Virtual Workshop
A Facilitated Conversation Around HIT
Optimized Care Coordination

Care Plans and Data to Support Care Plans

December 19, 2014
Agenda

1:00  Welcome and Introductions (Carolyn Padovano and Hunt Blair)

1:05  Framing the Discussion for the Common Care Coordination Infrastructure Needs (Patricia MacTaggart, GWU)

1:10  Creating a Common “Care Coordination Plan” Starting Place (Kevin Larsen, Terry O’Malley and Evelyn Gallego)

• Common problem no matter what you call it
• “Lego” approach to data/data sets standardization
• What is currently available and/or in process (policies, technology, implementation)

1:20  State Facilitated Discussion: Are These the Issues?

1:45  State Facilitated Discussion: Next Steps

1:55  Closing Statements

2:00  Adjournment
Shared SIM State Key Components:

- “Whole person” health care delivery transformation, behavioral and physical health integration, and payment reform incentives related to “outcomes”

- Sharing of relevant, actionable, impactable information between:
  - Health care team members and health care providers and providers of care that impacts health to improve the care delivered,
  - Individuals (and their families or caretakers) and their providers to actively engage individuals in their own care,
  - States and their MCOs/CCOs/ACOs, providers and individuals for financial and quality oversight and improvement

- Care coordination information based on accurate, reliable, standardized data and IT infrastructure that automates the collection, retention, analysis, transformation of data into usable information, and dissemination

*Is a more person-centered focus for care and service consistent with your state policy? What issues, if any, does this shift in orientation raise?*
State policies (with supporting federal policy):

- Different terms for “care plans” – same standard and technology needs
- Health home/PCMH/ACO accreditation or contract requirements (fed policy: Medicare Chronic Care Management Payment requires e-plan)
- MCO Quality Strategy and contract requirements for MLTSS

Standards and technology (at CCO/MCO/ACO and provider levels) to ensure computable care coordination data sets and tools that can be used by virtual care team

- What is standardized that States can use (C-CDA)? What is in “conceptual” agreement stage? What hasn’t been started?

Implementation/Care/Business Processes:

- Care plans used in hospital, LTPAC settings and some primary care settings, service plans by LTSS. Processes to create, use and maintain e-shared care plans are needed to enable virtual team coordination
Implementation

Building Better Care One Lego® at a Time

Standardized

Wide Variety

Reusable
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
- Risks/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

Patient Status
- Functional
- Cognitive
- Physical
- Environmental

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

Risk Factors
- Age, gender
- Significant Past Medical/Surgical Hx
- Family Hx, Race/Ethnicity, Genetics
- Historical exposures/lifestyle (e.g. alcohol, smoke, radiation, diet, exercise, workplace, sexual...)
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

Updates and displays Care Plan; stores/submits data

Care Team
CLINICAL/INSTITUTIONAL SETTING

PHR App

Individual & Caregiver

(Health) Information Exchange Mechanism

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

Payer System
Extract, Transform, & Load Care Plan
Are these the right questions?

- What information do providers need for service delivery? What information do you need as the State for oversight and management? How do your beneficiaries share their preferences?
- What state policies and programs can reinforce provider use of e-care plans and integration of LTSS in your delivery and payment models? Do you need to leverage MCO or ACO contract requirements, QI strategy or other levers?
- What data and technology infrastructure do your providers, state and/or other payers need to facilitate integrated e-care and service plans?
- What are your implementation needs, like MC contract changes or vendor-provider collaborative for work flow changes?
- Is there a need for a conversation in your State and if so, what would be helpful?
- Where do you see some cross-state synergy possibilities?
1. **Concrete components of a care coordination tool kit:**
   - Work on a framework based on sub-populations & services, communication requirements, and corresponding data sets.
   - Develop model contract language States can use in procurement and contracts with MCOs/ACOs/CCOs informed by current and future certification requirements.
   - Other??

2. **Deeper dive into subject areas of interest to build a clearer common understanding.**

3. **Other technical assistance??**
How do we go from here? 

