Overview of Longitudinal Coordination of Care (LCC)

Presentation to HIT Steering Committee
June 20, 2012

Speaker’s Notes: LCC is a bit of an experiment in S&I, anticipating that there won’t always be ARRA funds for every initiative we have pursue a community led initiative in LCC. Much higher ratio of volunteers to support staff. VERY engaged community.
LCC: Defining the Challenges and Establishing a Vision

Challenges
- Lack of robust EHR systems across the Long Term and Post Acute Care (LTPAC) spectrum with the ability to electronically exchange clinical information with other providers
- Absence of an interoperable, longitudinal care plan which aligns, supports and informs care delivery regardless of setting or service provider
- LTPAC not included in the current Meaningful Use Incentive programs.

Vision
- Support and advance patient-centric interoperable health information exchange across the LTPAC spectrum
- Promote Longitudinal Care Management between all relevant settings and providers built around the needs and experience of the patient
- LTPAC influences in Meaningful Use Stage 3

SPEAKER’S NOTES: Why are we doing this?
This is projected to be a $600B segment in 2012 and $1,800B in 2026.
LCC: Addressing the Challenges

Longitudinal Coordination of Care Workgroup

- Providing subject matter expertise and coordination of SWGs
- Developing systems view to identify interoperability gaps and prioritize activities

Longitudinal Care Plan Sub-Workgroup

- Near-Term: Developing an implementation guide to standardize the exchange of Form CMS-485 (Home Health Certification and Plan of Care)
- Long-Term: Identify and develop key functional requirements and data sets that would be supported by a longitudinal care plan

LTPAC Care Transition Sub-Workgroup

- Identifying the key business and technical challenges that inhibit long-term care data exchanges
- Defining data elements for LTPAC information exchange using a single standard for LTPAC transfer summaries

Patient Assessment Summary Sub-Workgroup

- Establishing the standards for the exchange of Patient Assessment Summary (PAS) documents
- Providing consultation to transformation tool being developed by Geisinger to transform the non-interoperable MDSv3 and OASIS-C into an interoperable clinical document (CDA IG)

Speaker’s Notes: Organized to provide focus and direction for the community
Care Plan Requirements and the Proposed Rules

The CMS proposed rule identifies some of the elements/components needed for a care plan:

- Problem (the focus of the care plan)
- Goal (the target outcome)
- any Instructions

The ONC proposed rule identifies the following as elements of care plan:

- Goal
- Instruction

S&I Longitudinal Care Plan and HL7 Activities

- **Problems** are typically linked to medical problems (based on Medical Diagnoses). However, in fact, Problems are identified from a number of sources. HL7 uses the concept of “Health Concern” to more completely express the range of patient deficits.

- **Goals** may need to be segmented by patient preferences and desired outcomes. Such segmentation would inform selected interventions and instructions.
Care Plan Requirements and the Proposed Rules

The Proposed Rules do NOT define the concept of the care plan nor identify all of the data elements/components needed for a care plan.

S&I Longitudinal Care Plan and HL7 Activities

S&I Workgroups are considering the following as additional needed components for Longitudinal Care Plans:

- **Assessments**: Used to identify patient deficits, inform the effectiveness of interventions and assist in updating the care plan.
- **Health Concerns**: (a more complete expression of the range of patient deficits (in contrast to “Problems)).
- **Interventions** linked to: Health Concern, Goals (i.e., Desired Outcome), and Team Member(s) responsible for the intervention (note: such linkage would allow for tracking the status of the intervention and effectiveness).
- **Goals segmented by**: patient preferences and desired outcomes.
- **Outcome Measurement**
Care Plan Requirements and the Proposed Rules

- The Proposed Rule uses the Consolidated CDA/Summary Care Record to incorporate, create and transmit the care plan and its components.
- The Proposed Rules do NOT consider the adequacy of the Consolidated CDA to support the creation and transmission of an interoperable care plan.
- The Proposed Rules do NOT describe how data elements used to create a Summary Care Record would be used to:
  - Create/inform the care plan.
  - Transmit the care plan.
  - Incorporate the care plan.

