**HL7 Care Plan Topic**

**Minutes**

**February 19, 2014**

Attendees:

Stephen Chu

Enrique Meneses

Lenel James

Laura Heermann Langford

Susan Campbell

Kevin Coonan

Becky Angeles

Nan Hou

Agenda:

Presentation by Lenel James and Susan Campbell re: the payor perspective of the Care Plan

Minutes:

Lenel read through of attached slide deck and storyboard.

Discussion pursued regarding purpose of storyboard to PCWG Care Plan Initiative. Determined it represented the multiple sites of care and care plan use. Needs improvement on clinical story line and in workflow/HIE representation of the tools in the case.

Next Steps for the storyboard:

* Lenel – tighten up workflow in the storyboard (workflow and HIE exchange,), tidy up the medications (those used, names etc), have Stephen and Kevin do clinical review.
  + Lenel will target Monday to have storyboard ready to send to Kevin and Stephen for clinical review.
* Need to look for list of pieces of data (medications, pieces of information that are needed to make this simple story happen)

Calendaring for team:

* Tomorrow:
  + Meet with LCC re: the terms removal from the Care Plan DAM (Care Plan , Plan of Care, Treatment Plan. )
* Next week :
  + Wednesday – look at ballot reconciliation.



**Storyboard 1 DRAFT 2: Case Management / Disease Management Care Coordination**

***Short Description of the health issue thread covered by this storyboard***

The purpose of this storyboard is to illustrate the communication flow and documentation of multiple Care Plans, between a patient, his or her Patient Centered Medical Home (PCMH) primary care provider, an orthopedic specialist and health Plan case manager involved in the treatment of a patient who has several health concerns.

Providing support and guidance to a patient as s/he navigates “across the continuum” has long been a hallmark of Care Management. The PCMH movement seeks to make consumer engagement a standard practice in provider offices as well as in the care management activities of Health Plans. Accordingly, Care coordination should be a central feature of interoperability tracked via Health Concerns , across several care settings and potentially multiple care providers and caregivers. The practice of Care Management is briefly discussed later in this document, following descriptions of a series of encounters of a hypothetical patient with multiple health concerns who needs coordination of care.

This storyboard consists of these patient encounters:

A. PCMH Primary Care Provider Encounter

B. Health Plan CM/DM Nurse Coordinator Encounter

C. Hospital Admission

D. PCMH Primary Care Provider Follow-up Visit

E. Specialist Visit

F. Health Plan CM/DM Nurse Coordinator Encounter

G. Primary Care Provider Follow-up Visit

***Storyboard Actors and Roles***

• PCMH Primary Care Provider: Dr. John Medical-Home, MD

• PCMH Care Coordinator Nurse: Nurse Betty, RN/Certified Case Manager

• Hospital Physician: Dr. Ken Cambridge, DO

• Patient: Craig Anyman

• Health Plan CM/DM Nurse: Pamela Coordinator, RN/BSN

• Specialist Physician: Dr. Charles Bone

**Encounter A: PCMH Primary Care Provider Encounter**

***Pre-condition***

Mr. Craig Anyman is a 52 year-old single man with asthma and early onset diabetes. He is overweight, at risk of cardiovascular disease, suffers from depression and is a heavy smoker and occasional drinker.

Craig resides in SC and is employed at Palmetto Inc. His insurance carrier is BCBS of IL. He is enrolled in a Patient Center Medical Home Program in South Carolina and is assigned to Dr. John Medical Home as his primary physician.

Craig arrives for his annual check-up with his physician (Dr. Medical Home)

