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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: Dr. Larry Garber & Dr. Bill Russell

March 27, 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
- Support the inclusion of these evolving standards in MU3 for ToC and Care Plans, including the HHPoC

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

MU2 ToC & Care Plan Exchange Requirements

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- Requires EPs to send **care summaries** during ToC
  - Care Plan content, if known, is required in a Summary Care Record
  - Summary Care Record content includes:
    - **Care Plan** section, including goals and instructions
    - **Patient Care Team**, including PCP of record and additional known care team members beyond referring or transitioning provider and the receiving provider
    - Requires EPs to exchange **functional status** and **cognitive status**
- These are only part of a Care Plan

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 Standards Gaps?

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1. Availability of standardized Care Plan terminology and definitions
2. Availability of Consolidated CDA (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 longitudinal 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
  - Omission of nutrition assessment and diet orders
  - No standard for codifying all of the Longitudinal Care team members
  - No standard on conveying when and how each section was last reconciled for a given patient
  - 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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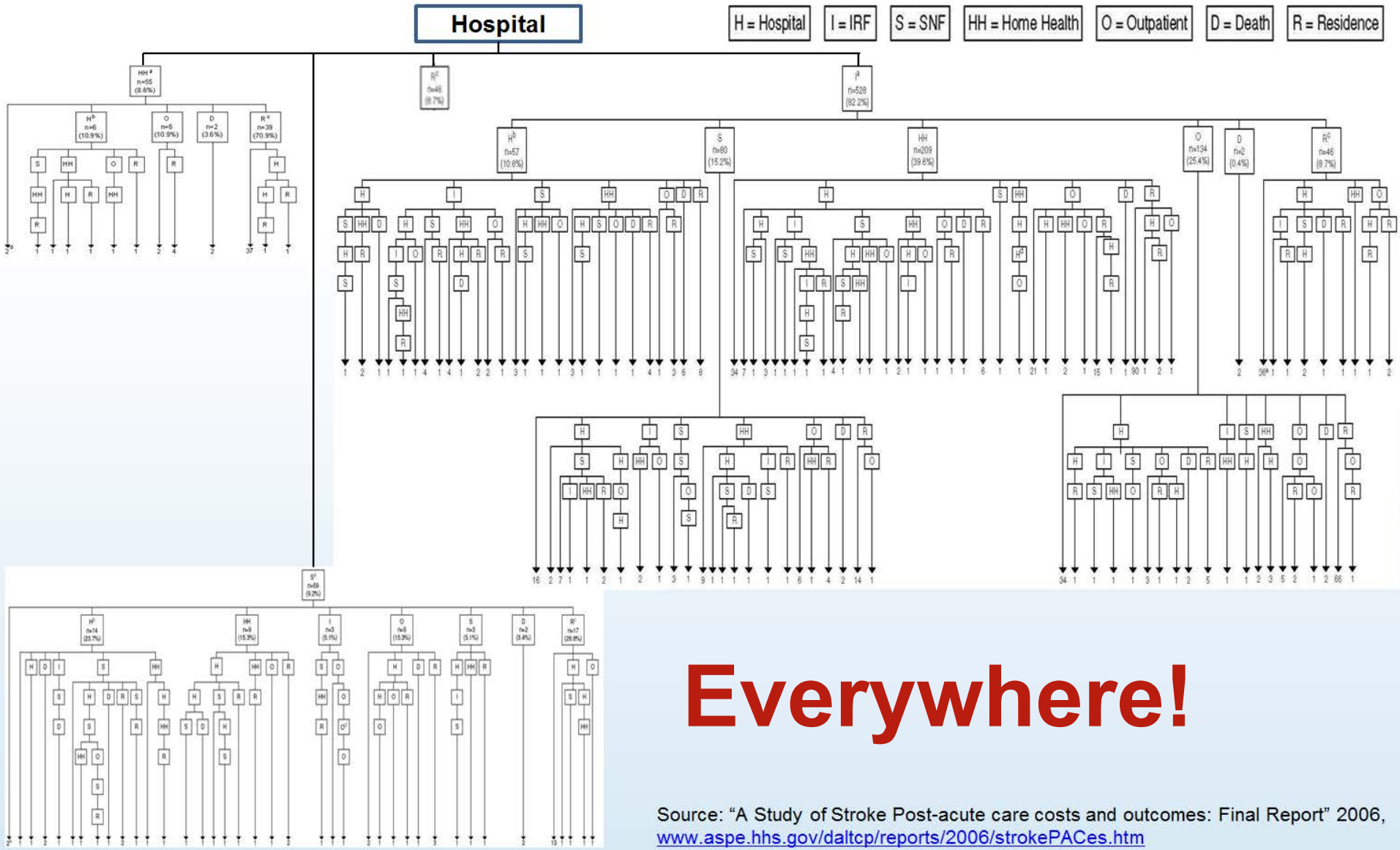
Where do patients go after hospital?