Process Options for Consideration

• Follow-up calls/web-conversations with interested States
• Face-to-face meeting(s) at the ONC Annual Meeting Feb 2-3, 2015
• Engagement through other SIM HIT Learning Cluster activities
• Development of formal Community of Practice or work group
Closing Statements and Adjournment
<table>
<thead>
<tr>
<th>Regulation</th>
<th>Issued By</th>
<th>Target Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 Medicare Physician Fee Schedule</td>
<td>CMS</td>
<td>Medicare</td>
</tr>
<tr>
<td>Community First Choice</td>
<td>CMS</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Conditions of Participation: Clinics, Rehabilitation Agencies and Public</td>
<td>CMS</td>
<td>Medicare/Medicaid</td>
</tr>
<tr>
<td>Health Agencies as Providers of Outpatient Physical Therapy and Speech-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language Pathology, Comprehensive Outpatient Rehabilitation Facilities,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHAs, Hospice, Hospital, Nursing Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EHR Incentive Program</td>
<td>CMS</td>
<td>Medicare/Medicaid</td>
</tr>
<tr>
<td>Prospective Payment Systems: Inpatient Prospective Payment System (IPPS),</td>
<td>CMS</td>
<td>Medicare</td>
</tr>
<tr>
<td>LTC, SNF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money Follows the Person</td>
<td>CMS</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Balancing Incentive Program</td>
<td>CMS/ACL</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Testing Experience of Functional Tools &amp; Assessments</td>
<td>CMS</td>
<td>Medicaid</td>
</tr>
<tr>
<td>ONC EHR Certification Criteria</td>
<td>ONC</td>
<td>Medicare/Medicaid</td>
</tr>
</tbody>
</table>
Additional Information: Datasets

Consultation Note:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc...

Referral Note:
- PCP to Consultant
- PCP, SNF, etc... to ED

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc...
- SNF, PCP, etc... to HHA
- PCP to new PCP
Clinical Document Architecture (CDA) is the base standard for building electronic clinical documents.

Templates provide the “building blocks” for clinical documents.

To help simplify implementations, commonly used templates were harmonized from existing CDA implementation guides and “consolidated” into a single implementation guide – the C-CDA Implementation Guide (IG).
## Additional Information:
**C-CDA R1.1: Existing Standard to Support MU2 Requirements**

**HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, Release 1.1 - US Realm**

**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

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

Section templates in YELLOW demonstrate CDA’s interoperability and reusability.
### Additional Information:

**C-CDA R2.0: NEW Standard to support Longitudinal Care Coordination**

<table>
<thead>
<tr>
<th>3 NEW Documents</th>
<th>6 NEW Sections</th>
<th>30 NEW Entries</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Transfer Summary</td>
<td>- Nutrition Section</td>
<td>- Advance Directive Organizer</td>
</tr>
<tr>
<td>- Care Plan</td>
<td>- Physical Findings of Skin Section</td>
<td>- Cognitive Abilities Observation</td>
</tr>
<tr>
<td>- Referral Note</td>
<td>- Mental Status Section</td>
<td>- Drug Monitoring Act</td>
</tr>
<tr>
<td>(Also enhanced Header to enable Patient Generated Documents)</td>
<td>- Health Concerns Section</td>
<td>- Handoff Communication</td>
</tr>
<tr>
<td></td>
<td>- Health Status Evaluations/Outcomes Section</td>
<td>- Goal Observation</td>
</tr>
<tr>
<td></td>
<td>- Goals Section</td>
<td>- Medical Device Applied</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Nutrition Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Nutrition Recommendations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Characteristics of Home Environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Cultural and Religious Observation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient Priority Preference</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provider Priority Preference</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- and lots more.....</td>
</tr>
</tbody>
</table>
• ONC S&I LCC Community sponsored updates to C-CDA and balloting of this new version through HL7
• One ballot package to address 4 revisions based on IMPACT Dataset:
  – Update to C-CDA Consult Note
  – NEW Consultation Request
  – NEW Transfer Summary
  – NEW Care Plan document type (includes HHPoC signature requirements and aligns with HL7 Patient Care WG's Care Plan Domain Analysis Model- DAM)
• Ballot Package received 1013 comments
  – All 1013 ballot comments were reconciled from Oct 2013 until March 2014
  – Final C-CDA R2.0 published Nov 2014