The Office of the National Coordinator for Health Information Technology

Virtual Workshop
A Facilitated Conversation Around HIT Optimized Care Coordination

Care Plans and Data to Support Care Plans

December 19, 2014

Putting the I in HealthIT℠
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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

Framing the Discussion: Coordination of Care

Policies, Technology, Implementation

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?

Creating a Common "Care Plan" Starting Place

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

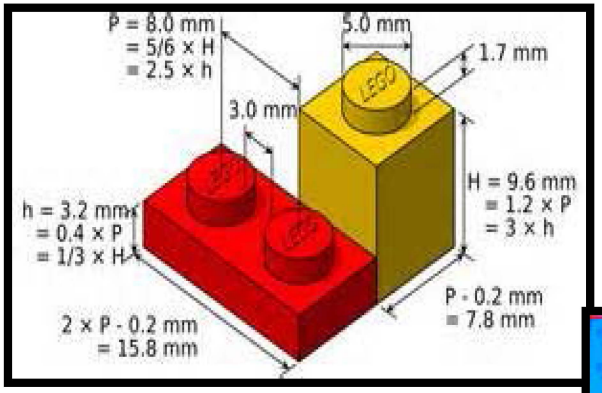
- What is standardized that States can use (C-CDA)? What is in "conceptual" agreement stage? What hasn't been started?

Implementation/Care/Business Processes:

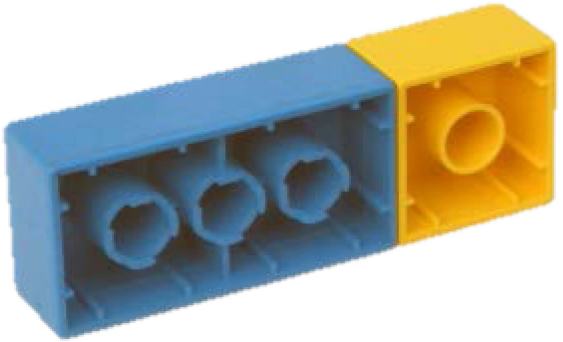
- Care plans used in hospital, LTPAC settings and some primary care settings, service plans by LTSS. Processes to create, use and maintain e-shared care plans are needed to enable virtual team coordination

Implementation

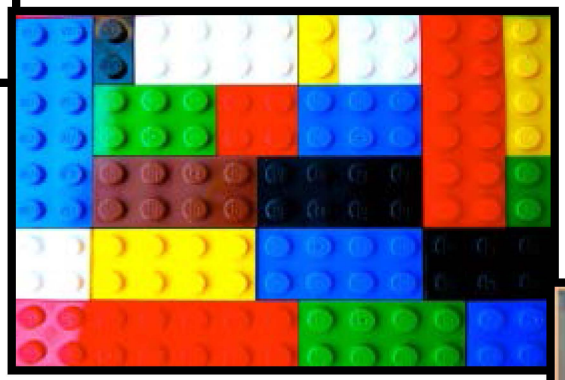
Building Better Care One Lego® at a Time