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

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IMPACT "Receiver" Data Needs Survey

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- Largest survey of Receivers' needs
- 46 Organizations completing evaluation
- 11 Types of healthcare organizations
- 12 Different types of user roles
- 1135 Transition surveys completed

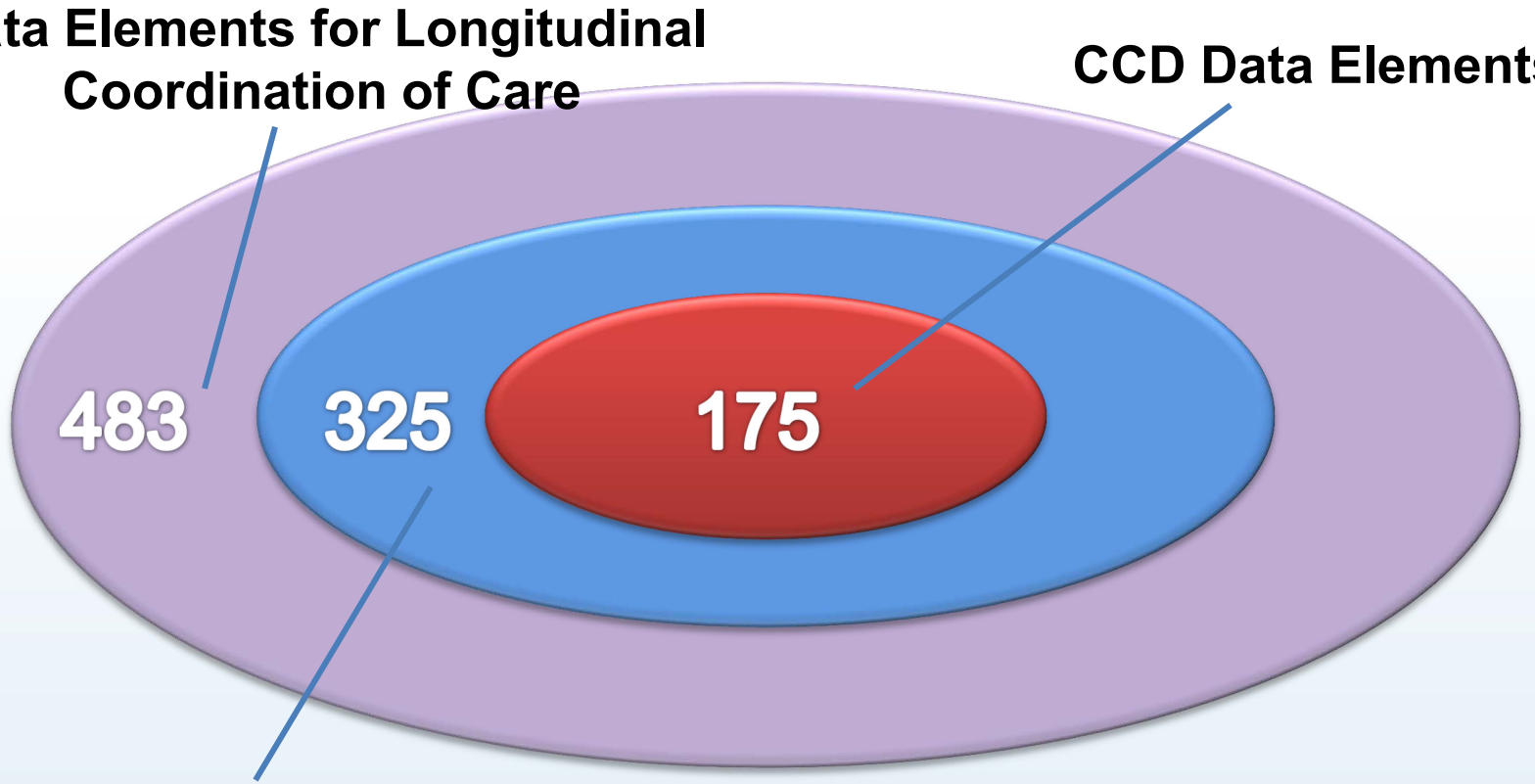
6		From Acute Care Hospital	From Emergency Department	From Skilled Nursing Facility
72	Chief Complaint	Required	Required	Required
73	Reason Patient is being referred	Required	Required	Required
74	Reason for Transfer	Not needed/No	Not needed/No	Not needed/No
75	Sequence of events proceeding patient's disease/condition	Optional	Optional	Required
76	History of Present Illness	Required	Required	Required

