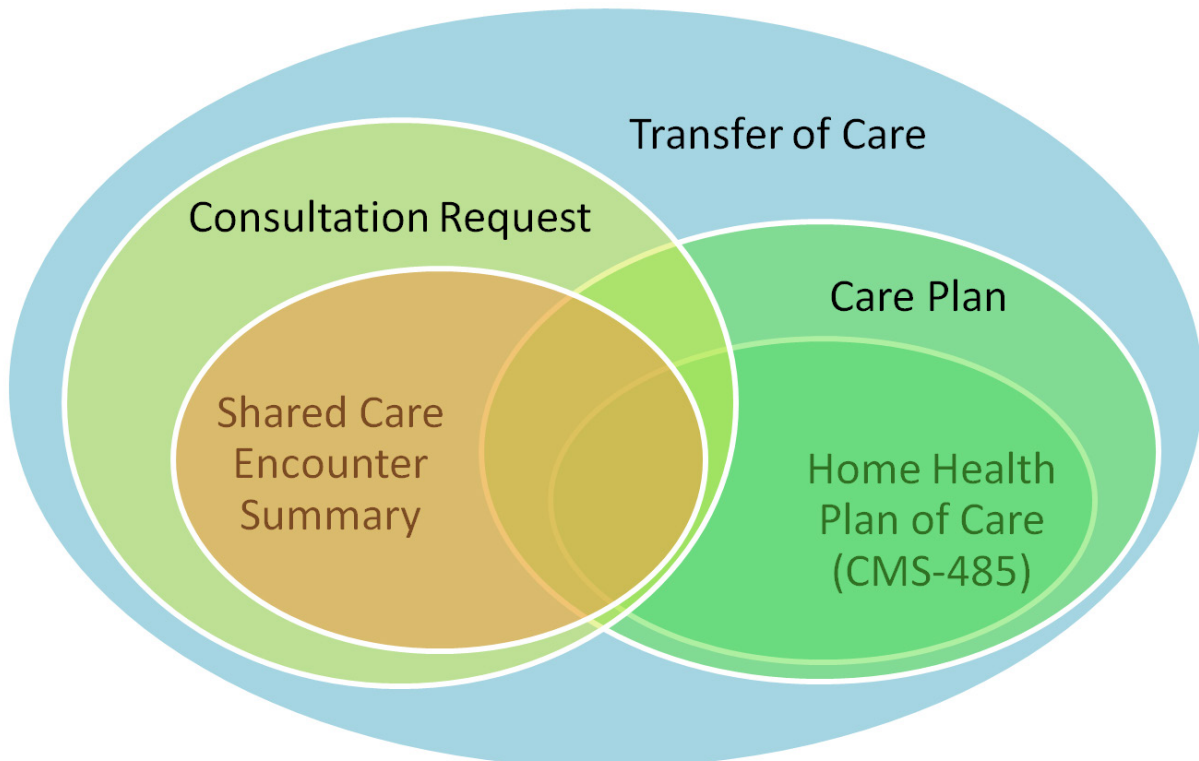
- State (Massachusetts):
 - IMPACT 16 pilot site learning collaborative participants
 - MA Universal Transfer Form workgroup
 - Boston's Hebrew Senior Life eTransfer Form
 - MA Coalition for the Prevention of Medical Errors
 - MA Wound Care Committee
 - Home Care Alliance of MA (HCA)

- National:
 - NY’s eMOLST
 - Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
 - Substance Abuse, Mental Health Services Agency (SAMHSA)
 - Administration for Community Living (ACL)
 - Aging Disability Resource Centers (ADRC)
 - National Council for Community Behavioral Healthcare
 - National Association for Homecare and Hospice (NAHC)
 - Transfer of Care & CCD/CDA Consolidation Initiatives (ONC’s S&I Framework)
 - Longitudinal Coordination of Care Work Group (ONC S&I Framework)
 - ONC Beacon Communities and LTPAC Workgroups
 - Assistant Secretary for Planning and Evaluation (ASPE)/Geisinger MDS HIE
 - Centers for Medicare & Medicaid Services (CMS)(MDS/OASIS/IRF-PAI/CARE)
 - **INTERACT (Interventions to Reduce Acute Care Transfers)**

Through this vetting process, additional data elements required for communication with the care team were identified, including those required for the Care Plan and Home Health Plan of Care (AKA CMS-485). In all, we have identified approximately 480 data elements necessary for some patients during care transitions and coordinated shared care, and 7 datasets (5 care transitions datasets plus the Care Plan and the Home Health Plan of Care) to group them.

