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S&I FRAMEWORK

Longitudinal Coordination of Care (LCC) Workgroup (WG)

Standards for Transitions of Care (ToC) and Care Plans in MU2 & MU3

Presented by: Evelyn Gallego-Haag

April 3, 2013

Objectives

- Discuss how current and proposed standards for Transitions of Care (ToC) and Exchange of Care Plans do not meet policy expectations for MU2 and MU3 for Eligible Providers (EPs)/Hospitals
- Understand the extensive national effort behind evolving standards for ToC and Care Plans and expected level of maturity for 2013
- Recognize the efforts that support the adoptability of these evolving standards

Limitations of Current & Proposed Standards to Support Meaningful Use Transitions of Care and Care Plans

Public & HITSC Response to MU3 ToC & Care Plan Exchange Recommendations

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- HITPC requested public input in several domains including ToC and Care Plans (SGRP 303/304/305)
- Summary of responses from Feb 6th, 2013 HITPC meeting:
  - Strong support for intent of objectives
  - Though ToC standards are available, adoption remains low
  - No standardized definitions for ToC (exchange of patient information from one entity to non-affiliated entity) and Care Plan/ Plan of Care
  - Concerns about the burden of work if data not reusable
  - Good standards for problems, medications, allergies and labs but limited for other areas.
  - More work needed to expand Consolidated CDA (C-CDA) (remaining standards gap) to enable interoperable exchange of care plans across care teams

What are the key MU3 Policy Gaps?

1. Lack of Care Plan definitions, relationships, and ability of Consolidated (C-CDA) to represent needed care plan content

2. Availability of C-CDA document types to meet the needs and responsibilities of EPs and Hospitals as senders and receivers of information during transitions of care

3. Maturity and adoptability of candidate standards

MU3 Gap 1: Standardized Care Plan definitions and terminologies

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- The concept of “Care Plan” and its component parts are ambiguously defined in MU and thereby impact the ability for interoperable exchange
- Current standards do not support the requirements to exchange a care plan
  - C-CDA focus on problem-specific goals, instructions and Care team
  - Omission of other critical Care Plan components: health concern, interventions, patients’ overarching goals
  - No standard for codifying all of the Care team members
  - No standard on conveying when and how each section was last reconciled for a given patient
  - Gaps in representing critical care plan content (e.g. nutritional status)
  - No standard to convey the many-to-many relationships between the components of the Care Plan

MU3 Gap 2: EP and Hospital Information Needs and Responsibilities for Transitions of Care

