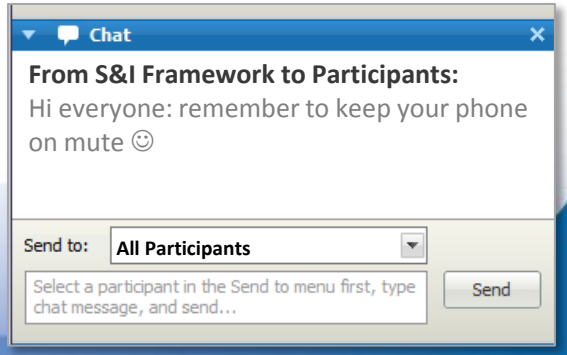
The Office of the National Coordinator for Health Information Technology

Longitudinal Coordination of Care Overview to HL7 Patient Care WG

Wednesday, March 27th, 2013

Meeting Etiquette

- Remember: If you are not speaking, please keep your phone on mute
- Do not put your phone on hold. If you need to take a call, hang up and dial in again when finished with your other call
  - Hold = Elevator Music = frustrated speakers and participants
- This meeting is being recorded
  - Another reason to keep your phone on mute when not speaking
- Use the “Chat” feature for questions, comments and items you would like the moderator or other participants to know.
  - Send comments to **All Participants** so they can be addressed publically in the chat, or discussed in the meeting (as appropriate).



Agenda

Topic	Presenter
LCC Background and Overview	Evelyn Gallego
Care Plan and Care Planning	Larry Garber
Alignment to HL7 PC Care Plan DAM	Russ Leftwich + LCC Leads

Longitudinal Coordination of Care Workgroup Overview

This is Part 1 of a two-part slide deck

S&I Longitudinal Coordination of Care (LCC) Workgroup

- Initiated in October 2011 as a ***community-led*** initiative with multiple public and private sector partners, each committed to overcoming interoperability challenges in long-term, post-acute care (LTPAC) transitions
- Supports and advances interoperable health information exchange (HIE) on behalf of LTPAC stakeholders and promotes LCC on behalf of medically-complex and/or functionally impaired persons
- **Goal is to** identify standards that support LCC of medically-complex and/or functionally impaired persons that are aligned with and could be included in the EHR Meaningful Use Programs
- Seeks to influence Meaningful Use Stage 3
- Consists of three sub-workgroups (SWGs):
  - Longitudinal Care Plan (LCP)
  - LTPAC Care Transition
  - Patient Assessment Summary (PAS)*

* The work of the PAS SWG completed in JAN13

LCC Sub Workgroups (SWG)

COMMUNITY-LED INITIATIVE

Longitudinal Coordination of Care Workgroup

- Providing subject matter expertise and coordination of SWGs
- Developing systems view to identify interoperability gaps and prioritize activities, and align identified standards with the EHR MU Program

Longitudinal Care Plan SWG

GOALS

- Identify standards for an interoperable, longitudinal **care plan*** which aligns, supports and informs person-centric care delivery regardless of setting or service provider

LTPAC Care Transition SWG

- Identify the key business and technical challenges that inhibit LTC data exchanges
- Define data elements for long-term and post-acute care (LTPAC) information exchange using a single standard for LTPAC transfer summaries

Patient Assessment Summary (PAS SWG)

- Established the standards for the exchange of Patient Assessment Summary (PAS) documents
- Provided consultation to the transformation tool being developed by Geisinger to transform the non-interoperable MDSv3 and OASIS-C into an interoperable clinical HL7 CDA document

***Care Plan standards will enable providers to create, transmit and incorporate care plans and needed content for the benefit of medically complex and/or functionally impaired individuals, their families and caregivers.**

LCC Initiative: Resources & Questions

LCC Leads

- Dr. Larry Garber (Lawrence.Garber@reliantmedicalgroup.org)
- Dr. Terry O'Malley (tomalley@partners.org)
- Dr. Bill Russell (drbruss@gmail.com)
- Sue Mitchell (suemitchell@hotmail.com)

LCC/HL7 Coordination Lead

- Dr. Russ Leftwich (Russell.Leftwich@tn.gov)

Federal Partner Lead

- Jennie Harvell (jennie.harvell@hhs.gov)

Initiative Coordinator

- Evelyn Gallego (evelyn.gallego@siframework.org)

Project Management

- Becky Angeles (becky.angeles@esacinc.com)
- Sweta Ladwa (sweta.ladwa@esacinc.com)