Contact Information | HomeHealth Nurse

Additional Contributor Input

- State (Massachusetts)
  - MA Universal Transfer Form workgroup
  - Boston's Hebrew Senior Life eTransfer Form
  - IMPACT learning collaborative participants
  - 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** (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers)
  - Transfer Forms from Ohio, Rhode Island, New York, and New Jersey

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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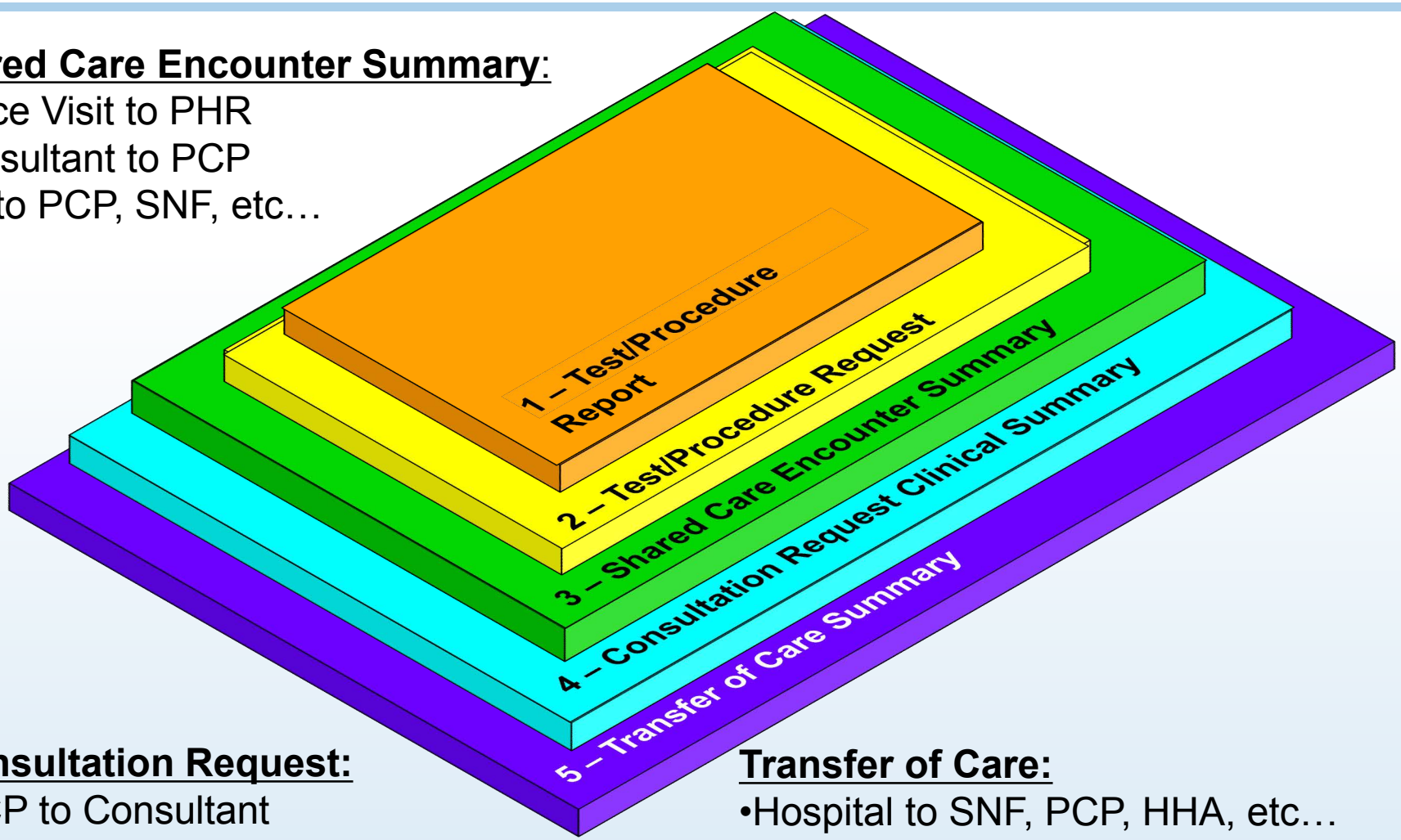
- **(JUNE 12) LCC Use Case 1.0**: Expanded from S&I ToC Use Case; identified 360+ additional data elements
- **(AUG 12) Care Plan Whitepaper** "Meaningful Use Requirements For: Transitions of Care & Care Plans"
- **(OCT 12) IMPACT Dataset**: Consensus built Transitions of Care and Care Plan/HHPoC dataset (483 data elements). Deep dive of LCC Use Case 1.0
- **(MAY- SEPT 12) Balloted 3 standards through HL7**: Stage 2MU C-CDA Refinements interoperable exchange of Functional Status, Cognitive Status, & Pressure Ulcer; Questionnaire Assessment; and LTPAC Summary IG
- **(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**