National Standards for Documenting Clinical Data for Care Coordination

We are now in the process of developing HL7 standards for the largest 5 of the 7 datasets, represented here to show their interrelationships:



HL7's Consolidated CDA (C-CDA) currently can represent only a limited portion of these 5 datasets. The C-CDA only has a limited version of the "Shared Care Encounter Summary" (i.e. Consultation Note), and does not have document types to adequately represent the Transfer of Care, Consultation Request, or Care Plan datasets, nor are all of the needed 480+ data elements representable in the current version of the C-CDA.

ONC's HIT Policy Committee recognized the importance of these expanded datasets to improve the care of our sickest and most vulnerable patients. The recently-released Meaningful Use Stage 3 Policy Committee Request For Comments solicited comments on EHR certification criteria that would require support for the Transfer of Care, Consultation Request, and Shared Care Encounter Summary document types.

ONC's S&I Framework Longitudinal Coordination of Care Workgroup (LCC WG) has been providing input into the definition of these datasets over the past year. We have now secured over \$500,000 in public and private funding to advance this work under the auspices of the LCC WG to create implementation guides for these 5 datasets and ballot them in HL7's August/September 2013 ballot cycle for inclusion in an updated version of the Consolidated CDA. These new national standards for transitions of care and the care plan will be piloted in several forums during 2013, and will be available for incorporation into Meaningful Use Stage 3's corresponding EHR certification criteria.

Knowing What Needs to be Documented

From our surveys of healthcare providers and patients, it was clear that the vast majority of communication among care team members does not require all 480+ data elements. So how can a team member know what data need to be captured and recorded in any particular situation? This can be accomplished, and has been done at Reliant Medical Group, by embedding clinical decision support functionality within the documentation tool, allowing the tool to actively guide the user to capture the necessary information and facilitate its recording.

At Reliant Medical Group, a 250-physician multi-specialty group practice located throughout central Massachusetts and a member of Atrius Health, our Electronic Health Record (EHR) system has this embedded clinical decision support functionality. Here are a few examples of how our EHR's clinical decision support guides capture of, and facilitates recording of, data based on the specific patient's age, gender, diagnoses, medications, test results, etc...

1. When a Reliant patient calls and speaks with a triage nurse about a problem, the nurse is prompted to use a problem-specific template that guides them to capture the information desired by the physician for that specific problem, and facilitates the documentation of that information with the most common answers and the ability to add free text.

2. When a patient goes online into their Reliant Personal Health Record because they have a problem, the patient completes a questionnaire that offers different questions based on their specific problem and their response to prior questions, capturing the information desired by their physicians.
3. When one of our Medical Assistants (MA) puts a patient in the room, they pull up a documentation template that automatically tells them what to do with that specific patient based on their current problems and type of visit. So for patients with a cough it tells them to have the patient undress and put on a hospital gown. If the patient is a diabetic, it tells the MA to have the patient remove their shoes in order to perform a Diabetic Foot Exam, and to collect a diabetes-relevant review of symptoms. At the same time, it helps create the note for the MA that documents what they did.
4. When a physician sees a patient for a comprehensive physical exam and they pull up their documentation template, the template automatically includes a Health Risk Assessment if needed for that patient, both guiding the physician to perform the assessment as well as facilitating its documentation.
5. When a patient calls for a renewal of a medication, the documentation template automatically determines the appropriate monitoring of symptoms and tests needed by the physician for that specific medication, identifies what monitoring has already been completed or ordered, and prompts the nurse to complete and document any missing monitoring assessments.

As standards are finalized this year for the care team's clinical information needs, clinical decision support functionality within documentation tools can be used to guide the appropriate clinician to perform the necessary assessments and facilitate their documentation. The EHR could identify existing care team members or impending transitions to new care team members to help determine requirements. The EHR would then compare these requirements to data that have already been captured and automatically present documentation templates to capture the missing data.

In the future, it would be helpful if "receivers" of patient data could use their EHR to instantly and efficiently provide feedback to the standards organizations for new data element requirements that are not part of the current datasets.

Documentation in support of care coordination is not only critical towards achieving the "Triple Aim" of better care, better health, and lower costs, but it is also the expectation of the Social Security Act (SSA) §1848 (o)(2)(A)(ii), as modified by Health Information Technology for Economic and Clinical Health (HITECH) Act.

Respectfully Submitted,

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