S&I Longitudinal Care Plan and HL7 Activities

- Initial discussions between S&I Workgroup members and HL7 suggest that the Consolidated CDA will require additional support and development (care planning) to fully represent a Longitudinal Care Plan that includes and links assessments, health concerns, segmented goals, and interventions.
- Further collaboration between S&I and HL7 is needed to consider whether/how a Summary Care Record could be used to create, transmit, and incorporate a Longitudinal Care Plan.
- An S&I Use Case on the creation, transmission, and incorporation of a Longitudinal Care Plan is under development along with the functional requirements for this plan.
- Once this Longitudinal Care Plan is developed, ONC may wish to solicit public comments on these requirements, their implications for clinical practice and coordination of care, and a strategy for advancing longitudinal care planning, for potential inclusion into MU Stage 3.
Longitudinal Care Plan SWG
Defining the Functional requirements for the Home Health Plan of Care (PoC)

LTPAC Care Transition SWG
Defining the functional requirements for the following priority transactions:

• Transitions of Care and Referral:
  – Acute Care to LTPAC (as represented by HHA)
  – LTPAC (as represented by SNF/ NF) to ED
  – ED to LTPAC (as represented by SNF/ NF)
• Patient Communications:
  – Copy all ToC and PoC transactions to patient/care giver PHR
• HHA Plan of Care:
  – Initial & Recertification PoC: from HHA to Physician, Physician to HHA
  – Interim Changes to PoC: from HHA to Physician, Physician to HHA

Patient Assessment Summary SWG

• The SWG is reviewing the work done in support of the CARE Tool project.
• Changes to the Consolidate CDA for the Functional Status, Cognitive Status and Pressure Ulcer are being balloted at HL7 since May 4, 2012.
• Targeting the rest of the PAS (CARE Tool based) requirements for proposed balloting in Fall 2012. The gap analysis and review is underway.
ONC Roundtable

- ONC conducted a roundtable for the LTPAC community on May 3, 2012.
- Attended by a significant number of community members excited by ONC’s interest in LTPAC.
- The following priorities areas were identified for ONC’s focus on LTPAC:
  - Federally required Patient Assessments
  - Dynamic Care Plan
  - Transitions of Care Criteria (Create, transmit and incorporate)
- All the activities in S&I LCC initiative since December, 2011 are perfectly aligned with these priorities, validating the vision established by the LCC Initiative community members.
- OPP is working on producing a White Paper based on this roundtable.

White Paper

- The LCC Sub Work Group is working on a White Paper that will define the long-term vision and requirements for LTPAC that will include all the care settings within the Long Term Care spectrum. The primary goal of this work is to drive the prioritization of additional use cases.
- Should include a timeline and priorities for inclusion into MU Stage 3.
LCC: Following the S&I Framework Process

Pre-Discovery:
- Call for Participation
- Organizational Structure
- Use Case and Functional Requirements Development
- WG & SWG Charters

Discovery:
- Standards Analysis & Recommendation
- Priority Datasets & Data Model
- Identification of Pilot Participants
- Standards Development and Coordination

We Are Here:
- Implementation Guidance Development

Implementation:
- Pilot/Demonstration Plan

Pilots:
- Evaluate Success Metrics

Evaluation:

Reusing artifacts and reviewing best practices from S&I Framework initiatives
SPEAKER’S NOTES to previous slide:
One learning is that while the LCC/LTPAC community is very engaged, understands the space very well (lots of SME) they are not familiar with standards development, harmonization, IG development etc. Contractor support will be necessary to get it to a point where it can be used in MU3.
We have a lot of support and energy around LTPAC from:
  - Community volunteers
  - ONC Round table
  - AHIMA Summit
Other agencies, CMS, we also would covet your feedback on the priority of LTPAC to the HITSC.
Q&A

Thank You!