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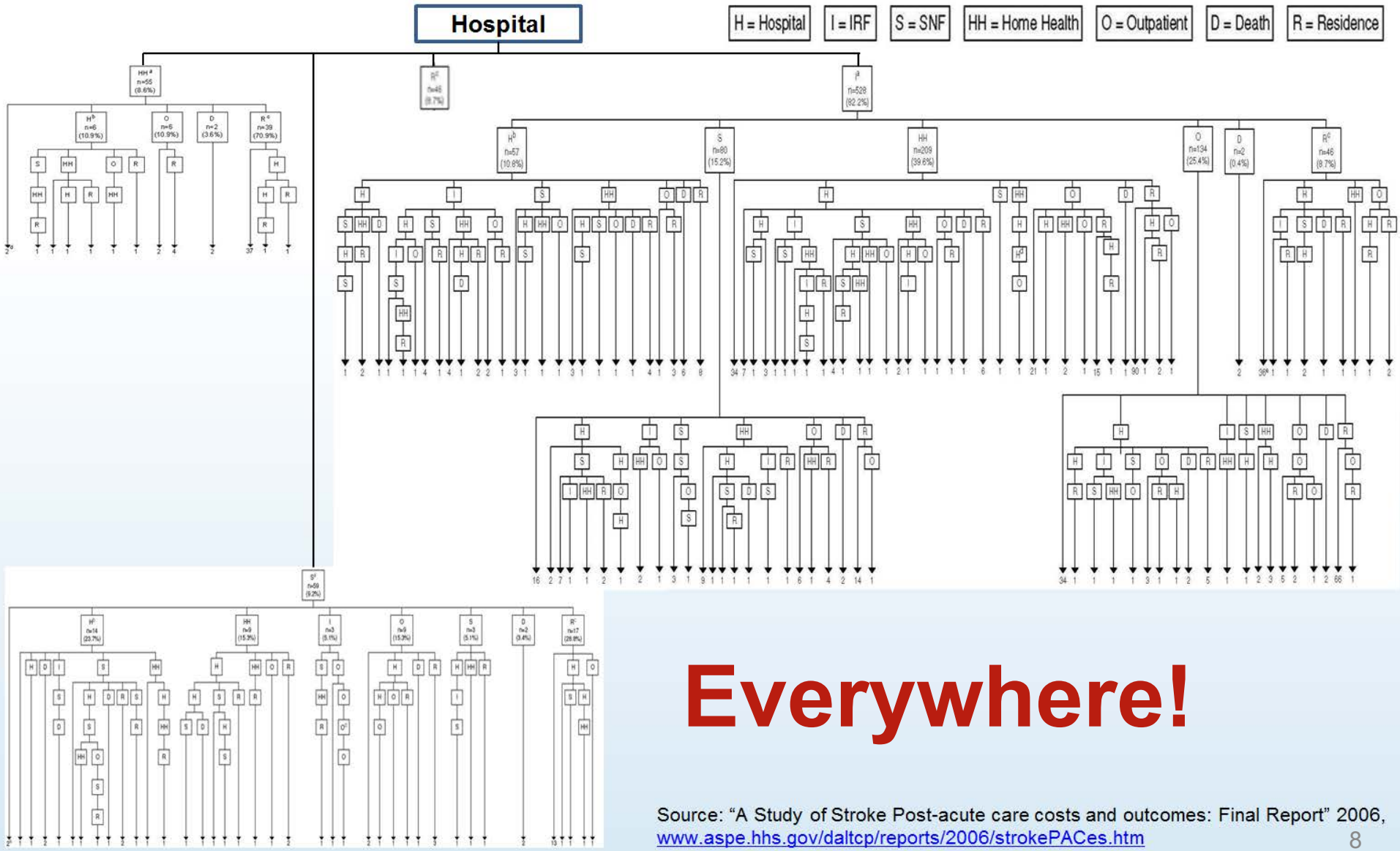
Where do patients go after hospital?



Everywhere!