LCC Wiki Site: http://wiki.siframework.org/Longitudinal+Coordination+of+Care

LCC WG Key Successes to meet MU3 needs

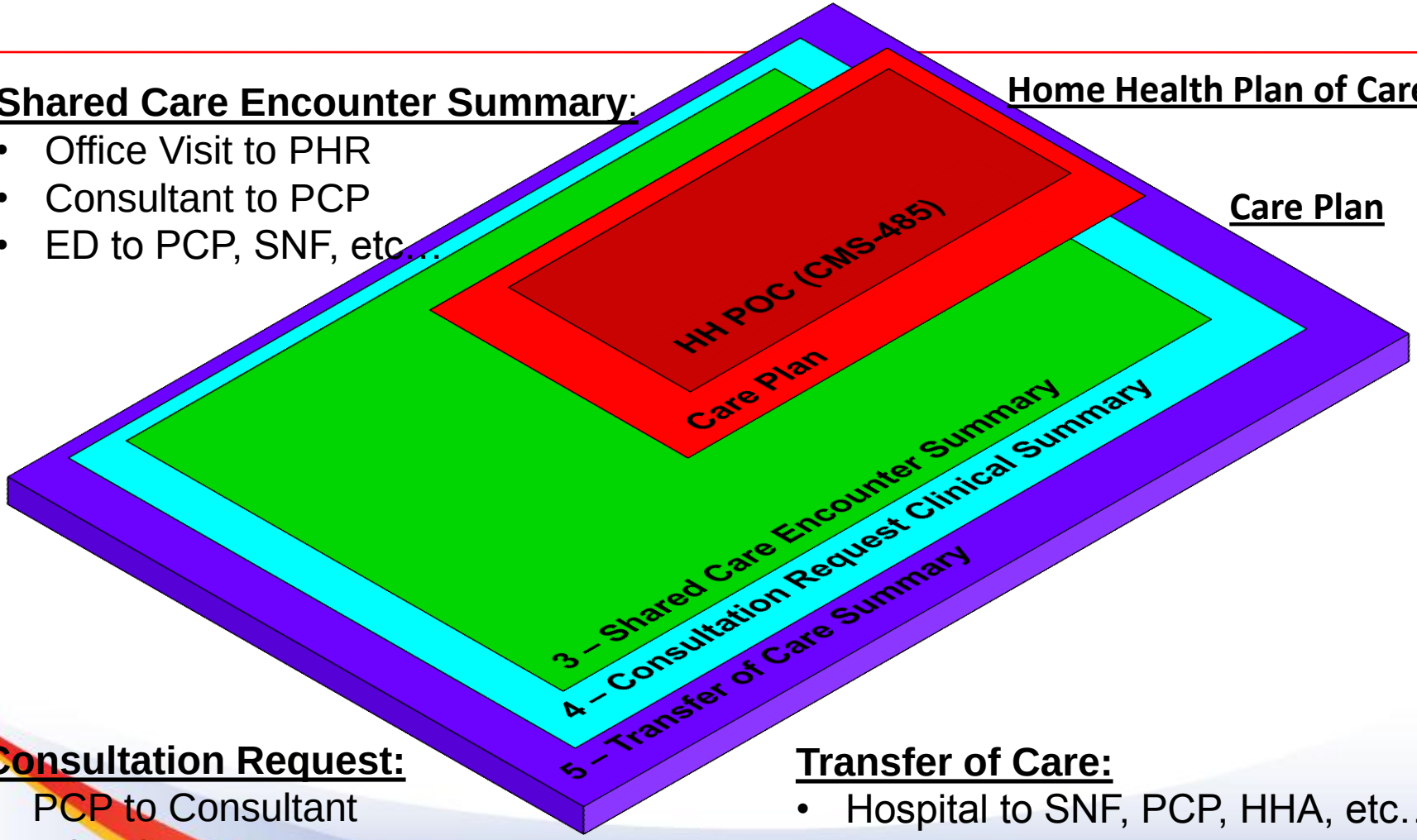
- **(JUNE 12) LCC Use Case 1.0**: Expanded from S&I ToC Use Case; identified 360+ additional data elements
- **(AUG 12) Care Plan Whitepaper** "Meaningful Use Requirements For: Transitions of Care & Care Plans"
- **(OCT 12) IMPACT Dataset**: Consensus built Transitions of Care and Care Plan/HHPoC dataset (483 data elements). Deep dive of LCC Use Case 1.0
- **(MAY- SEPT 12) Balloted 3 standards through HL7**: C-CDA Refinements interoperable exchange of Functional Status, Cognitive Status, & Pressure Ulcer; and LTPAC Summary IG. Also balloted through HL7 standards for Questionnaire Assessment. Stage 2 MU incorporated requirements for functional and cognitive status.
- **(OCT 12) Stage 3 MU Care Plan Questions** for HITPC MU WG
- **(DEC 12) Care Plan Glossary**
- **(JAN 13)** Community Led submission to HITPC **RFC Stage 3 MU**
- **(MAR 13) IMPACT ToC High-level IG**

Lantana has been contracted to work with LCC to make and ballot HL7 CDA IGs

The Office of the National Coordinator for Health Information Technology

Shared Care Encounter Summary:

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



Consultation Request:

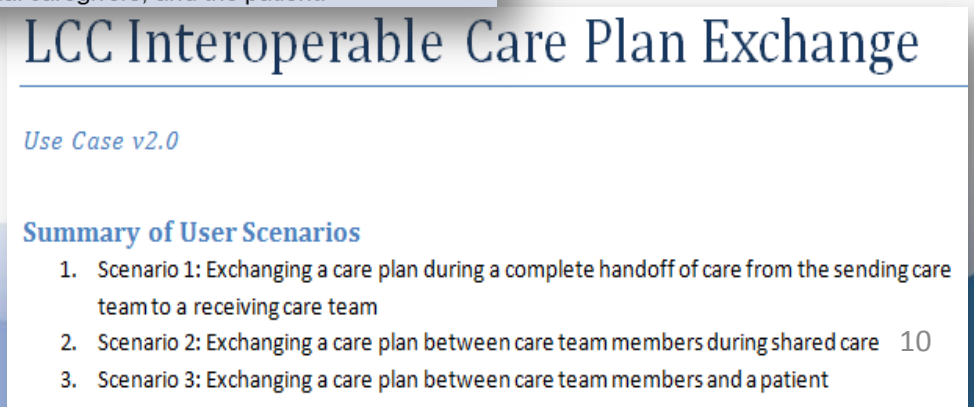
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer of Care:

- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP

LCC WG Care Plan Artifacts: Glossary and Use Case

Term/ Component	LCC Proposed Definition
Care Plan	The term "care plan" considers the whole person and focuses on a number of health concerns to achieve high level goals related to healthy living. Care Plan and Plan of Care share the **SIX** components: health concern, goals, instructions, interventions, outcomes, and team member
Health Concern	Reflect the issues, current status and 'likely course' identified by the patient or team members that require intervention(s) to achieve the patient's goals of care, any issue of concern to the individual or team member
Goals	A defined outcome or condition to be achieved in the process of patient care. Includes patient defined goals (e.g., prioritization of health concerns, interventions, longevity, function, comfort) and clinician specific goals to achieve desired and agreed upon outcomes.
Instructions	Information or directions to the patient and other providers including how to care for the individual's condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice. Detailed list of actions required to achieve the patient's goals of care.
Interventions	Actions taken to maximize the prospects of achieving the patient's or providers' goals of care, including the removal of barriers to success. Instructions are a subset of interventions.
Outcomes	Status, at one or more points in time in the future, related to established care plan goals.
Team Member	Parties who manage and/or provide care or service as specified and agreed to in the care plan, including: clinicians, other paid and informal caregivers, and the patient.


LCC Interoperable Care Plan Exchange

Use Case v2.0

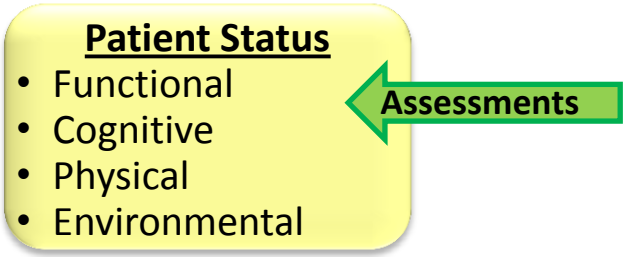
Summary of User Scenarios

1. Scenario 1: Exchanging a care plan during a complete handoff of care from the sending care team to a receiving care team
2. Scenario 2: Exchanging a care plan between care team members during shared care
3. Scenario 3: Exchanging a care plan between care team members and a patient

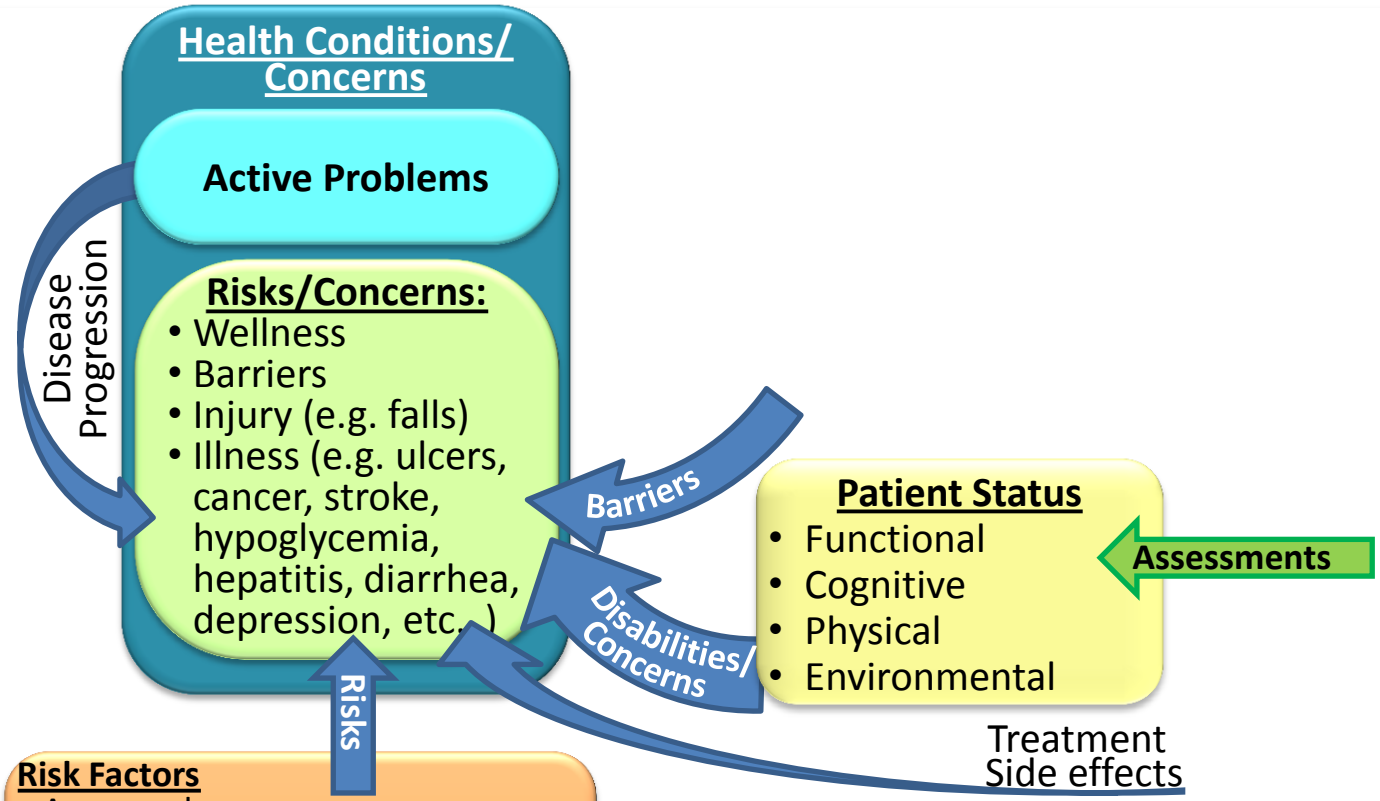
Care Plan & Care Planning

Key Discussion Points

- The HL7 Care Model is great! Let's work together to ensure our "clinical" speak aligns with your "modeling" speak
- Barriers and Risks
- Goals (patient and provider / computable vs. behavior vs. patient-specified)
- Team Members (include patient and family)