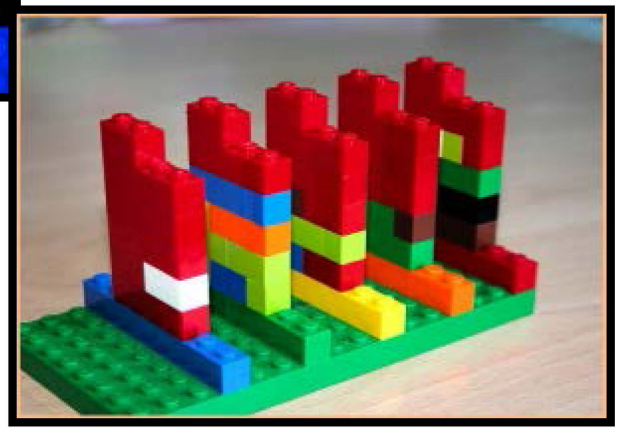
Standardized

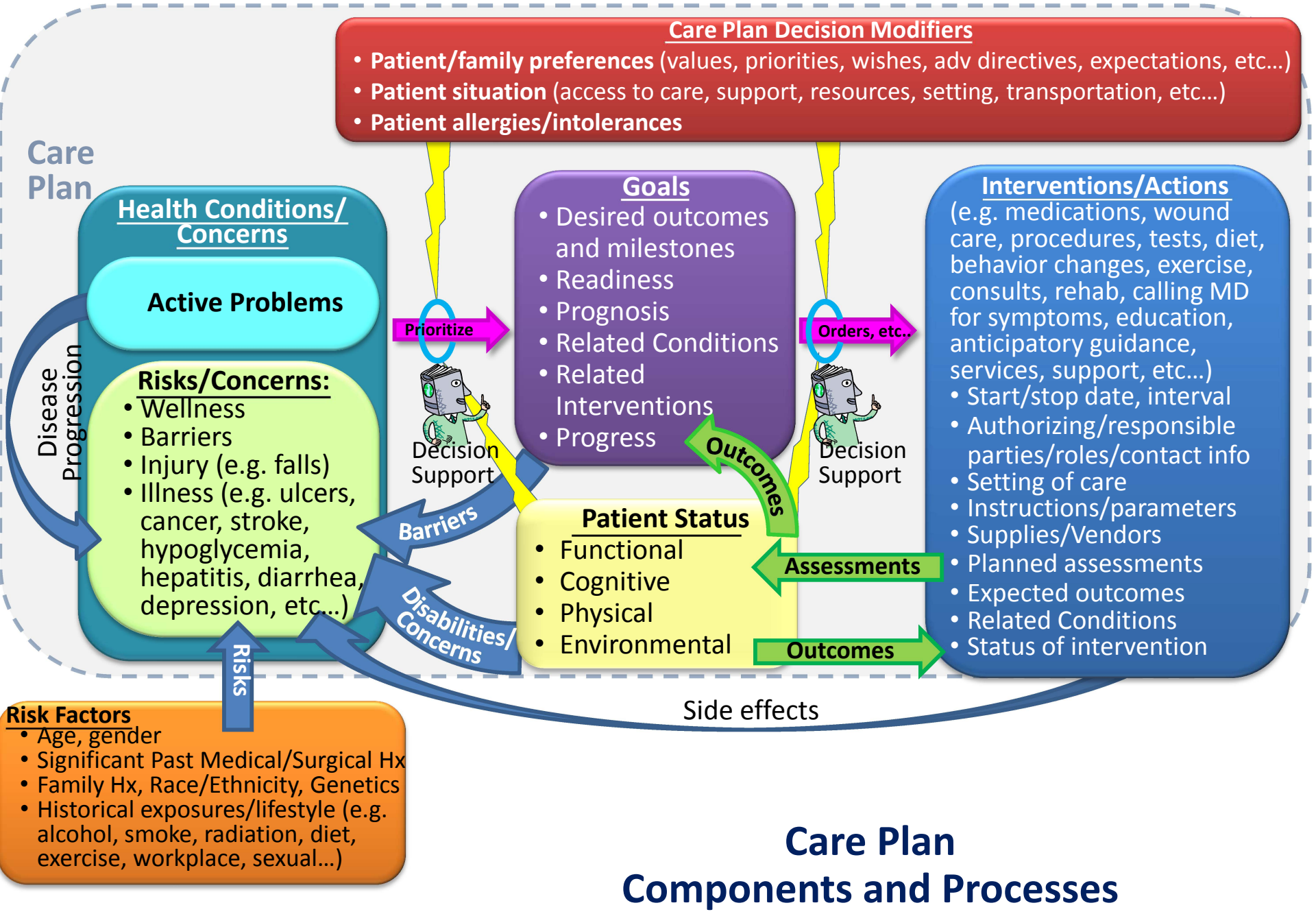


Wide Variety



Reusable





Care Plan Components and Processes

Care Plan Exchange: Conceptual Workflow

Updates and displays Care Plan; stores/ transmits data

Other IT System

Service Team

HCBS SETTING

Updates and displays Care Plan; stores/transmits data

PHR App

(Health) Information Exchange Mechanism

Clinical IT System

Updates and displays Care Plan; stores/ submits data

Care Team

CLINICAL/ INSTITUTIONAL SETTING

Individual & Caregiver

Payer System

Extract, Transform, & Load Care Plan

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

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?