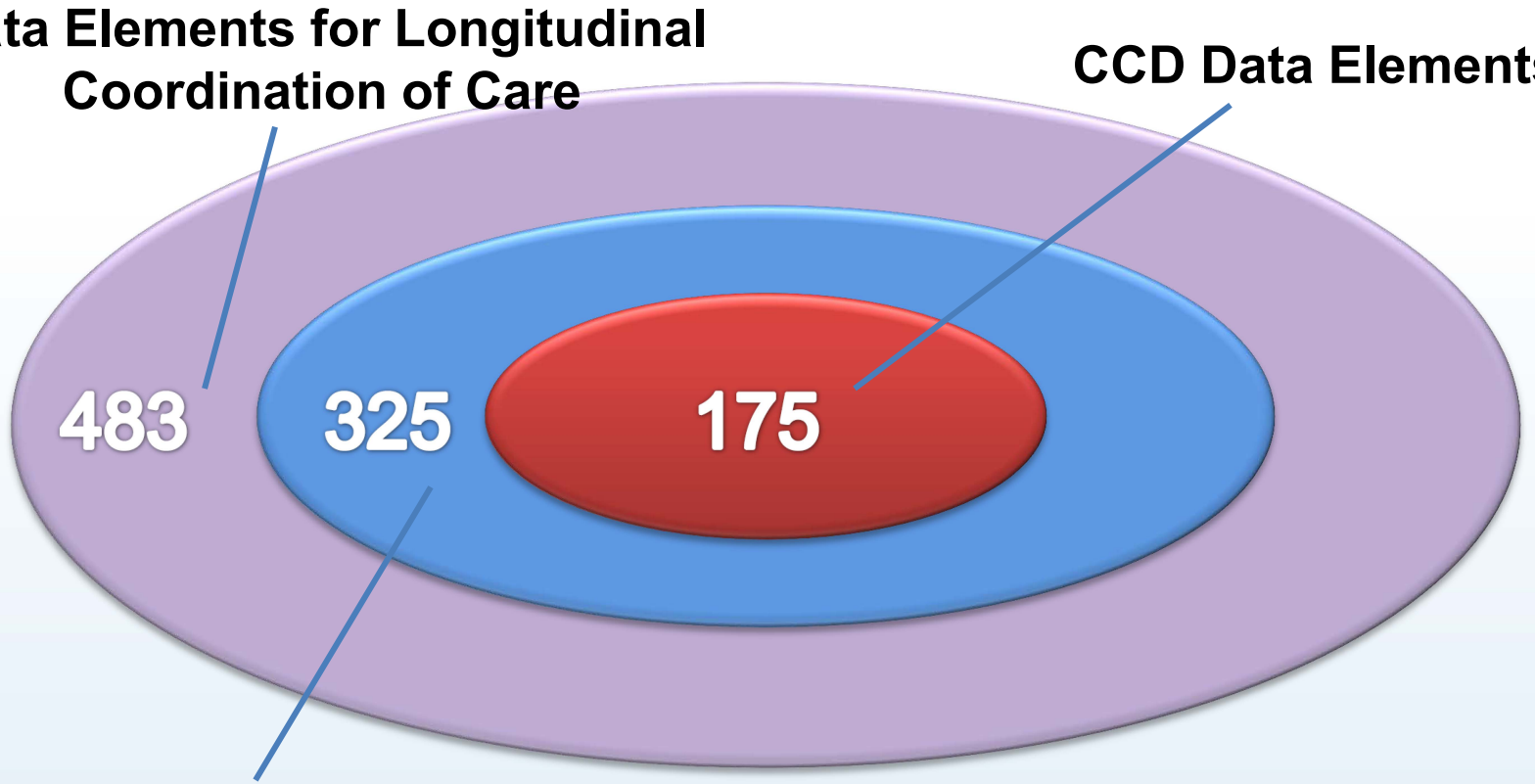
Source: "A Study of Stroke Post-acute care costs and outcomes: Final Report" 2006, www.aspe.hhs.gov/daltcp/reports/2006/strokePACes.htm

MU's Impact on LTPAC

- ~40% of Medicare patients are discharged to traditional LTPAC settings (SNF, Home Health, Inpatient Rehab Facility, etc…)
- These patients are the sickest population and account for ~80% of Medicare costs
- Hospitals must be responsible, and given the tools, to convey the information needed by the recipient of a patient during care transitions

Sources:
http://aspe.hhs.gov/health/reports/2011/pacexpanded/index.shtml#ch1
http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf

MU3 Gap 2: C-CDA Data Element Gaps



- Many "missing" data elements can be mapped to CDA templates with applied constraints
- 30% have no appropriate templates

MU3 Gap 3: Maturity and adoptability of candidate standards

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- Work has been ongoing for the past few years to address the insufficient standards for transitions of care and care plans:
  - ONC S&I ToC, esMD and LCC WGs
  - HL7 Patient Care Workgroup
  - IHE Patient Care Coordination Technical Committee
  - AHIMA LTPAC HIT Collaborative
- All 6 groups have been coordinating their efforts