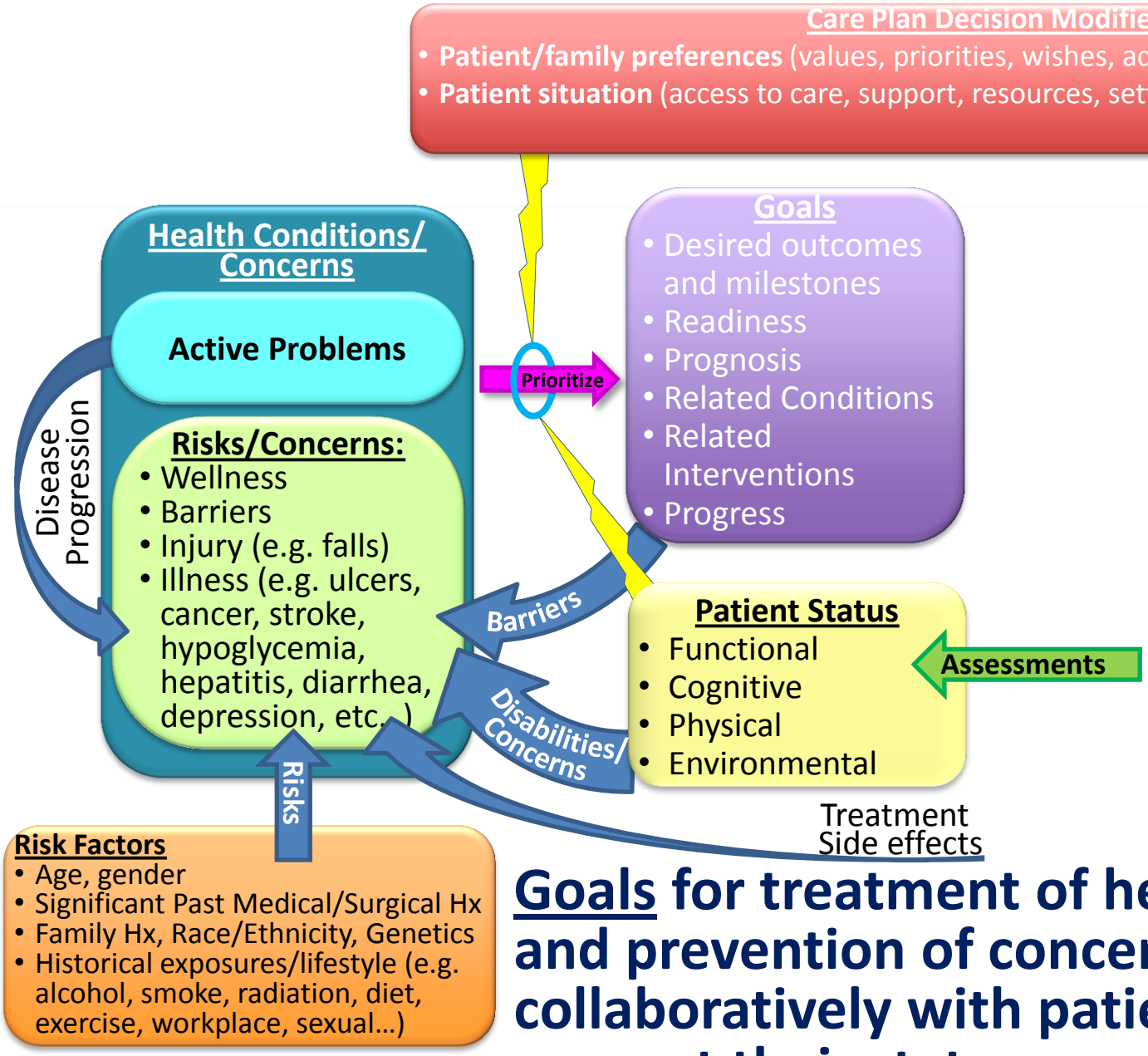


Patients are evaluated with assessments (history, symptoms, physical exam, testing, etc…) to determine their status

