

Prepared Panel 3 Statement by William M. Russell, MD

Summary:

Electronic notes capturing clinical transactions can inform and improve encounters, make critical concepts available for reuse and can promote patient centered care across multiple disciplines, settings, and episodes of care. There is a need to go beyond the medical information model to structure and harmonize clinical documents across the care and service delivery network and to share information to promote collaboration and goal directed, whole person care. Barriers to this vision include the lack of candidate standards for document components and data elements supporting the clinical concepts generated by the many members of the care team, and the lack of availability and adoption of base-certified EHR technology beyond the incented provider communities allowing for technology enabled exchange of these concepts. Semantically interoperable assessments promoting effective Transitions of Care and shared, Longitudinal Care leading to an interoperable set of guiding principles called a Care Plan are the goals of the Longitudinal Coordination of Care workgroup at the Standards and Interoperability Framework.

How do you define clinical documentation?

Clinical documentation needs to be seen through the lens of the patient or care recipient. Any transaction or event that contributes to the determination of the health status of a person, their prognosis, or actual or potential treatments should be available as part of a person's health record to the patient and every authorized participant in their care and service delivery team member. These include but are not limited to encounters, clinical summaries, care plans, applicable clinical practice guidelines and protocols, conversations among care team members, and any and all services provided on the persons behalf intended to promote optimal health status.

How is clinical documentation used to support care coordination?

Care planning and coordination are the processes by which the aforementioned clinical concepts are processed by a care team to develop a comprehensive, interdisciplinary care plan. With increasing comorbidity and illness and as other factors contribute to the functional decline of the person, the need for more robust, well constructed and well executed care plans increases. The greatest value of the process of care planning and coordination is the ability to individualize the vast array of potential interventions to glean those of highest benefit, and eliminate those of greatest potential burden. Again, the application of a single practice guideline to a single condition is evidence based and often straightforward, but as a person acquires multiple diagnoses, and treatments, and as functional status contributes to a need for increasing assistance with basic activities of daily living, evidence based medicine must be supplemented by a whole person approach. Practice guidelines are nearly always defined by the ability to contribute to a longer life for the person affected by an illness, but as life span approaches life expectancy, or as the burdens of daily living increase, a person's life and health goals change dramatically and should not be jeopardized the overzealous application of clinical practice guidelines.

In the nursing home and in home care and hospice, I see patients who are on 15 or even 20 medications. There is usually a good reason for each of them but there is seldom a good reason for all of them. How

does a clinician prioritize which conditions are best treated, knowing that a person might only be able to take 8 or 9 medications, or even less, before adverse drug events become worse than untreated illness?

It is, in fact, the obligation of the care team to determine a person's overall health status, and all the potential interventions for that person and to work with that person and their loved ones to establish realistic and achievable goals of care. This requires a tremendous amount of information which then must be processed in a patient centric way. It includes assessments by a wide variety of care team members, not just medical providers, and it must include a well documented conversation with the patient and other involved parties regarding both desired and realistic or expected outcomes and the overall goals of care. The current state of the art for care planning and coordination is a robust team approach where each care team member brings a wealth of discipline specific insight into the factors that contribute to understanding the status of the patient, status of the care plan and any needed changes required to the plan and the team. State of the art care planning occurs in conjunction with the patient, processes the potential or actual health concerns, each potential intervention and the totality of the interventions, and the realistic and expected outcomes against the patients desired outcomes and between these care planning sessions. Through this process, the activities of the care team are aligned and guided by the plan and the status of the patient is monitored and reported to ensure that any deviations from expected outcomes are reported and acted upon quickly.

Which aspects of clinical documentation are most critical/important for care coordination?

The coin of "whole person care" has two faces. We have focused on assessment data and summary documents and hyper-focused on medical documentation. In fact, I consider assessment data to be the "reverse" of the coin. The glorious "obverse" of the coin is the comprehensive approach to achieving realistic goals and optimized health status. The two are highly inter-related.

The critical elements are:

1) What are the health concerns for the person?

This is greater than a list of diagnoses and represents all the factors which might interfere with a person's capacity to achieve the major goals of life: longevity, comfort leading to contentment, and functional independence. It must include the status of the concern and its short and long term impact on the person's health status.

2) What are the person's goals of care?

It is most telling that in clinical summaries and most of the core functional requirements for electronic health records, that there is nearly no space reserved for the capture and maintenance of the patient's specific health and life goals. While Advance Directives have begun to serve for the tiny subset of goals reserved for end-of-life care and are valuable, electronic records and clinical documentation should promote the creation, collection, aggregation and prioritization of person centered goals of care.

These two pillars of care planning allow for the creation of an appropriate and realistic care plan that can then be shared by all participants in care delivery and maintained over time.

- 3) Within your organization, have you developed a formal or informal process to ensure that these elements are always captured?

Throughout my career, and long before the automation of the health care enterprise, I have worked to create high performing, patient centered care teams characterized by competency, compassion and commitment over time. These remain critical success variables regardless of information flows. However, the ability to capture critical assessment data and make that data available to a care team both through a flow of information into the care planning process and the ability to create decision support tools and to analyze the actual performance of a care team member and the care plan itself, is facilitated enormously by the use of electronic documents.