Evolving Standards for Transitions of Care and Care Plans

LCC WG Key Successes to meet MU3 needs

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- **(JUNE 12) LCC Use Case 1.0**: Expanded from S&I ToC Use Case; identified 360+ additional data elements
- **(AUG 12) Care Plan Whitepaper** "Meaningful Use Requirements For: Transitions of Care & Care Plans"
- **(OCT 12) IMPACT Dataset**: Consensus built Transitions of Care and Care Plan/HHPoC dataset (483 data elements). Deep dive of LCC Use Case 1.0
- **(MAY- SEPT 12) Balloted 3 standards through HL7**: 1) C-CDA Refinements interoperable exchange of Functional Status, Cognitive Status, & Pressure Ulcer; 2) Questionnaire Assessment; and 3) LTPAC Summary IG. MU2 incorporated requirements for functional and cognitive status.
- **(OCT 12) Stage 3 MU Care Plan Questions** for HITPC MU WG
- **(DEC 12) Care Plan Glossary**
- **(JAN 13)** Community Led submission to HITPC **RFC Stage 3 MU**
- **(MAR 13) IMPACT Transfer of Care High-level IG**
- **(MAY 13) LCC Use Case 2.0:** Focus on functional requirements for Care Plan exchange

LCC WG Care Plan Artifacts: Glossary

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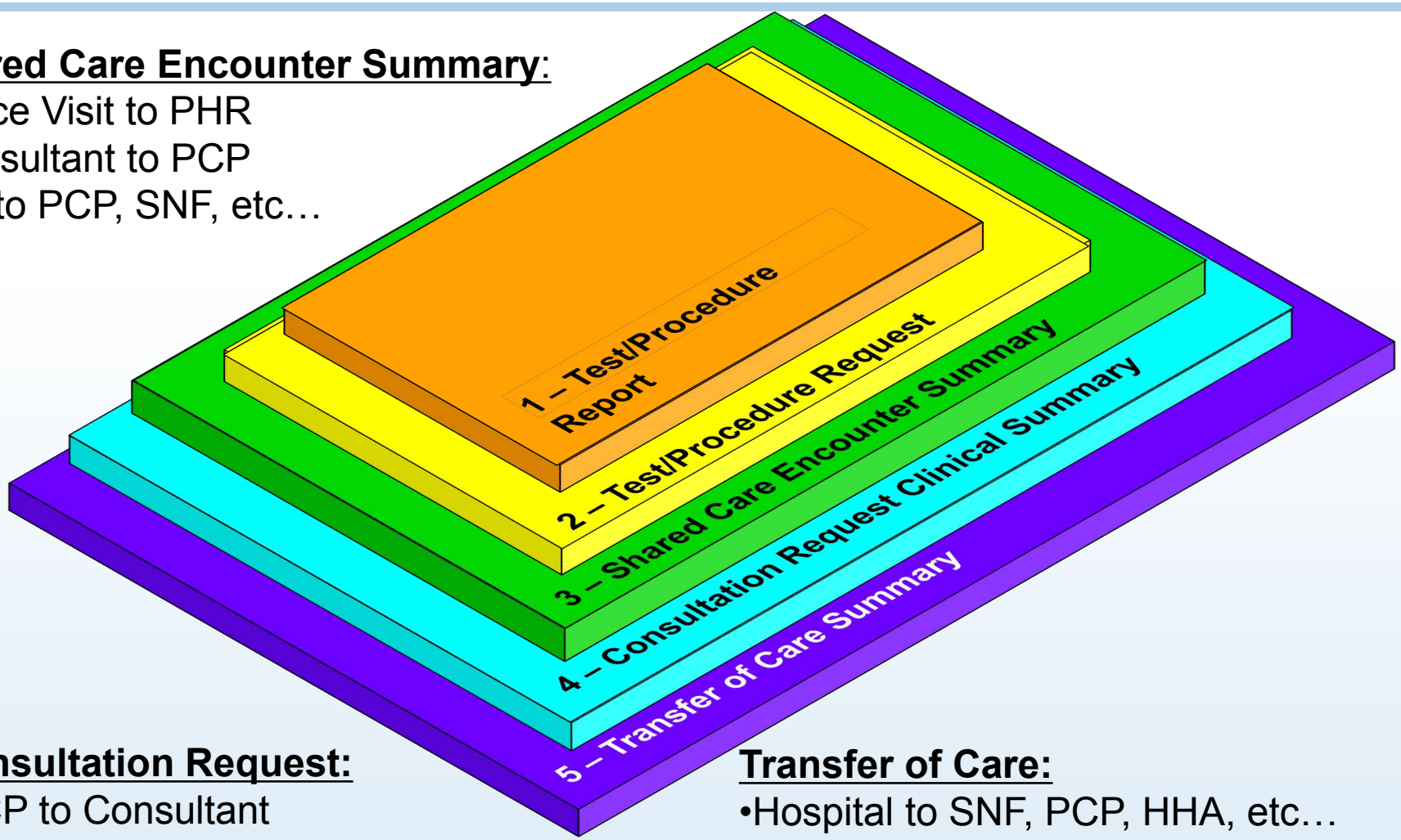
Term/ Component	LCC Proposed Definition
Care Plan	The term "care plan" considers the whole person and focuses on a number of health concerns to achieve high level goals related to healthy living. Care Plan and Plan of Care share the **SIX** components: health concern, goals, instructions, interventions, outcomes, and team member
Health Concern	Reflect the issues, current status and 'likely course' identified by the patient or team members that require intervention(s) to achieve the patient's goals of care, any issue of concern to the individual or team member
Goals	A defined outcome or condition to be achieved in the process of patient care. Includes patient defined goals (e.g., prioritization of health concerns, interventions, longevity, function, comfort) and clinician specific goals to achieve desired and agreed upon outcomes.
Instructions	Information or directions to the patient and other providers including how to care for the individual's condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice. Detailed list of actions required to achieve the patient's goals of care.
Interventions	Actions taken to maximize the prospects of achieving the patient's or providers' goals of care, including the removal of barriers to success. Instructions are a subset of interventions.
Outcomes	Status, at one or more points in time in the future, related to established care plan goals.
Team Member	Parties who manage and/or provide care or service as specified and agreed to in the care plan, including: clinicians, other paid and informal caregivers, and the patient.