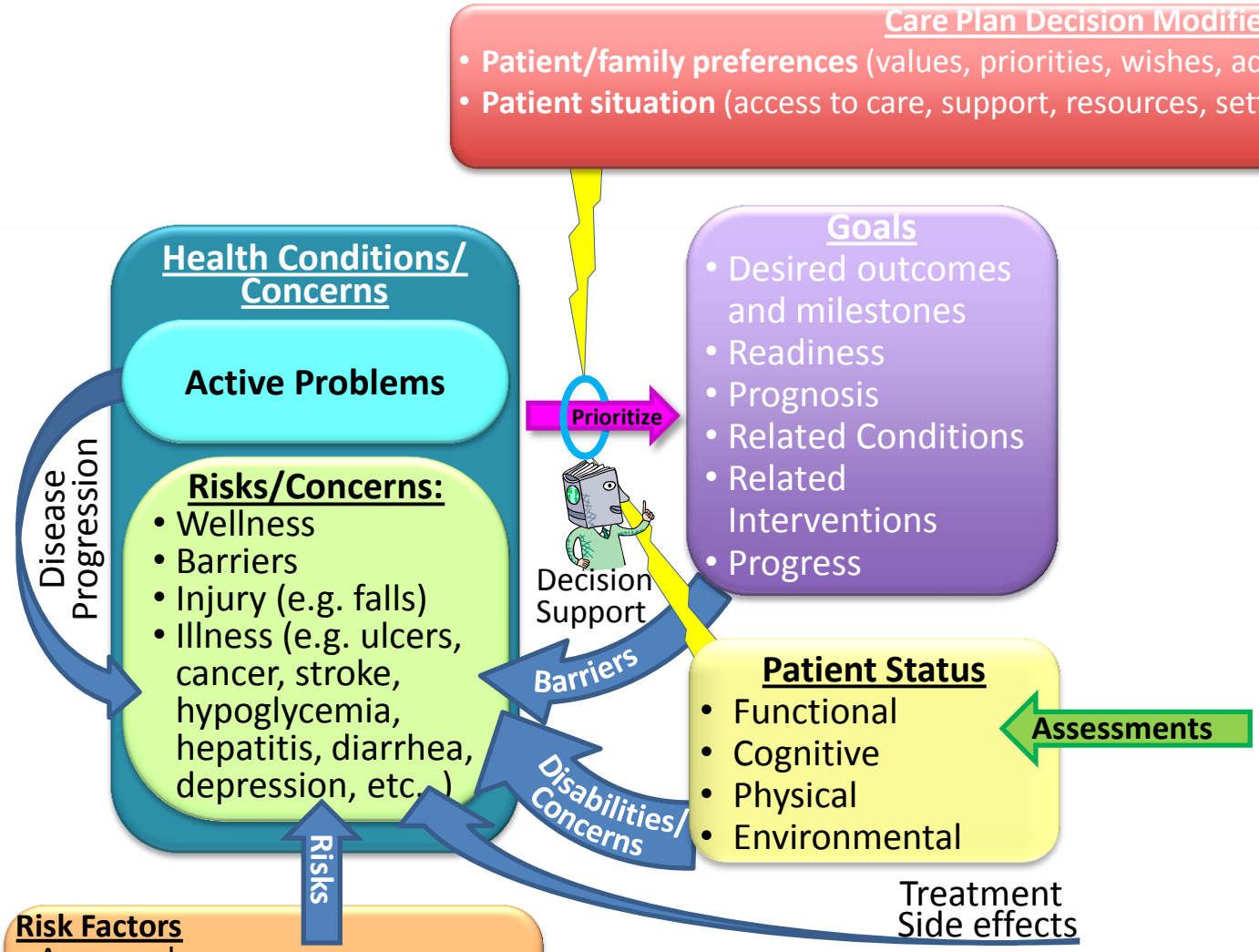


Patient Status helps define the patient's <u>current conditions, concerns, and risks for conditions</u>

