Aligning Health IT Implementation with Delivery System Transformation

Health IT Optimized Care Coordination: Care Plans and Data To Support Care Plans

Health IT Learning Cluster
February 12, 2014
Carolyn Padovano
Health IT Learning Cluster Lead, RTI
HEALTH IT OPTIMIZED CARE COORDINATION: CARE PLANS AND DATA TO SUPPORT CARE PLANS

Patricia MacTaggart, Senior Advisor, Office of the National Coordinator, Office of Care Transformation
Building Better Care
One Lego® at a Time

Standardized

Wide Variety

Reusable
<table>
<thead>
<tr>
<th>“Silo”</th>
<th>Which of these connections is your priority?</th>
<th>For what priority purpose is the information exchanging (Why are we doing this?) (A-E, see key below )</th>
</tr>
</thead>
</table>
| **Medical/Health Care Providers (Hospitals/Primary Care/Specialists)** | 1. BH Providers  
2. LTPAC/LTSS  
3. Primary/Hospitals/Specialists  
4. Ind./Caretakers  
5. Community Care Organizations  
   - Vermont & MN: 1-4  
   - Maine: 1-3  
   - Massachusetts: 1-5 | **Maine:** Hospitals-Shared care across the continuum (C); Primary Care -Shared care plan support care team communication (D)  
**Vermont:** Started to collect BH, LTPAC, and LTSS providers (not yet individuals), so far mainly with ADTs and lab reports - point-to-point patient care, population health, and analytics to support ACOs (A – D); Medical to Medical connected for ADT, Lab reports, VXU, CCD, transcribed reports (A-D)  
**Massachusetts:** BH – thru MassHiway (A-D); LTPAC/LTSS - thru Mass Hiway connection & Community Links Portal (A-D); Community Care Orgs. – e-referrals for B-D; Individuals/Caretakers - for D patient portal initiatives req. by Ch 224  
**Minnesota:** A-D for all except individual; Individual D |
| **Behavioral Health Providers** | 1. Primary/Hospitals/Specialists  
2. LTPAC/LTSS  
3. Ind./Caretaker  
   Massachusetts: 1,2, 4  
   Vermont & MN: 1-3 | **Massachusetts:** Primary, Specialists, BH and LTPAC/LTSS – A-D; Community Organizations for e-referrals-B-D  
**Minnesota:** A-D for all except individual; Individual D |

A - Permanent transfer of care; B - Temporary transfer (B-1: consult B-2: procedure); C - Shared care (e.g. HHPoC); D - Information to Support Process of Care (care team communication); E - Other (name)
For these priority exchanges of information – what is the purpose of the exchange of information?

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<tr>
<td>LTPAC/LSSS</td>
<td>1. Primary/Specialists/ Hospitals</td>
<td><strong>Massachusetts</strong>: Primary/Specialist &amp; BH: through MassHiway -A-D; other LTSS providers- A-D (Section Q referrals, AGD) Community Orgs –e-referrals B-D; Individual - thru Community Link portal – D <strong>Minnesota</strong>: A-D for all except individual; Individual D</td>
</tr>
<tr>
<td>Providers</td>
<td>2. BH Providers</td>
<td></td>
</tr>
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<td>Individual &amp;</td>
<td>1. Primary/Specialists/ Hospitals</td>
<td><strong>Massachusetts</strong>: for LTPAC/LSSS thru community link portals D</td>
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<tr>
<td>Community</td>
<td>2. BH Providers</td>
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</tr>
<tr>
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<td>Massachusetts: 3</td>
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**Key:**

- A - Permanent transfer of care;
- B - Temporary transfer (B-1: consult B-2: procedure);
- C - Shared care (e.g. HHPoC);
- D - Information to Support Process of Care (care team communication);
- E - Other (name)
Framing the Discussion: For these priority exchanges of information – what do you need?

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<th>For these priority exchanges of information, what do you need? (See key below)</th>
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<td><strong>Medical/Health Care Providers</strong></td>
<td>BH Providers LTPAC/LTSS Providers Community Orgs.</td>
<td>Maine: (A) Common vocabulary, data elements and (C) develop a focused plan for a HIE solution for a shared care plan that focuses on a specific population &amp; the business &amp; clinical requirements &amp; workflow related to the selected population. Vermont: A &amp; C Massachusetts: BH – mental health CCD and consent, legal guidance around exchanging information with non HIPPA covered entities (MOU’s etc.) (A-D); LTPAC/LTSS - workflows for new connection/referral types (C); Community Care Orgs. – connecting to non-medical organizations &amp; use cases and workflows for specialist referrals, to community organizations (A-C) MN: all but community (A, C, D – based on MN roadmap activity (not yet determined)</td>
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<td><strong>Behavioral Health Providers</strong></td>
<td>Primary/Specialists Providers LTPAC/LTSS Providers</td>
<td>Maine: A &amp; C Vermont: A &amp; C Massachusetts: Primary: MH CCD and consent, legal guidance around exchanging information with non HIPPA covered entities (MOU’s etc.) (A-D); Specialists, BH and LTPAC/LTSS - MH CCD and consent, workflows for new connection/referral types (B,C); Community Organizations for e-referrals - use cases and workflows for BH referrals to community organizations, legal guidance around exchanging information with non HIPPA covered entities (MOU’s etc.) (C) MN: (A, C, D – based on MN roadmap activity (not yet determined)</td>
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A - Common vocabulary-specification; B - Model contract language (please specify: for IT vendor; for MCO/CCO/etc. ); C - Guidance on operational/workflow business requirements ; D - Other (please specify)
### Framing the Discussion: For these priority exchanges of information – what do you need?