Five Transition Datasets

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 facility)
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

Five Transition Datasets

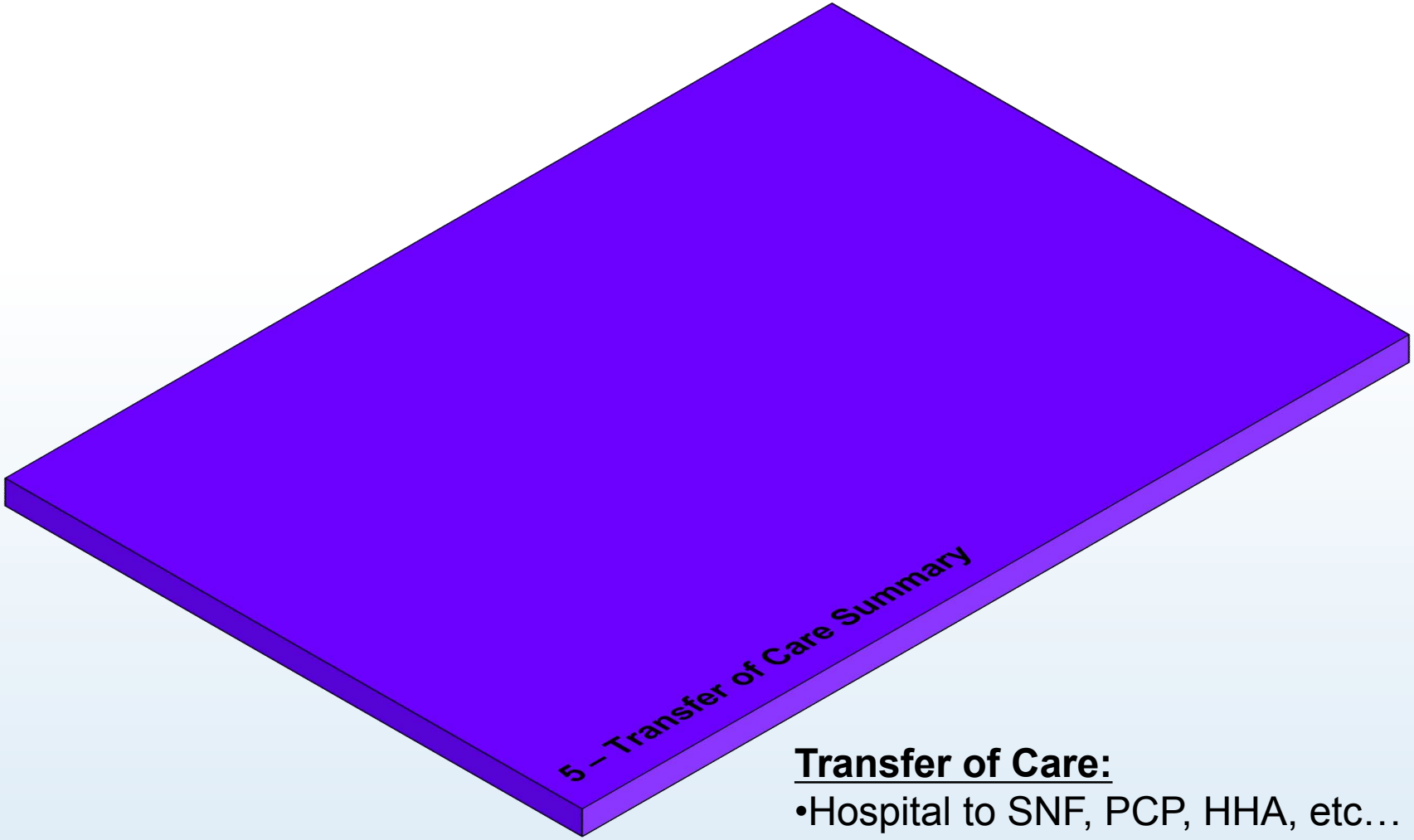
Shared Care Encounter Summary:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc…