Five Transition Datasets

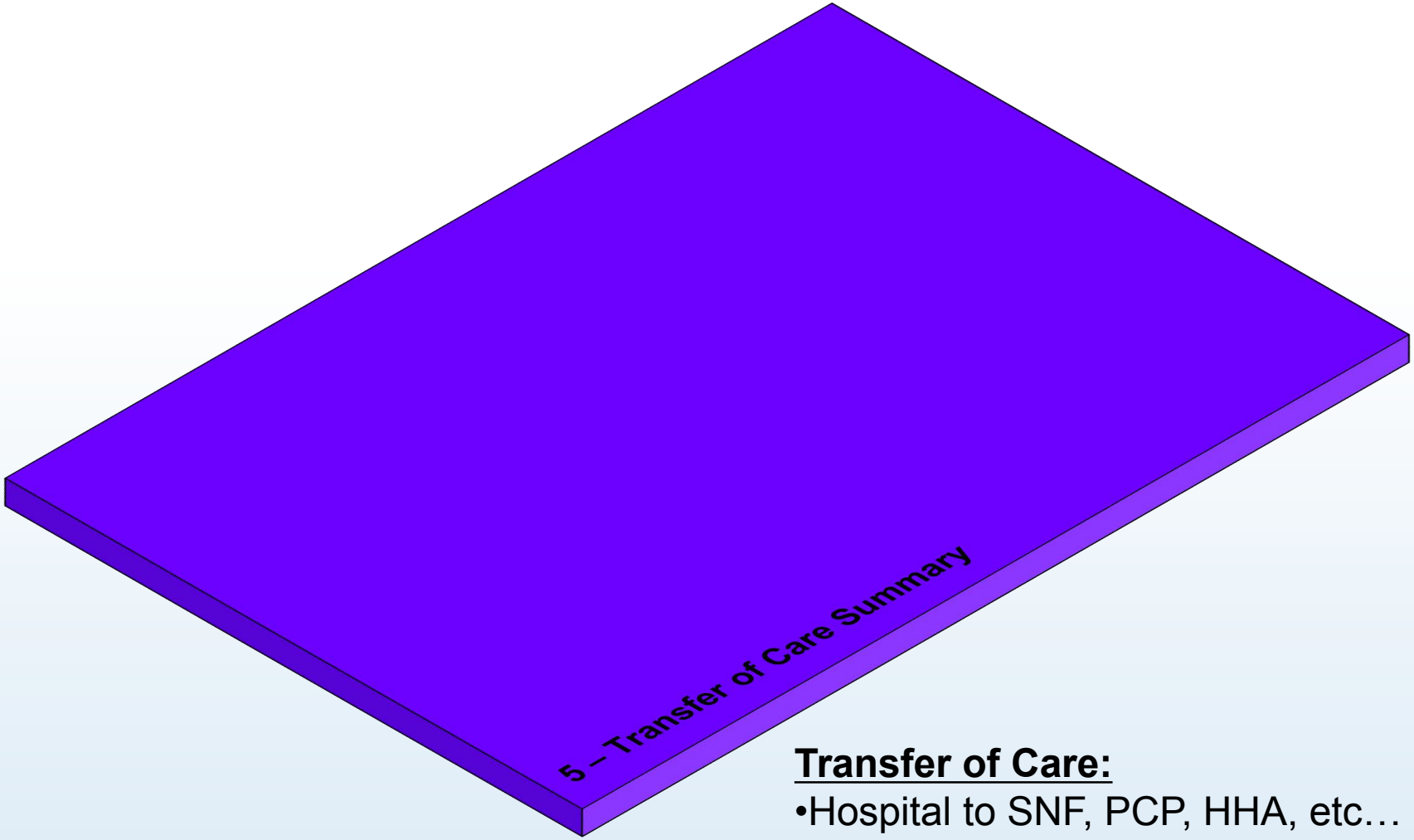
Shared Care Encounter Summary:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc…



Consultation Request:
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer of Care:
- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP

IMPACT Transfer of Care Dataset



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S&I Lantana HL7 CDA IG Development & Ballot Work

