Putting Patients and Families at the Center of Health and Care Planning

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Care Planning Hearing
Certification/Adoption & Meaningful Use Workgroups
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national partnership for women & families

About Us

The **National Partnership for Women & Families** is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care, and policies that help women and men meet the dual demands of work and family.

The **Consumer Partnership for eHealth** (CPeH) is a coalition led by the National Partnership for Women & Families since 2005 of more than 50 consumer, patient, and labor organizations working at the national, state, and local levels to advance private and secure health information technology (health IT) in ways that measurably improve the lives of individuals and their families.

More information is available at
www.NationalPartnership.org

CPeH Consumer Partnership for eHealth

national partnership for women & families

From Advance Directives to Care Plans Generally

- **Advance Directives**
  - Critical and well-accepted way that people identify the care they do and do not want **when certain conditions or illnesses occur**
  - Patient preference information that providers must have and know in order to act according to their patients' choices
  - Essential for patient- and family-centered care
- **Care Plans**
  - Critical way that people can identify their goals and preferences for their health and their health care **across a range of life situations**
  - Patient preference information that providers must have and know in order to act according to their patients' choices
  - Essential for patient- and family-centered care
  - Essential for supporting patients and families in the progression toward better health and functioning

Some Building Blocks of Advance Directives & Care Plans

- **Capturing information about a person's goals for health and care is a foundational step of developing a comprehensive, shared care plan**
  - True of Advance Directives in particular, and Care Plans in general
- **Care planning process can identify and communicate goals, values, and preferences for ALL care, including advance directives**
  - Shift from episode or illness-based planning to all-encompassing health & wellness planning
- **Must incorporate the different cultural and linguistic preferences and literacy of diverse patient populations and caregiver communities**
  - Essential for the patient to express an informed preference or goal

Consumer Principles for Health & Care Planning

1) **Care plans should be goal-oriented, dynamic tools (not static documents).**
2) **Tools that facilitate care planning should enable all members of the care team to securely access and contribute information, according to their roles.**
3) **Care plans should identify and reflect the ability and readiness of an individual (and caregiver) to successfully meet their goals, as well as potential barriers.**
4) **Care planning and tools should facilitate decision-making and specify accountability.**
5) **Every individual would benefit from care planning and tools.**

Source: Consumer Partnership for eHealth, [Draft] Care Plans 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment (Sept. 2013).

Care Plans 2.0
The Next Generation

Consumer Vision:

- **A multidimensional, person-centered health & care planning process facilitated by a dynamic, electronic platform that connects individuals, their family and other personal caregivers, paid caregivers (such as direct care workers and home health aides), and health care and social service providers, as appropriate.**
- **The care plan supports all members with actionable information to identify and achieve the individual's health and wellness goals.**

Meaningful Use Policy—
Advance Directives

Stage 2 Final Rule	Stage 3 Request for Comment	CPeH Comments
EHs Only—Menu: •50% of patients 65 years or older have advance directive status recorded as structured data *Menu objective* →*No change from Stage 1*	**EHs—Core:** •50% of patients 65 years or older have advance directive status recorded as structured data →*Transition from menu to core objective* **EPs—Menu:** • 50% of patients 65 years or older have advance directive status recorded as structured data →*Added as menu objective*	• Require **content** of Advance Directive to be available, too • Revise age limit to all adults (18+) • *Future Stage*: AD content should inform Clinical Decision Support (CDS) tools

Meaningful Use—Care Plans

Stages 2 & 3	Proposed for Future Stage	Comments
N/A	**EPs & EHs:** Give receiving provider and patient/ caregiver electronic care plan info for 10% of transitions of care/referrals, including: ➢ Medical diagnoses; functional status ➢ Social, financial info; environmental factors ➢ Most likely course of illness or condition ➢ Cross-setting care team member list from each active provider setting ➢ Patient's long-term goal(s) for care, including time frame and initial steps ➢ Specific advance care plan (POLST) **Certification criteria:** Develop standards for shared care plan and structured recording of data elements such as patient goals	How to advance an electronic shared care planning and collaboration tool that crosses care settings and providers, encourages team-based care, and includes patients and their non-professional caregivers?

To answer the hearing questions:

- **We can and should do more to build health and care plans into Stage 3.**
- **If you build it with us, we will already be there—and we will get there faster.**
- **That's the best outcome!**

For more information

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