SIMergy – State Innovations Model
Interactive Learning Environment

Innovation for the States; by the States

Center for Medicare & Medicaid
INNOVATION

STATE INNOVATION MODELS
Creating an Environment for Sustainable Health Care Transformation

NATIONAL ACADEMY
for STATE HEALTH POLICY

RTI
INTERNATIONAL

The Office of the National Coordinator for
Health Information Technology

Aligning Health IT Implementation with Delivery System Transformation

Health IT Optimized Care Coordination: Care Plans and Data To Support Care Plans
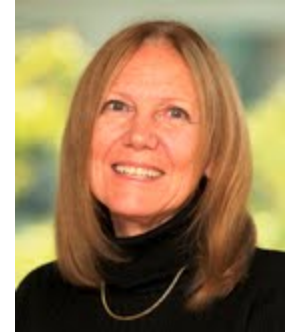
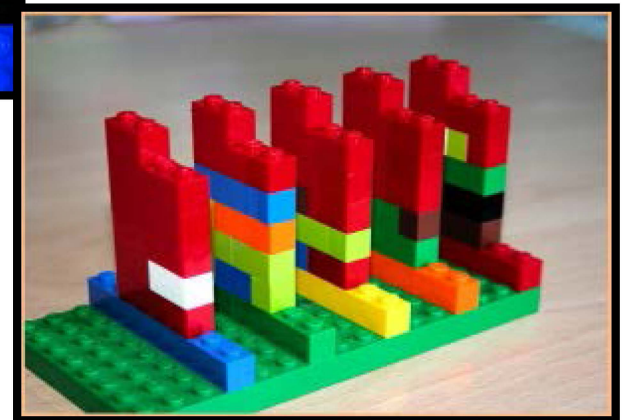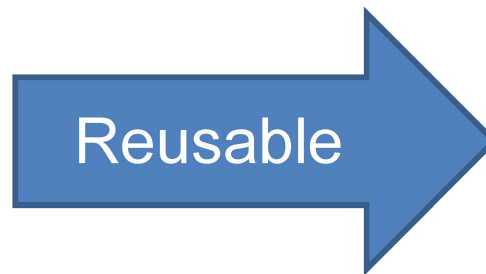Health IT Learning Cluster
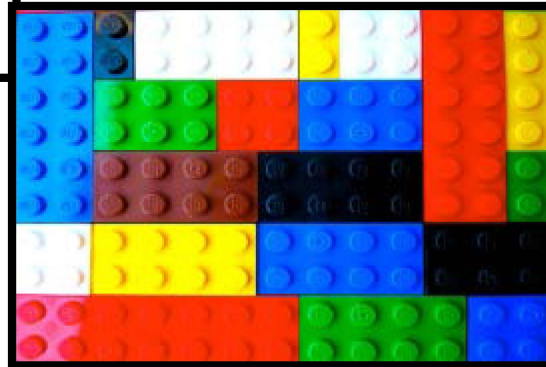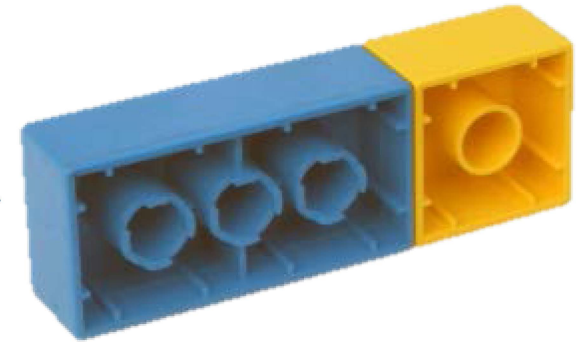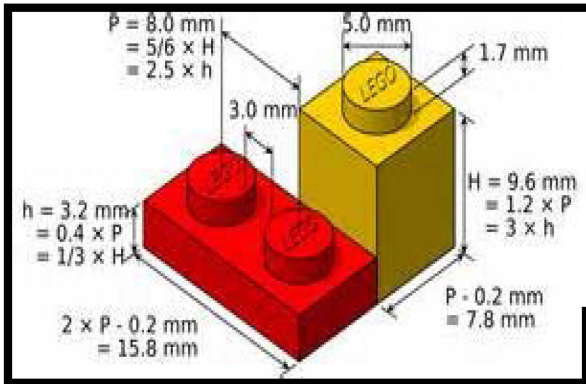
February 12, 2014

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

Standardized

Wide Variety

Reusable

For these priority exchanges of information – What is the purpose of the exchange of information?