Examples of processes which capture and share key clinical data points in electronic notes which are then shared to coordinate care across disciplines include:

- a) At Erickson Communities, the creation of a summary of care record for nursing home residents which allowed the care team in a facility to report on critical issues to physicians during monthly or urgent visits. Such items as any recent occurrences of falls or near falls, new or worsening pressure ulcers, the frequency and consequences of any burdensome behaviors resulting from cognitive impairment or mental illness, nutritional status and nutritional risk screening, functional capacity and trends over time, and continence were all available for electronic exchange to the medical provider and the medical provider's assessments were then available for review by the interdisciplinary team. As part of a comprehensive approach to technology enabled care coordination, decision support and quality improvement, the long term care residents of Erickson Communities experienced improved outcomes as evidenced by reduced use of antipsychotic medicines and medicines in general, reduced falls with injury and improved wound care and improved communication with patients and families.
- b) In the Oklahoma Transition of Care Challenge Grant, change in condition in nursing homes is documented and transmitted across shifts of between nurses and other care staff and to physicians off site using secure messaging. The result is a more prompt interdisciplinary assessment resulting in reduced ER visits and reduced readmissions.
- c) In Massachusetts ToC Challenge Grant, the data specified for receivers of patients in transitions of care and for care team members in shared care, have specified a more robust summary document which will require the creation of standard assessments with well specified vocabularies and value sets which will increase both the ability of staff to describe the health status of the patient and to communicate that assessment to across the spectrum of care.
- d) There are also valuable exemplars of robust and patient specific documentation describing the health status and goals of a patient such as the efforts at Keystone Beacon community in Central PA to summarize and transmit Federally required assessments for home care and nursing home residents, and the emerging

standards for the exchange of the Home Health Plan of Care underway at the S and I Framework.

- 4) What challenges have you faced integrating data across care teams and settings? What solutions have you identified to address these challenges?

Clinical documentation and care planning and coordination for vulnerable populations will often involve service delivery across multiple settings, multiple disciplines and potentially aligned and non-aligned service providers. Clinical concepts are not easily harmonized across disciplines. While clinical documents are well structured in the medical provider community, a similar structure for other clinical documents such as nursing, behavioral health and rehab notes is not well established. Common terms are used differently by each discipline, and there is a bias toward the validity of medical information over the direct observations of care staff, even though, for example, a nurse aide may see a patient for over a hundred hours a month and record thousands of clinical events such as the provision of ADL support, and a physician may spend but a few minutes, however, there is no easy way to incorporate the input of all the care team members in the care planning process. Among the barriers to care delivery team input into the care plan process include the lack of reporting and trending outputs for some volume transactions such as dysfunctional behavior and the lack of semantically interoperable clinical documents for supportive care staff which can then inform the care plan are not available in many systems. This requires a separate summary document to be created if the care delivery team is to be represented in care planning, which is a difficult workflow.

At Seasons Hospice and Palliative Care, we are undertaking a comprehensive approach to clinical documentation where all assessments from all disciplines will align with a clinical domain model and draw from a library of semantically harmonized assessment elements including both vocabularies and value sets which attempt to be relevant and applicable across most disciplines and settings of care and are assembled into individual electronic documents which are then specified by the encounter type and discipline. All data would then be available across the care spectrum and has the potential to inform the care plan process through a mapping of health concerns evidenced in assessments to the associated care plan problems and all care plan problems, goals and interventions will be available and guide the clinical documents. Lastly, a core set of assessment data points are aligned with highly specified quality measures which will allow for real time reporting of provider level performance as well as the potential for decision support tools.

The driver for this effort is simple: leverage technology to improve quality as demonstrated by measurable and improved outcomes while optimizing the user and patient experience.

The biggest challenge to this approach has been twofold:

- The lack of available candidate standards for the majority of documents types and sections, as well as harmonized vocabularies and value sets for the assessment items required;
- And the lack of interoperability and intra-operability in non-certified electronic health records results in an inflexible implementation. The ability of LTPAC

vendors to support optimized clinical processes is limited by the ability to share and evaluate information across disciplines and processes in real time and over time which imposes significant workflow challenges for the users.

5) Is there a tool, instrument, or artifact that will assist in coordination?

Again, coordination depends on the relationship between care planning and assessments. The standardization of structure and harmonization of content across disciplines in the current Seasons project was aided significantly by three artifacts;

- The clinical domain model used for Hospice was inspired by the work of the IMPACT project and takes the concept of a core set of data elements and section headers required for patient transitions to home care (type 5 dataset) and uses similar concepts into the hospice workflow and the assessments which support data capture during care delivery. Essentially, while IMPACT focuses on transitions of care, the clinical documentation project at Seasons Hospice views interdisciplinary care delivery as a series of similar, frequent internal data exchanges which benefit greatly from highly specified data made possible by electronic notes.
- In addition, the modeling of the care plan and content done at the S and I Framework served to guide the information streams between assessments and care plans.
- Finally, the use of a small subset of the standardized vocabularies and value sets specified by the CARE initiative at CMS and aligning those elements with federally required quality reports has been very helpful, especially for standardizing terminologies for the core assessment of functional status and cognitive status.

Coordination of care is a much more elusive goal. While there are a number of electronic tools to support collaboration, the ability for such tools to connect the key information streams between clinical documents and care plans and provide secure messaging and governance of the care plan are very limited. This is an area of weakness not just in non certified EHR's but also in the certified products as well. I believe the activities of the LCC Workgroup at the S and I Framework will continue to diligently expand the register of appropriately structured, relevant clinical information and promote the development of standards necessary to allow these concepts to be exchange and processed during episodes of shared care across settings and includes non-aligned providers.

Respectfully submitted,

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