***Description of Evaluation and Management***

Dr. Medical-Home performs a history and physical examination. As part of his intervention, he administers the [PHQ-2 patient health questionnaire](http://www.cqaimh.org/pdf/tool_phq2.pdf) for depression screening. Because Craig answers “yes” to both questions, he is also asked to complete two standardized 500 assessment scales for depression severity (PHQ-9 and HADS). Dr. Medical-Home discusses the nature of depression, and asks Mr. Anyman to consider which symptoms are most bothersome and use these to set goals. Mr. Anyman was told recently that his position will be eliminated and uncertain of his future employment. As a result, his depression has worsened due to anxiety and stress. Because Craig also smokes and has previously planned to quit, Dr. Medical-Home suggests Wellbutrin for his depression and a plan of care for major depressive disorder in adults as well as participation in a local, evening smoking cessation program. The plan includes appropriate depression intervention. He is prescribed albuterol for his asthma which flares up seasonally. Dr.Medical-Home suggests physical exercise and balanced diet for weight management. Given the depression, Dr. Medical-Home recommends that Craig visit the office health coach to set some individualized goals for calorie reduction and increased activity. Mr. Anyman is asked to make a follow up visit in three months.

***Post-condition***

Both the PHQ-9 and HADS indicate moderately severe depression and the substance abuse screen indicates occasional binge drinking. Craig Anymay dutifully fills his prescription for Wellbutrin for his depression and smoking cessation, albuterol for his asthma, and signs up with the health coach to discuss physical exercise and balanced diet for weight control. Mr. Anyman schedules a follow-up visit in three months.

**Encounter B: Health Plan Disease Management Nurse Coordinator Encounter**

***Pre-condition***

Through Palmetto Inc’s voluntary disease screening program and through data mining to identify candidates for disease management outreach at his health insurance Plan, Mr Anyman had been previously identified as a candidate for an asthma program. He had been sent email about the program, encouraging him to take a health risk assessment; He did the on-line risk assessment and initially followed the email instruction. Craig was compliant at first and stabilized but then stopped filling his inhaler and measuring his peak flow. This day, though, Pamela Coordinator, the Health Plan Disease Management Nurse sees the additional care activities from real-time claims from the Dr. Medical Home visit, which triggered a yellow alert flag for Craig Anyman, since the inhaler was also not refilled. So she initiates the formal Health Plan process for enrolling and engaging Mr. Anyman in the Plan’s Asthma disease management (DM) program. The DM Plan of Care includes interventions such as use of a peak flow meter to establish baseline lung capacity and plan and methodology for monitoring and documenting the severity of the patient’s asthma attacks.

***Description of Health Plan Disease Management Nurse Coordinator Encounter* *Evaluation and Management***

Given Mr. Anyman’s medication and claims history, BCBS of IL initiates action to enroll Mr. Anyman in their asthma program. Given his recent PCMH visit and work with a health coach,l he has a positive response to the outreach email and subsequent scheduled phone call. Mr. Anyman resolved to really take advantage of the support this time. Nurse Pamela Coordinator called Mr. Anyman one evening after work. Asked about his symptoms, Craig related that he has been wheezing with exertion and has been avoiding physical activity as a result. Nurse Pamela Coordinator was enrolled Mr. Anyman in the telephonic asthma program and they chose a frequency of every two weeks for a follow up call. She asks if he understands how to use a peak flow meter. Mr. Anyman says he has used one in the past and would appreciate picking up a new one at the pharmacy. Because he is diabetic, she also discusses his latest Hemaglobin AIC result which was elevated at 7. Mr. Anyman acknowledges that “worry eating” has been a feature of his evenings as he thought obsessively about where he could turn for help if his job is eliminated. She asked if he would like to participate in the Health Plan’s diabetes disease management program. Feeling a bit overwhelmed and welcoming the added help, Mr. Anyman accepts enrollment. Nurse Pamela encourages him to follow up with the health coach in his doctor’s office with whom he had already established rapport.

***Post-condition***

A disease management (DM) program dispensed peak flow meter prescription was sent electronically to the pharmacy to be picked up at no cost by the patient along with his asthma inhaler and spacer. The Health Plan DM Care Plan is updated by Pamela Coordinator with new goal to obtain a baseline peak flow reading and monitor when wheezing starts. A letter and email are sent to patient’s provider Dr. John Medical-Home to document establishing of the new DM Program patient relationship as well as the intention to facilitate and coordinate other interventions as they arise.

**Encounter C: Hospital Admission**

***Precondition***

The patient was attending an out-of-town business conference in Cambridge, Massachusetts and was admitted to Cambridge Hospital due to a severe fractured ankle as a result of a bike collision.