"Silo"	Which of these connections is your priority?	For what priority purpose is the information exchanging (Why are we doing this?) (A-E, see key below)
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/S pecialists 2. LTPAC/LTSS 3. Ind/caretaker 4. Community Org. 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?

"Silo"	Which of these connections is your priority?	For what priority purpose is the information exchanging (Why are we doing this?) (See key below)
LTPAC/LSSS Providers	1. Primary/Specialists/ Hospitals 2. BH Providers 3. LTSS Providers 4. Individual/caretakers 5. Community Orgs. • Vermont & MN: 1-4 • Massachusetts 1-3, 5	*Massachusetts*: *Primary/Specialist & 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 *Minnesota*: A-D for all except individual; Individual D
Individual and caretakers	1. Primary/Specialists/ Hospitals 2. BH Providers 3. LTPAC/LTSS Providers 4. Community Orgs. MN: 1-3 Massachusetts: 3	*Massachusetts*: for LTPAC/LSSS thru community link portals D *Minnesota*: A-D for all except individual; Individual D
Community Providers	1. Primary/Specialists/ Hospitals 2. BH Providers 3. LTPAC/LTSS Providers 4. Community Orgs Massachusetts: 1-4 MN: 1-3	*Massachusetts:* for e-referrals for all B-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)

Framing the Discussion: For these priority exchanges of information – what do you need?

"Silo"	For priority providers identified for priority purpose identified earlier slides	For these priority exchanges of information, what do you need? (See key below)
Medical/ Health Care Providers	BH Providers LTPAC/LTSS Providers Community Orgs.	*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 & the business & clinical requirements & workflow related to the selected population. *Vermont*: A & 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 & 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)
Behavioral Health Providers	Primary/Specialists Providers LTPAC/LTSS Providers	*Maine:* A & C *Vermont:* A & 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)