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



Transfer of Care:

- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP

Testing the Transfer of Care Dataset

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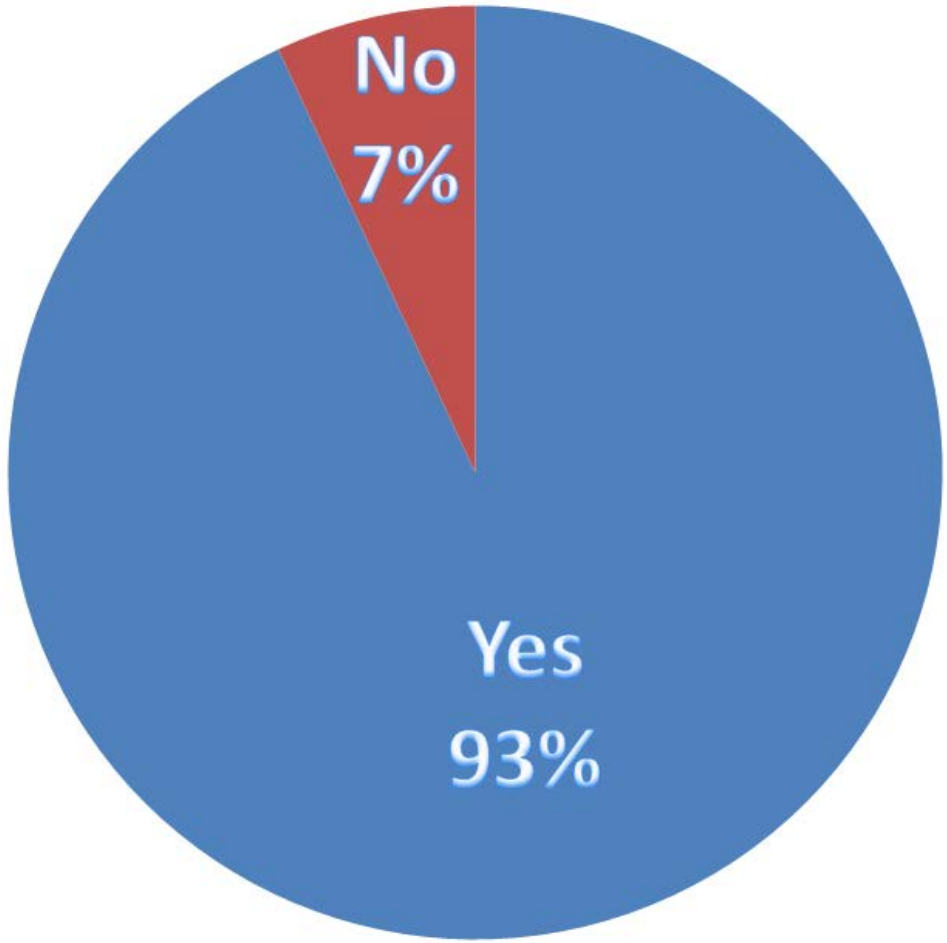
Spring 2012, on paper:

2 hospitals, 2 large group practices, 2 home health agencies, 8 SNFs, 1 IRF, 1 LTACH, and **several hundred patient transfers…**

Senders found the data



…and we'll be testing 1000+ electronic transfers per month of the full dataset starting June 2013!

IMPACT Transfer of Care CDA Document

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Lantana CONSULTING GROUP

Surrogate EHR Environment (SEE)
Transfer of Care Implementation Guide, Release 1.1

March 2013

4.1 *Transfer of Care Document*

[ClinicalDocument: templateId 2.16.840.1.113883.10.20.22.1.12 (open)]

Table 22: Transfer of Care Document Contexts

Used By:	Contains Entries:
	Advance Directives Section (entries optional) Allergies Section (entries required) Assessment Section Chief Complaint and Reason for Visit Section Encounters Section (entries required) Family History Section Functional Status Section History of Past Illness Section History of Present Illness Section Hospital Discharge Diagnosis Section Immunizations Section (entries required) Medical Equipment Section Medications Section (entries required) Payers Section Plan of Care Section Problem Section (entries required) Procedures Section (entries required) Results Section (entries required) Social History Section Vital Signs Section (entries required)

```
<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
     xsi:schemaLocation="urn:hl7-org:v3 ../../CDA_Resources/CDAR2Normative/infrastructure/cda/CDA_SDTC.xsd"
     xmlns="urn:hl7-org:v3" xmlns:cda="urn:hl7-org:v3" xmlns:sdtc="urn:hl7-org:sdtc">
     <!--
**********************************************************
  CDA Header (updated 12/27)
**********************************************************
     -->
     <realmCode code="US"/>
     <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
     <!-- Identifies document as conformant to
      US General Header Template -->
     <templateId root="2.16.840.1.113883.10.20.22.1.1"/>

     <!--
PART 1:  DOCUMENT IDENTIFICATION INFORMATION
            -->

     <!-- Transfer Summary Document
          Conforms to the document specific requirements  -->
     <templateId root="2.16.840.1.113883.10.20.22.1.12"/>
     <!--1.1 DocumentID: unique ID for the document -->
     <id root="04fc2b90-10e0-11e2-892e-0800200c9a66"/>
```

LCC WG Care Plan Artifacts: Glossary and Use Case

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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 care, including Instructions ar
Outcomes	Status, at one
Team Member	Parties who m plan, including

LCC Interoperable Care Plan Exchange

Use Case v2.0

Summary of User Scenarios

1. Scenario 1: Exchanging a care plan during a complete handoff of care from the sending care team to a receiving care team
2. Scenario 2: Exchanging a care plan between care team members during shared care
3. Scenario 3: Exchanging a care plan between care team members and a patient