***Description of Hospital Admission Evaluation***

Community-acquired pneumonia was documented on the second day of the hospital stay.

Dr. Cambridge prescribes Percocet in combination with NSAID/Aleve for pain management, explaining that they will start to taper from the Percocet within a few days, Levaquin to treat the pneumonia and then after discussing and praising the patient’s resolving depression and success in smoking cession renews the Wellbutrin . The mornings are hardest for Mr. Everyman so Dr. Cambridge adds a Nicotine inhaler, instructing Mr. Anyman to use it before even getting out of bed. While inpatient, he will receive it with his morning medications.

***Post-condition***

Dr. Cambridge documents new Plan of Treatment in formal Discharge Summary and recommends that the patient follow up with primary physician within 5 days of discharge to check his lungs as well seeing an orthopedic specialist for his ankle fracture. A hard copy of the discharge summary is given to Craig and a C-CDA file of the Discharge Summary is sent to the PCMH primary of record and to the Health Plan.

**Encounter D: Primary Care Provider Follow-up Visit**

***Precondition***

Mr. Anyman was discharged from hospital recovering from ankle surgery and pneumonia, and was told to follow-up with his primary in five days. Discharge Summary is received by the EHR of the PCMH.

***Description of Primary Care Provider Evaluation***

Mr. Anyman shares a copy of the discharge summary with Dr. Medical-Home who had already obtained it electronically. Dr. Medical-Home refers the patient to a participating orthopedic specialist, Dr. Charles Bone. Dr. Medical-Home prescribes a refill for the Percocet and NSAID, and switches the Advil to Tylenol, at the patients request.

***Post-condition***

Dr. Medical-Home updates the Care Plan by performing a medication reconciliation to include the antibiotic, and new prescriptions for pain and nicotine craving management . A C-CDA Continuity of Care Document is created that includes the updated Care Plan and medications prescribed. The CCD including the Discharge summary, radiologist report and radiographs from Cambridge Hospital are sent with Direct to Dr. Charles Bone. As part of payment innovation with the Health Plan, a copy of the CCD is also sent to the Health Plan.

**Encounter E: Specialist Visit**

***Precondition***

Mr. Anyman is 3 weeks post ankle surgery and is receiving follow-up care with a local orthopedic specialist, Dr. Charles Bone. The CCD, the hospital Discharge Summary and Radiologist Report is received by the EHR system of Dr. Bone.

***Description of* Specialist *Evaluation***

Dr Bone review the CCD and radiology report on his tablet PC during the office visit with Craig Anyman.

Dr. Charles Bone removes pins from the patient’s ankle in his office and recommends physical therapy for rehabilitation. Dr. Charles Bone suggests stepping down to NSAID/Tylenol only for pain medication as needed and one half hour prior to physical therapy.. Mr. Anyman is doing well and is expected to make a full recovery.

***Post-condition***

An updated plan of treatment is entered in Dr. Bones EHR. A CCD with the new Care Plan and medication changes sent to the Health Plan and a hard copy (Clinical Summary) was provided to patient A electronic notice is automatically sent to the local HIE that updated information is available on patient Craig Anyman. (NOTE: This specialist routine practices, as part of payment innovation is to send CCDs to the Health Plan and notify the local HIE of patient activities and updates).

**Encounter F: Health Plan Disease Management Nurse Coordinator Encounter**

***Precondition***

Nurse Pamela Coordinator has been monitoring Mr. Anyman’s claim activity since the hospitalization in Cambridge.