Where do we go from here?
Cross-State Effort Options for Consideration

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

Additional Information
Care Coordination Policies & Incentives

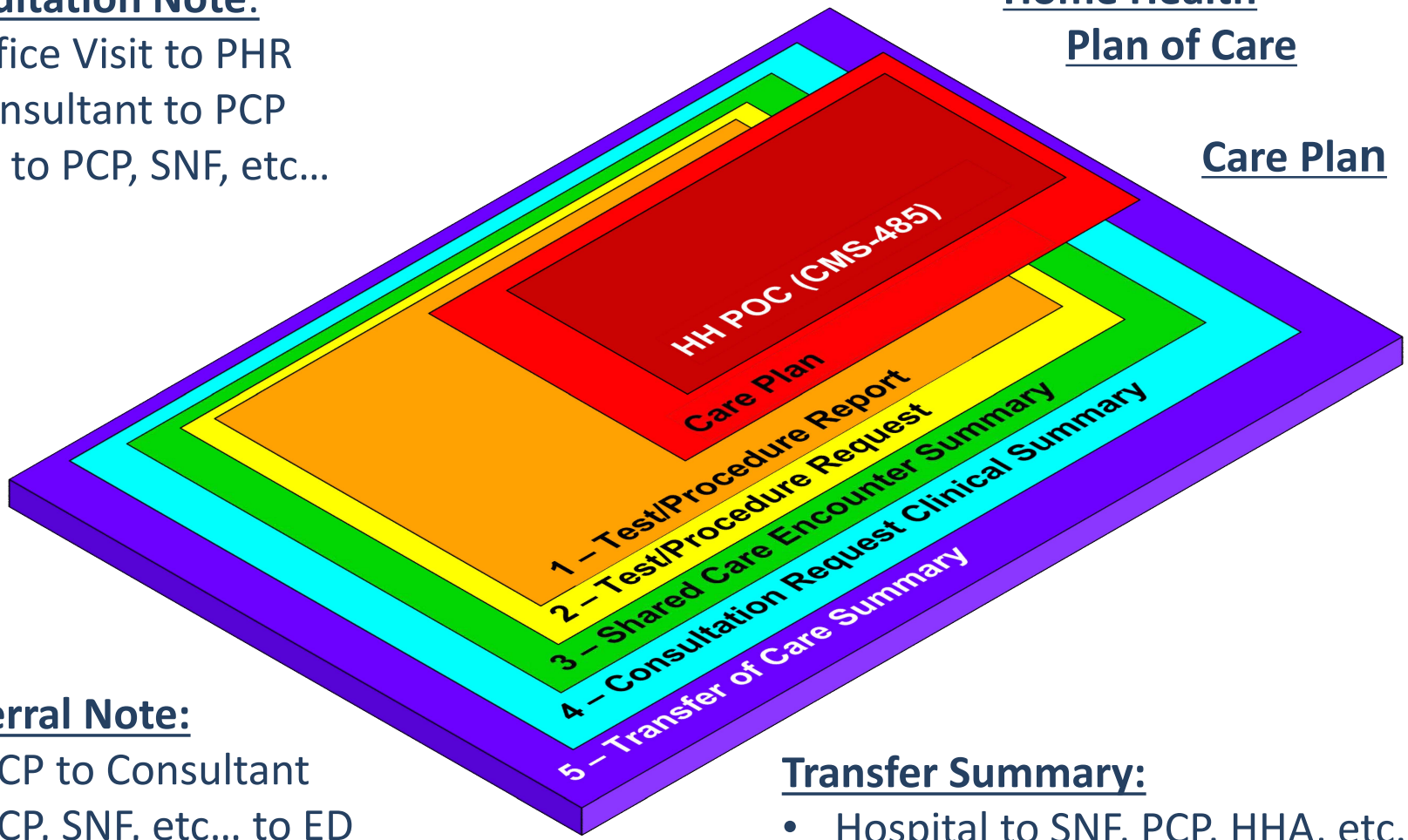
Regulation	Issued By	Target Program
2014 Medicare Physician Fee Schedule	CMS	Medicare
Community First Choice	CMS	Medicaid
Conditions of Participation: Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology, Comprehensive Outpatient Rehabilitation Facilities, HHAs, Hospice, Hospital, Nursing Home	CMS	Medicare/Medicaid
EHR Incentive Program	CMS	Medicare/Medicaid
Prospective Payment Systems: Inpatient Prospective Payment System (IPPS), LTC, SNF	CMS	Medicare
Money Follows the Person	CMS	Medicaid
Balancing Incentive Program	CMS/ACL	Medicaid
Testing Experience of Functional Tools & Assessments	CMS	Medicaid
ONC EHR Certification Criteria	ONC	Medicare/Medicaid

Additional Information:
Datasets

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

Home Health Plan of Care

Care Plan

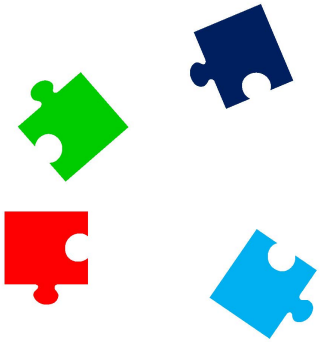


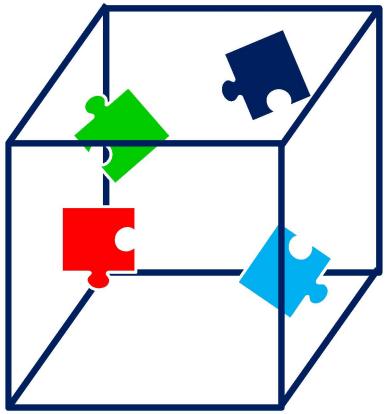
Referral Note:
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP

Additional Information:
CDA and Consolidated-CDA (C-CDA)

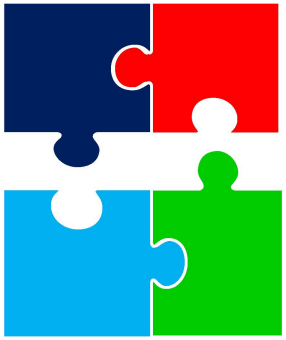
Clinical Document Architecture (CDA) is the base standard for building electronic clinical documents





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

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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

Document Template	Section Template(s)		
Continuity 0f 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 YELLOW 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

Additional Information:

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

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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…..

Additional Information
C-CDA Revisions Project

- 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