Lantana HL7 CDA IG development & ballot work

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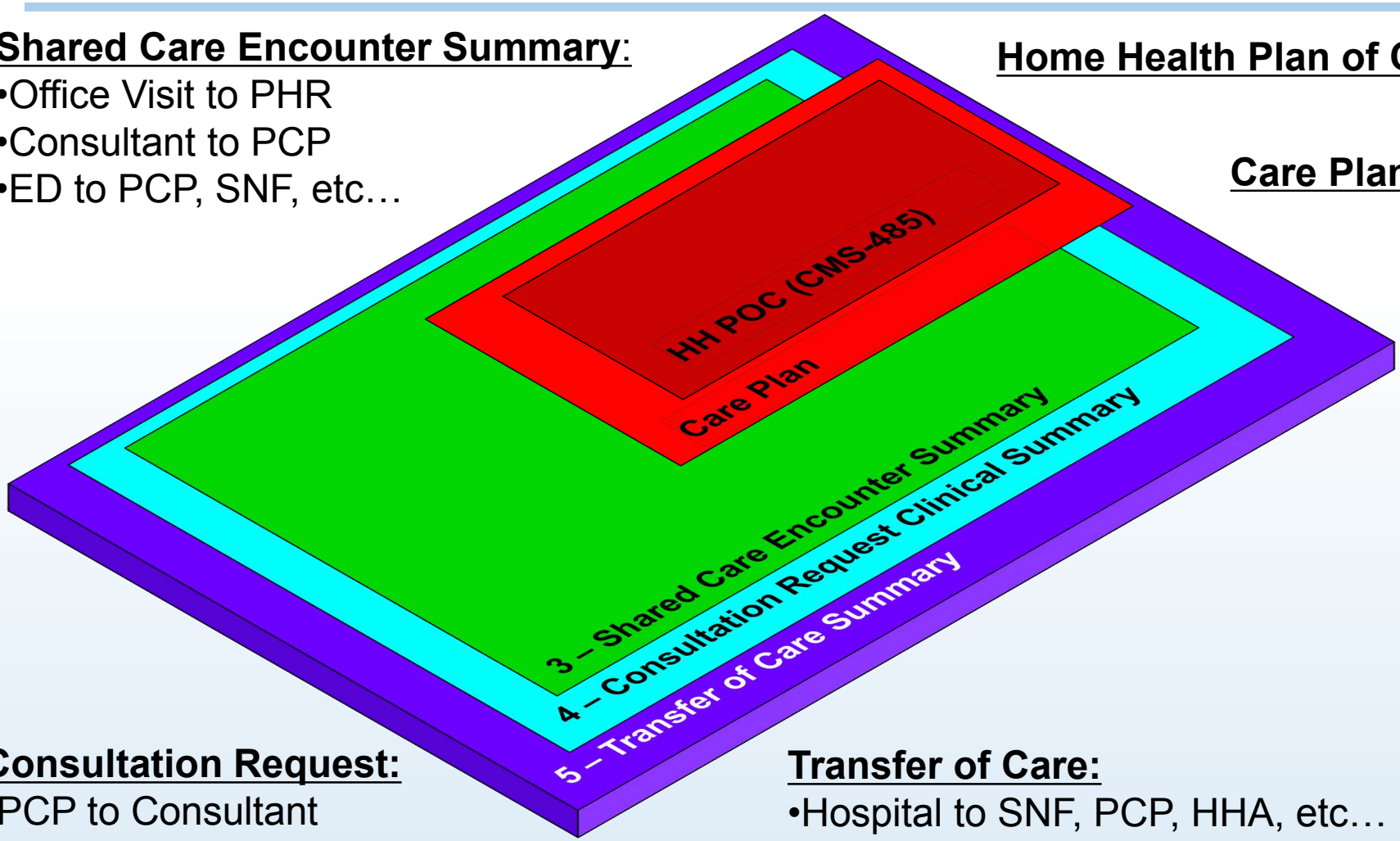
Shared Care Encounter Summary:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc…