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| LTPAC/LSSS Providers    | Medical/HC Providers, BH Providers, LTSS Providers, Individual/caretakers       | **Maine**: A & C  
**Vermont**: A & C  
**Massachusetts**: Primary/Specialist & other LTSS providers - workflows for new connection/referral types (C); BH – MH CCD and consent, workflows for new connection/referral types (B-C); Community Orgs - Use cases and workflows for LTPAC/LTSS referrals to community organizations; (C); Individuals/Caretakers guidance to Individuals and Caretakers (A,C)  
**MN**: (A, C, D – based on MN roadmap activity (not yet determined)) |
| Individual and caretakers | Medical/HC Providers, BH Providers, LTPAC/LTSS Providers                        | **Massachusetts**: LTPAC/LTSS - A, C – Guidance to Individuals and Caretakers  
**MN**: A, C, D – based on MN roadmap activity (not yet determined) |
| Community Orgs.         |                                                                                   | **Massachusetts**: Primary – Connecting to non-medical organizations (e.g., YMCA) – A-C; Specialists, BH, LTPAC/LTSS and Community Organizations - use cases and workflows for referrals to community organizations- C; BH - legal guidance around exchanging information with non HIPPA covered entities (MOU’s etc.)-C |

A - Common vocabulary-specification; B - Model contract language (please specify: for IT vendor; for MCO/CCO/etc. ); C - Guidance on operational/workflow business requirements ; D - Other (please specify)
1. Focus Provider Type(s):

2. Focus Purpose:

3. Schedule a call to focus on: ________________________________

4. Other: ____________________________________________

5. Last Comments: ________________________________
Information from last web-discussion for background:

Care Plan Decision Modifiers
- Patient/family preferences (values, priorities, wishes, adv directives, expectations, etc...)
- Patient situation (access to care, support, resources, setting, transportation, etc...)
- Patient allergies/intolerances

Health Conditions/Concerns
- Active Problems
  - Wellness
  - Barriers
  - Injury (e.g. falls)
  - Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Risk/Concerns:
- Wellness
- Barriers
- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Health Conditions/Concerns
- Risk/Concerns:
  - Wellness
  - Barriers
  - Injury (e.g. falls)
  - Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Goals
- Desired outcomes and milestones
- Readiness
- Prognosis
- Related Conditions
- Related Interventions
- Progress

Interventions/Actions
(e.g. medications, wound care, procedures, tests, diet, behavior changes, exercise, consults, rehab, calling MD for symptoms, education, anticipatory guidance, services, support, etc...)
- Start/stop date, interval
- Authorizing/responsible parties/roles/contact info
- Setting of care
- Instructions/parameters
- Supplies/Vendors
- Planned assessments
- Expected outcomes
- Related Conditions
- Status of intervention

The Care Plan (Concerns, Goals, Interventions, and Care Team), along with Risk Factors and Decision Modifiers iteratively evolve over time
C-CDA Release 1.1 Documents:
8 standard document templates

<table>
<thead>
<tr>
<th>Document Template</th>
<th>Section Template(s)</th>
</tr>
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<tbody>
<tr>
<td>Continuity of Care Document (CCD)</td>
<td>Allergies Medications Problem List Procedures Results Advance Directives Encounters</td>
</tr>
<tr>
<td>History &amp; Physical (H&amp;P)</td>
<td>Family History Functional Status Immunizations Medical Equipment Payers Plan of Care</td>
</tr>
</tbody>
</table>

Section templates in GREEN demonstrate CDA’s interoperability and reusability.

Document Templates: 9
- Continuity of Care Document (CCD)
- Consultation Note
- Diagnostic Imaging Report (DIR)
- Discharge Summary
- History and Physical (H&P)
- Operative Note
- Procedure Note
- Progress Note
- Unstructured Document

Section Templates: 60

Entry Templates: 82
3 NEW Documents

- Transfer Summary
- Care Plan
- Referral Note

(Also enhanced Header to enable Patient Generated Documents)

6 NEW Sections

- Nutrition Section
- Physical Findings of Skin Section
- Mental Status Section
- Health Concerns Section
- Health Status Evaluations/Outcomes Section
- Goals Section

30 NEW Entries

- Advance Directive Organizer
- Cognitive Abilities Observation
- Drug Monitoring Act
- Handoff Communication
- Goal Observation
- Medical Device Applied
- Nutrition Assessment
- Nutrition Recommendations
- Characteristics of Home Environment
- Cultural and Religious Observation
- Patient Priority Preference
- Provider Priority Preference
- and lots more.....
Care Plan Exchange: Conceptual Workflow

Updates and displays Care Plan; stores/transmits data

Service Team
HCBS SETTING

Other IT System

Updates and displays Care Plan; stores/submits data

Clinical IT System

Care Team
CLINICAL/INSTITUTIONAL SETTING

Payer System
Extract, Transform, & Load Care Plan

Move from Patient-Centered to Person-Centered Planning and Information Exchange
Wrap-Up

Let us know if you have any questions!

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