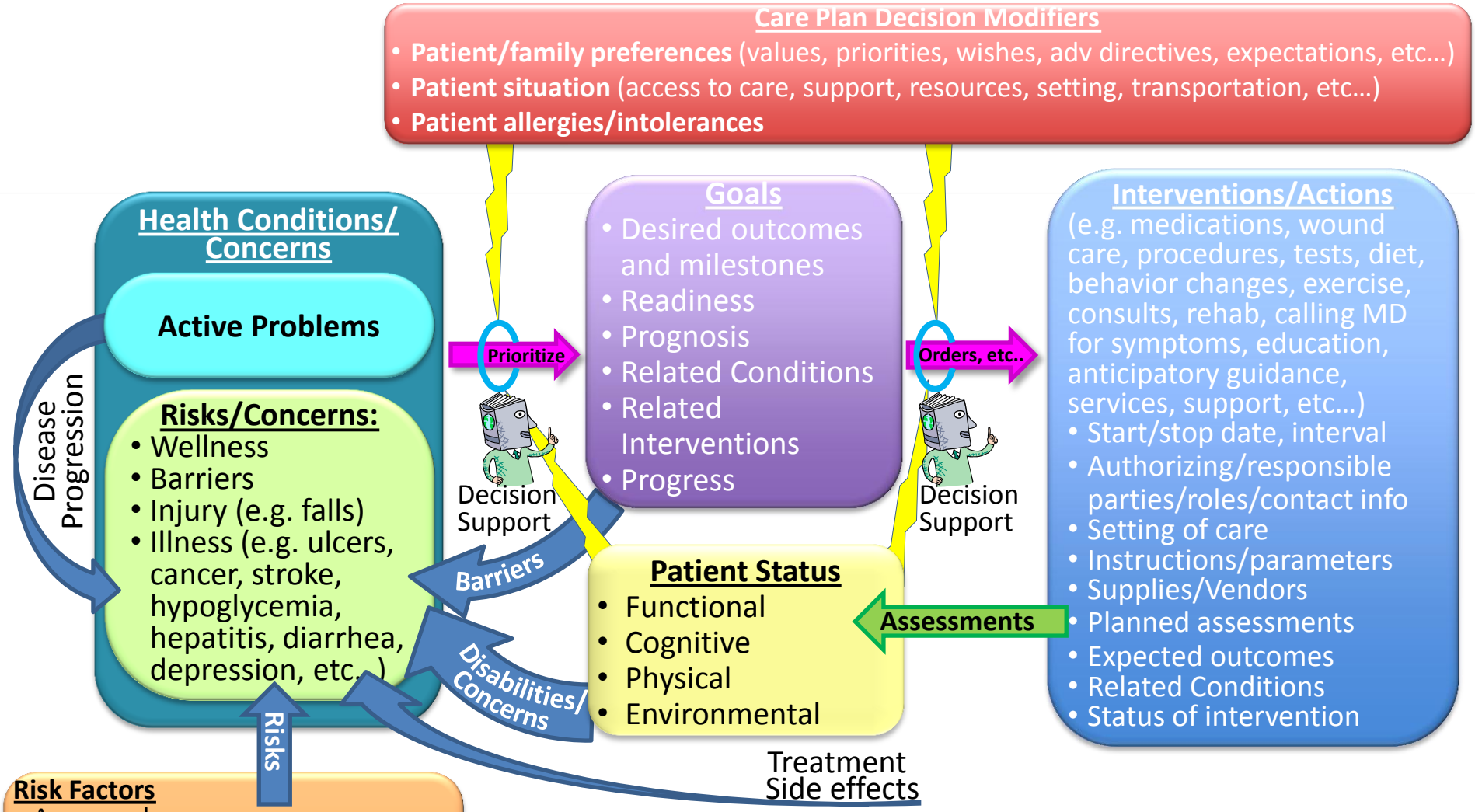
Risks/concerns come from many sources



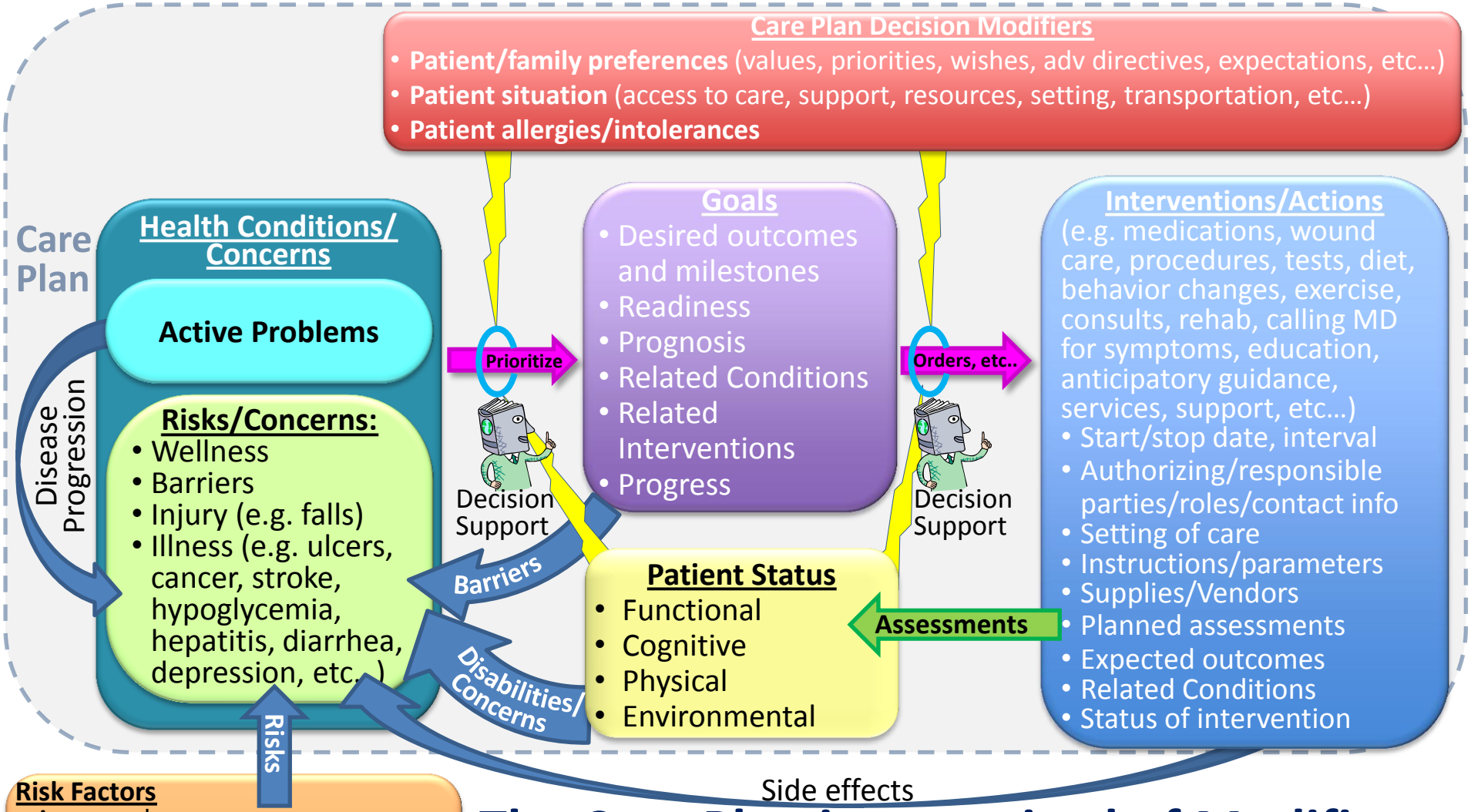
Goals for treatment of health conditions and prevention of concerns are created collaboratively with patient taking into account their statuses and Care Plan Decision Modifiers