Home Health Plan of Care

Care Plan



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

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

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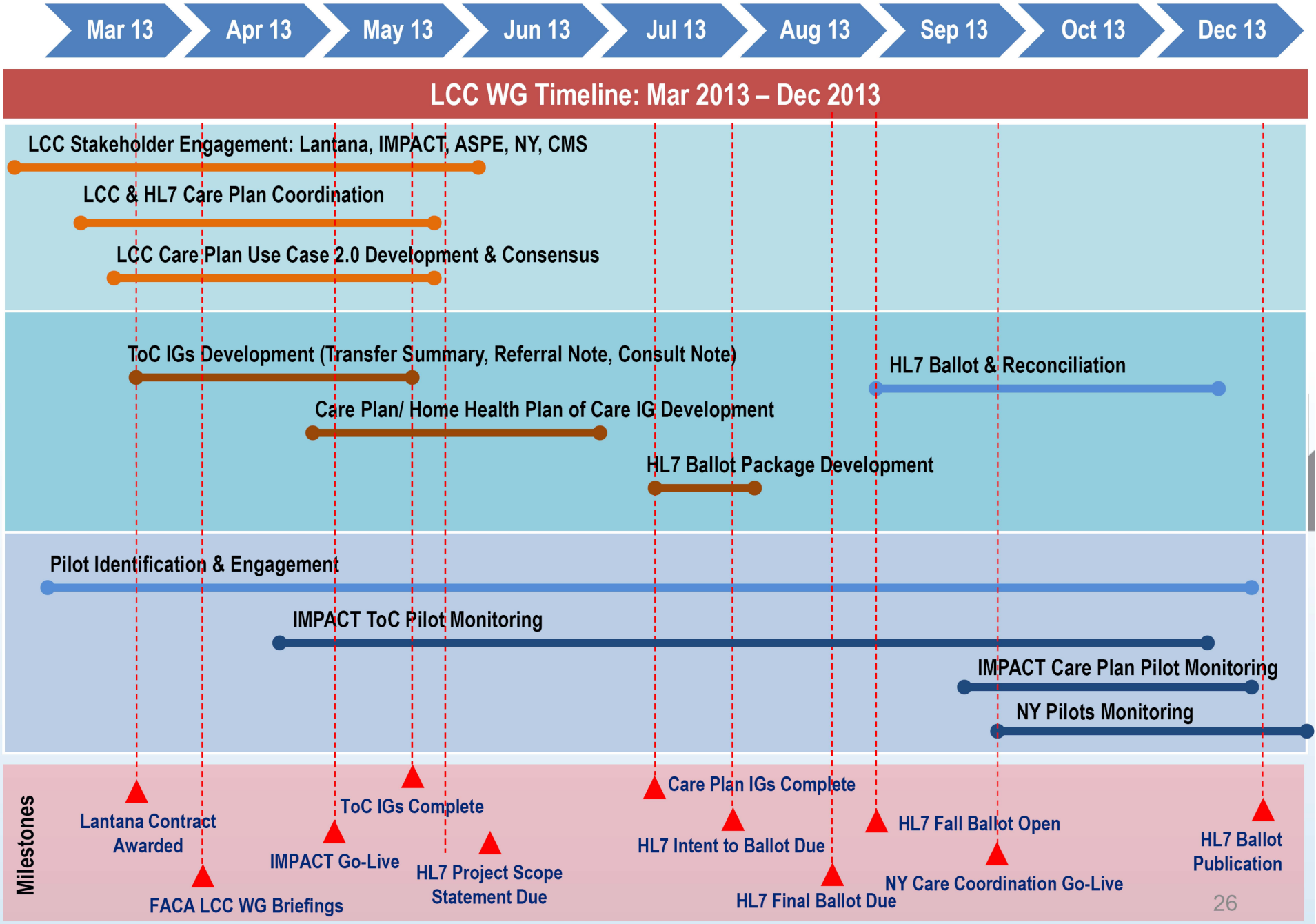
- Multiple vendors are participating in LCC
- Multiple vendors are exploring incorporating the standards into their products
- Several intend to pilot the pre-balloted versions in their products in Massachusetts and New York by September
- Several national LTPAC providers are exploring incorporating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

Facilitating Adoption & Summary

Facilitating adoption of ToC & Care Plan CDA standards

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- Standards extend the existing C-CDA documents (e.g. CCD)
- Will be incorporated into C-CDA during next C-CDA ballot
- Open source documents (Implementation Guides) and sample .xml documents
- Displayable using standard CDA .xsl stylesheet
- Supports bilateral asynchronous cut-over
- Open source SEE tool to edit and generate new documents
- Intent to make Companion Guide in 2014

Summary & Closing Remarks

- Current standards for Transitions of Care and exchange of Care Plans do not meet policy expectations for MU2 and MU3 for Eligible Providers and Hospitals
- Extensive research and national participation has formed the foundation for evolving standards for ToC and Care Plans expected to complete HL7 balloting fall 2013
- Extending the C-CDA template set and availability of open source tools are facilitating multiple pilots of these new CDA documents this year
- We look forward to HITSC support in including these evolving standards in MU3 for ToC and Care Plans

LCC Initiative: Resources & Questions

- **LCC Leads**
  - Dr. Larry Garber (Lawrence.Garber@reliantmedicalgroup.org)
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- **Project Management**
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  - Sweta Ladwa (sweta.ladwa@esacinc.com)

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