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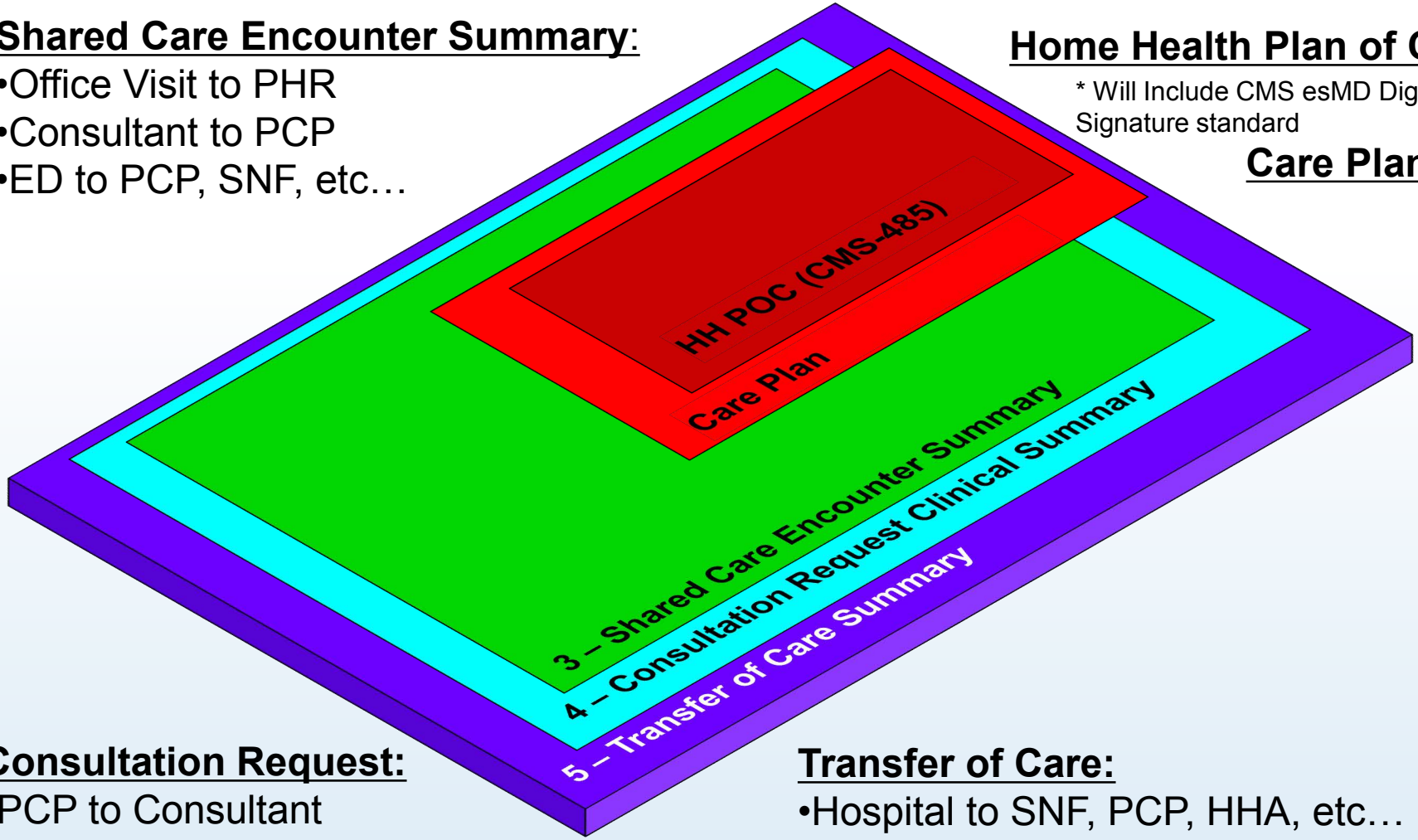
Home Health Plan of Care

* Will Include CMS esMD Digital Signature standard

Care Plan



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Significant EP, Hospital, and LTPAC EHR vendor interest in standands