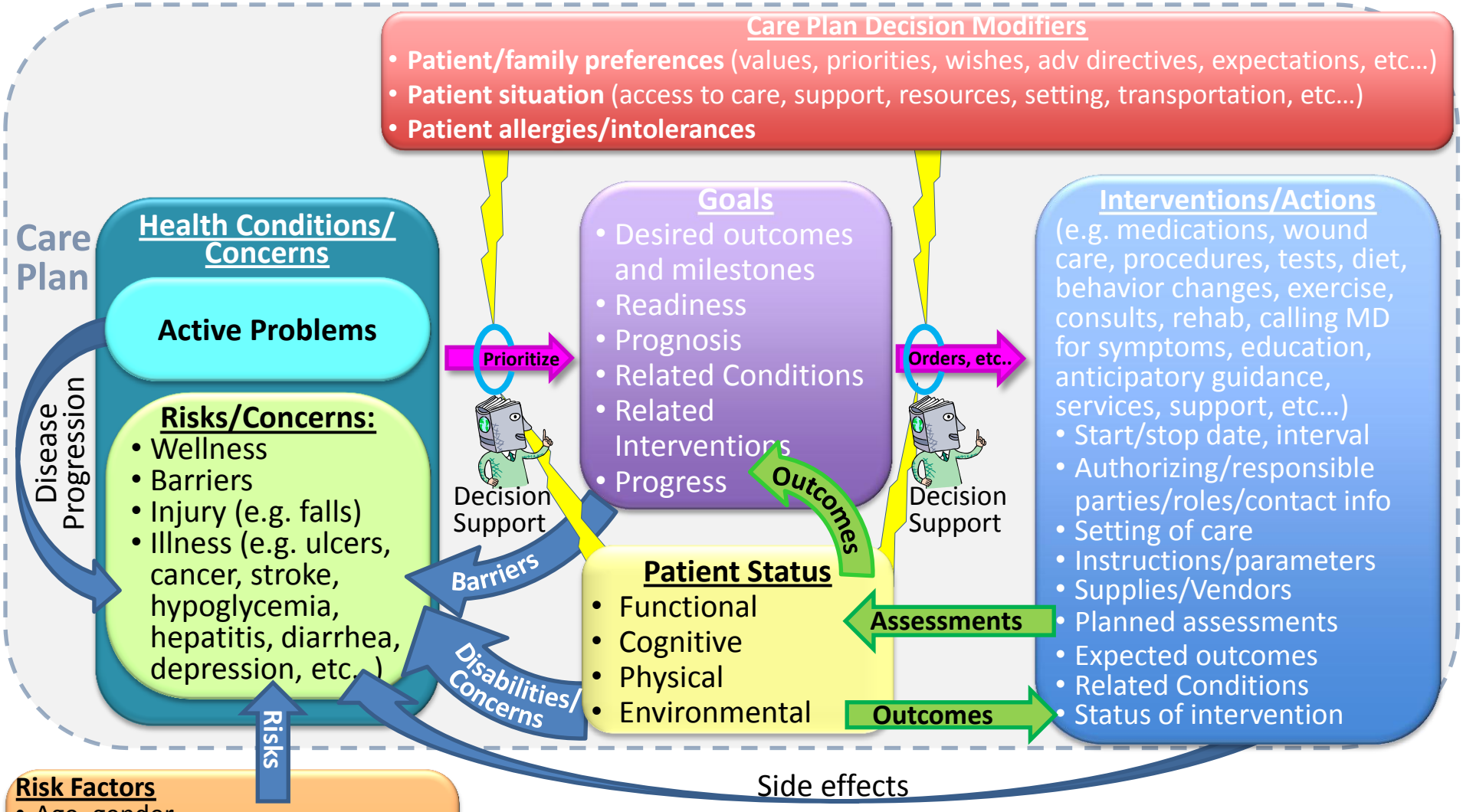
Decision making is enhanced with evidence based medicine, clinical practice guidelines, and other medical knowledge