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?
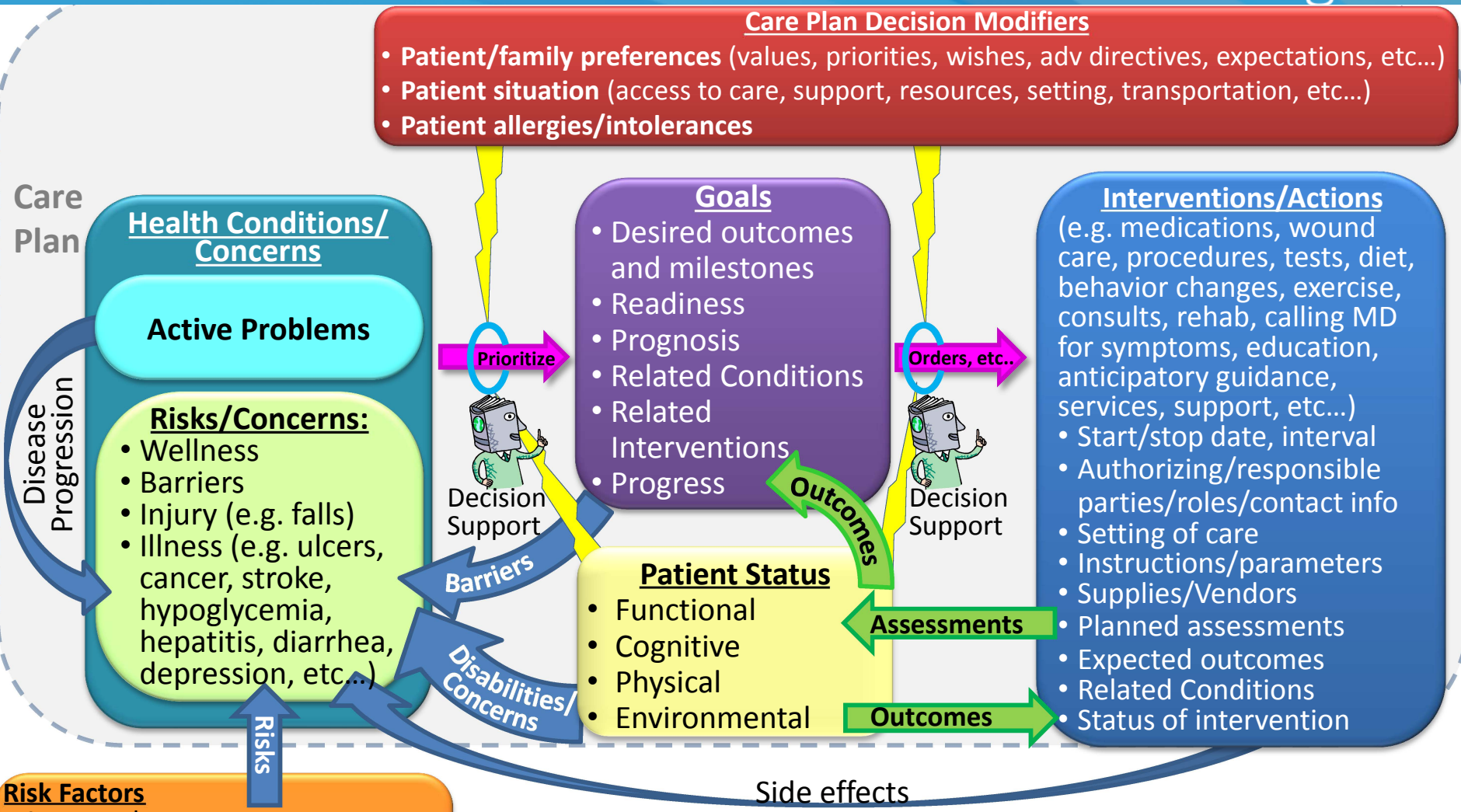
"Silo"	For priority providers identified for priority purpose identified earlier slides	For these priority exchanges of information, what do you need? (See key, below)
LTPAC/LSSS Providers	Medical/HC Providers BH Providers LTSS Providers Individual/caretakers	*Maine:* A & C *Vermont:* A & C *Massachusetts*: *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**: _____

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**

Care Plan

Health Conditions/ Concerns

Active Problems

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

Disease Progression

Decision Support

Prioritize

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

Decision Support

Orders, etc..

Outcomes

Barriers

Disabilities/ Concerns

Risks

Patient Status
- Functional
- Cognitive
- Physical
- Environmental

Assessments

Outcomes

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

Side effects

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…)

The Care Plan (Concerns, Goals, Interventions, and Care Team), along with Risk Factors and Decision Modifiers iteratively evolve over time

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C-CDA Release 1.1 Documents: 8 standard document templates

HL7 Implementation Guide for CDA R2:

IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) July 2012

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

Document Template	Section Template(s)		
Continuity of Care Document (CCD)	Allergies Medications Problem List Procedures Results Advance Directives Encounters	Family History Functional Status Immunizations Medical Equipment Payers Plan of Care	**Section templates in GREEN demonstrate CDA's interoperability and reusability.**
History & Physical (H&P)	Allergies Medications Problem List Procedures Results Family History Immunizations Assessments	Assessment and Plan Plan of Care Social History Vital Signs History of Present Illness History of Present Illness	Chief Complaint Reason for Visit Review of Systems Physical Exam General Status

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

PHR App

Individual & Caregiver

(Health) Information Exchange Mechanism

Updates and displays Care Plan; stores/transmits data
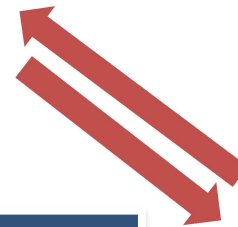
Other IT System

Service Team
HCBS SETTING

Clinical IT System
Updates and displays Care Plan; stores/ submits data

Care Team
CLINICAL/ INSTITUTIONAL SETTING

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

Payer System
Extract, Transform, & Load Care Plan

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Wrap-Up

Let us know if you have any questions!

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