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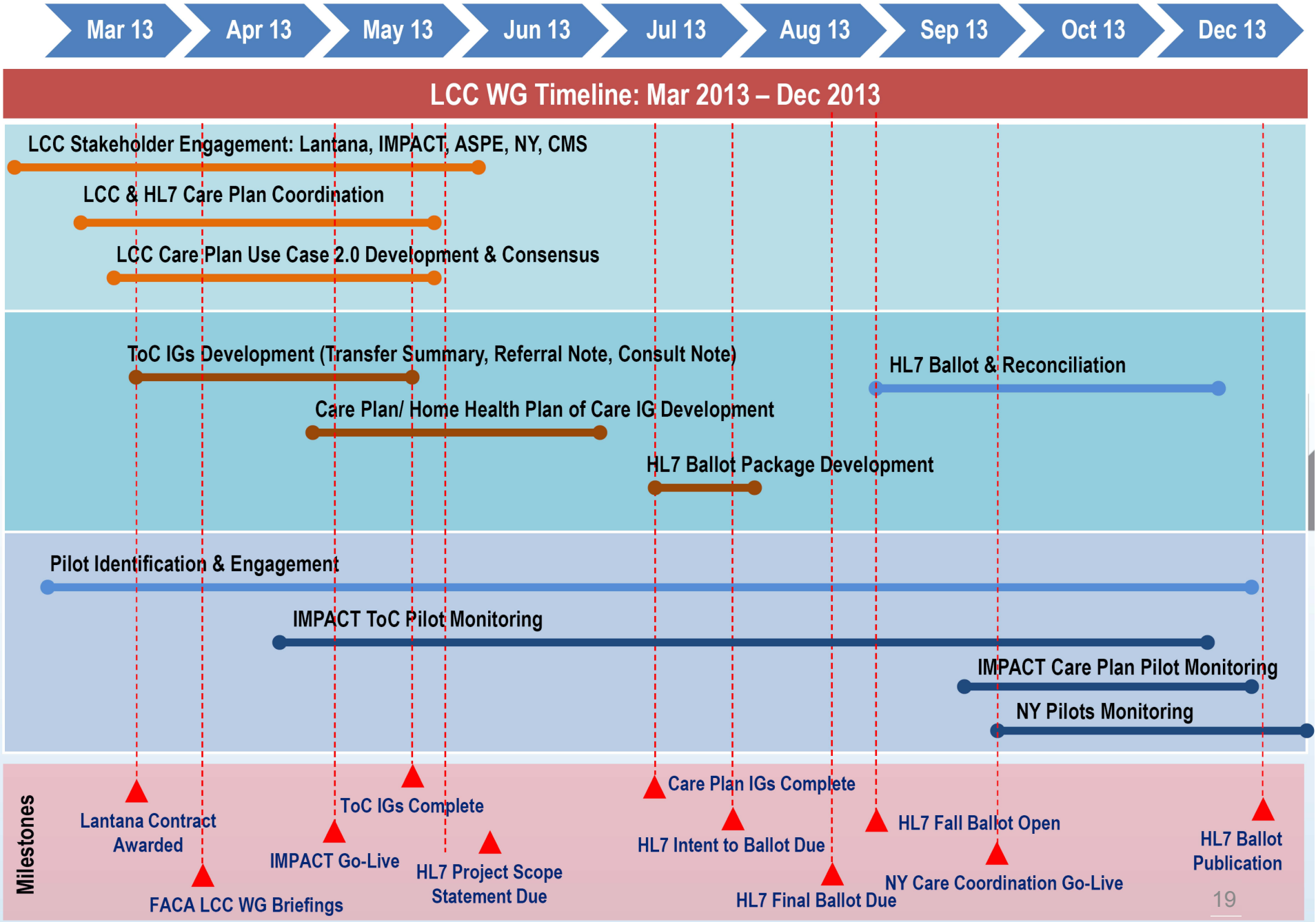
- Multiple vendors are participating in LCC
- Multiple vendors are exploring incorporating the standards into their products
- Several intend to pilot the pre-balloted versions in their products in Massachusetts and New York by September
- Several national LTPAC providers are exploring incorporating these standards into their products


Mar 13
Apr 13
May 13
Jun 13
Jul 13
Aug 13
Sep 13
Oct 13
Dec 13
LCC WG Timeline: Mar 2013 – Dec 2013
LCC Stakeholder Engagement: Lantana, IMPACT, ASPE, NY, CMS
LCC & HL7 Care Plan Coordination
LCC Care Plan Use Case 2.0 Development & Consensus
ToC IGs Development (Transfer Summary, Referral Note, Consult Note)
HL7 Ballot & Reconciliation
Care Plan/ Home Health Plan of Care IG Development
HL7 Ballot Package Development
Pilot Identification & Engagement
IMPACT ToC Pilot Monitoring
IMPACT Care Plan Pilot Monitoring
NY Pilots Monitoring
Milestones
Lantana Contract Awarded
FACA LCC WG Briefings
ToC IGs Complete
IMPACT Go-Live
HL7 Project Scope Statement Due
Care Plan IGs Complete
HL7 Intent to Ballot Due
HL7 Final Ballot Due
HL7 Fall Ballot Open
NY Care Coordination Go-Live
HL7 Ballot Publication

LCC Initiative: Resources & Questions

- **LCC Leads**
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LCC Wiki Site: http://wiki.siframework.org/Longitudinal+Coordination+of+Care