***Description of Health Plan Disease Management Nurse Coordinator Evaluation***

Nurse Coordinator updates the patient’s profile. He is now identified as a member of Medically Complex case management - given recent health events. The Health Plan DM Treatment Plan has been updated to include diabetes management. A notice was sent to patient’s provider Dr. John Medical-Home to facilitate and coordinate patient’s interventions as appropriate. Nurse Pamela puts in a phone call to the patient’s home and they review his discharge plan. She learns he has still been taking the Percocet even though Dr.Bone recommended shifting to NSAID only. She discusses the potential for medical addiction to opiates. Going over his symptoms, he mentions that he’s been having some difficulty with elimination. Pamela Coordinator suggests that he drink more fluid and increase fiber in his diet. The combination of spending more time on the couch, mild dehydration due to difficulty getting up and down and carrying drinks, taking the opiate which slows bowel motility, and eating mostly refined-flour containing foods like sandwiches delivered to his home are causing the problem. Craig is relieved to know this is not a new problem that will need another office visit for. He has some apples and dried prunes in the refrigerator. They discuss how to dose the fruit in keeping with his diabetic food plan. They agree that Mr. Anyman is self-sufficient and does not need a home nursing evaluation. Nurse Pamela Coordinator schedules a call for the next day to check on him. She will recommend that he flush his Percocet if he has been free of discomfort for 24 hours on the Tylenol he is taking now for pain control. Based on a system flag, Nurse Pamela shares the risk of Tylenol adverse reaction versus the origin hospital prescription of Aleve. He has none of the reaction issues, but reminds him to stay away from alcohol until the Percocet is flushed from the system, and notes the issues and discussion on the DM Care Plan.

***Post-condition***

Nurse Pamela coordinator updates Mr. Anyman’s treatment plan to reflect recent health activity including complex case management and diabetes care, as well as the now problem with slowed bowel motility, and the continued use of Percocet. A notice was sent to patient’s provider Dr. John Medical-Home to facilitate and coordinate patient’s interventions as appropriate. DM interventions are updated. The aggregated Care Plan, with the updated DM/CM interventions, and drug interaction concerns is sent to PCMH Dr. John refers the complaint of constipation to his office nurse and a request that PCMH Nurse Betty make a call or send email to verify the patient has stopped taking Percocet – she did so and learned both issues had resolved. The patient was doing well on Tylenol and was regular again in his bowel habits. Mr. Anyman reports that although his pain is usually a “1” or “2” on the Wong-Baker scale, he prefers being in a little discomfort to running the risk of opiate addiction. He promises to flush the Percocet if he still feels ok in another 24 hours. The nurse Betty updated the Care Plan to reflect the conversation with patient Craig, drug-drug interaction concerns and the pain scale update.

**Encounter G: Primary Care Provider and Care Team Meeting Follow-up Visit**

***Precondition***

Receipt of the Aggregated Care Plan from payer

Receipt of the payer copy of the CCD from the specialist & Discharge Summary from Cambridge

Update of the PCMH Care Plan by Nurse Betty

***Description of Primary Care Provider Follow-up Visit Evaluation***

* Dr John identifies a wound problem that could be evidence of a deep tissue infection. Because the patient is already partially weight-bearing the PCP thinks that bone healing is progressing properly, but thinks the cellulitis needs aggressive therapy with intravenous antibiotics. Due to complexity of the wound, specialist care is preferred.
* Nurse Betty reviews the Orthopedic options with the patient based on transparency information from Payer Case manager on quality and co-pay cost options – the patient can return to his orthopedic surgeon office with the potential of subsequent referral to infectious disease, or go directly to infectious disease.
* Reconciliation of the individual Plans of Care is performed by the practice-based Nurse Case Manager and create a multi-discipline Care Plan with new and updated interventions, and their probable timing. It is determined that most of care that is needed can be performed in the patient’s home by the high tech company for iv antibiotic therapy and visiting nurses for wound care. The office-based Nurse Case Manager refers this monitoring to Pat Coordinator at the health Plan who will oversee it unless a new problem emerges that needs the PCP’s review.

***Post-condition***

* Referral to the Ortho was selected by the patient. An X-ray is ordered and performed, but no bone-related problems are identified. It seems to be an infection of soft tissue.
* CCD with updated multi-disciplinary Care Plan is sent to Ortho and to the payer
* The PCMH Nurse Betty manager calls Pamela Coordinator, the payer case manager to schedule home visit for wound care and conveys an order for i.v. antibiotic recommended by Dr. Charles Bone to be performed by a high tech company that makes home visits. Pamela Coordinator locates a contracted high tech home care organization and conveys the referral for care.