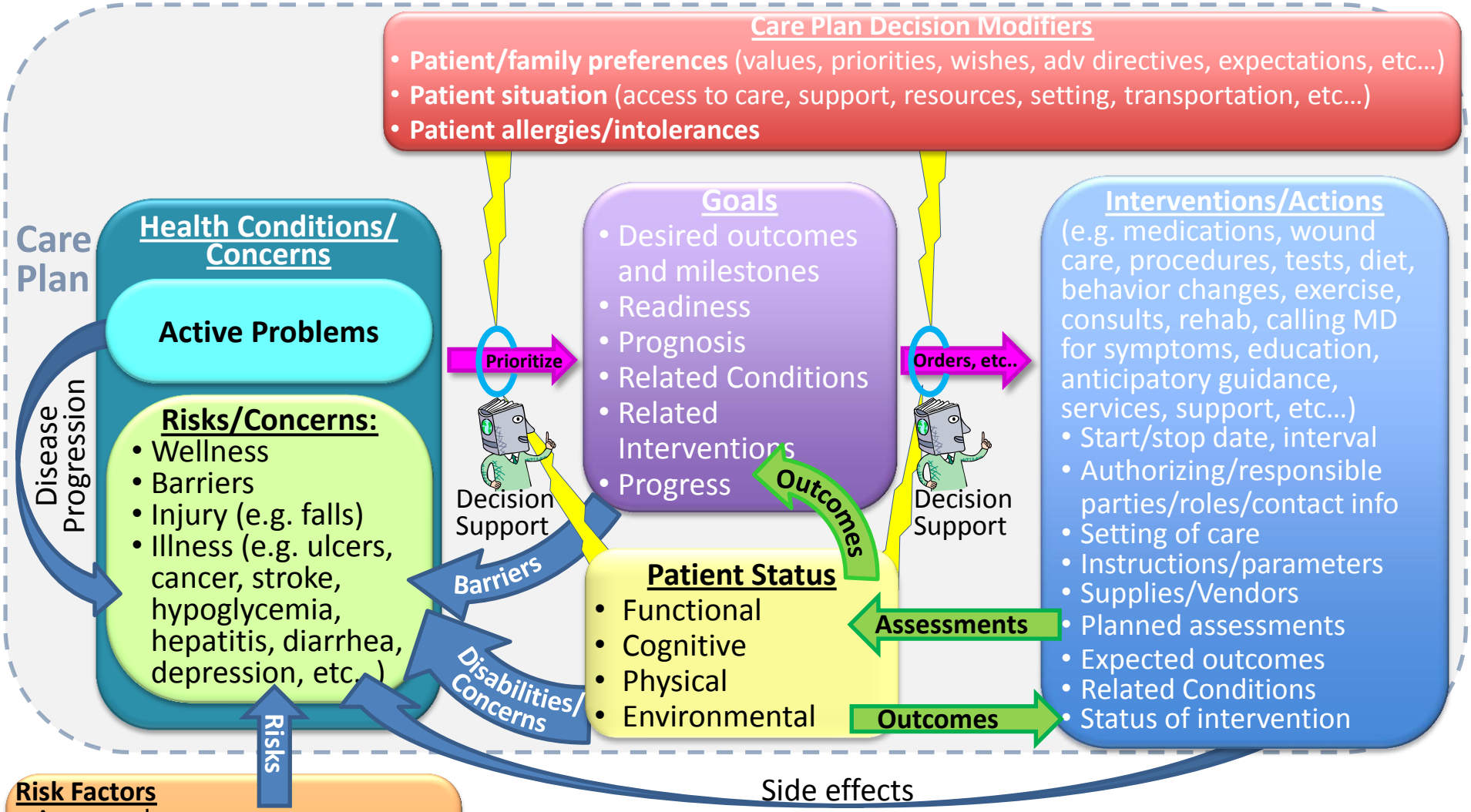
Interventions and actions to achieve goals are identified collaboratively with patient taking into account their values, situation, statuses, risks & benefits, etc…



The Care Plan is comprised of Modifiers, Conditions/Concerns, their Goals, Interventions/Actions/Instructions, Assessments and the Care Team members that actualize it



Interventions and actions achieve <u>outcomes</u> that make progress towards goals, cause interventions to be modified, and change health conditions



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

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

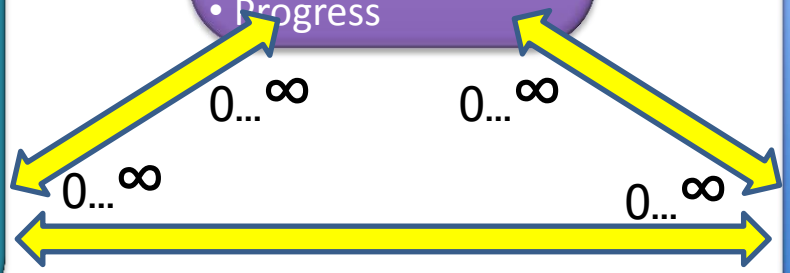
Active Problems

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



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

A many-to-many-to-many relationship exists between Health Conditions/Concerns, Goals and Interventions/Actions

Care Team Members

each have their own responsibilities

Care Plan Decision Modifiers

- **Patient/family preferences** (values, priorities, wishes, adv directives, expectations, etc…)
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Goals

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- 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
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- Expected outcomes
- Related Conditions
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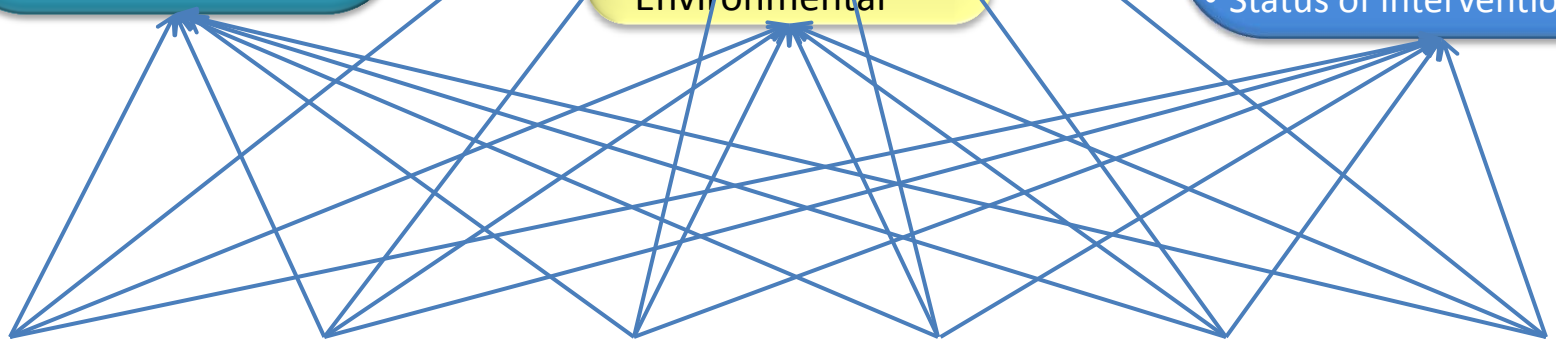

Patient | Family | Physicians | Non-physician Providers | Nursing | Coordinators

How to represent many-to-many-to-many-to-many???

Care Plan Decision Modifiers

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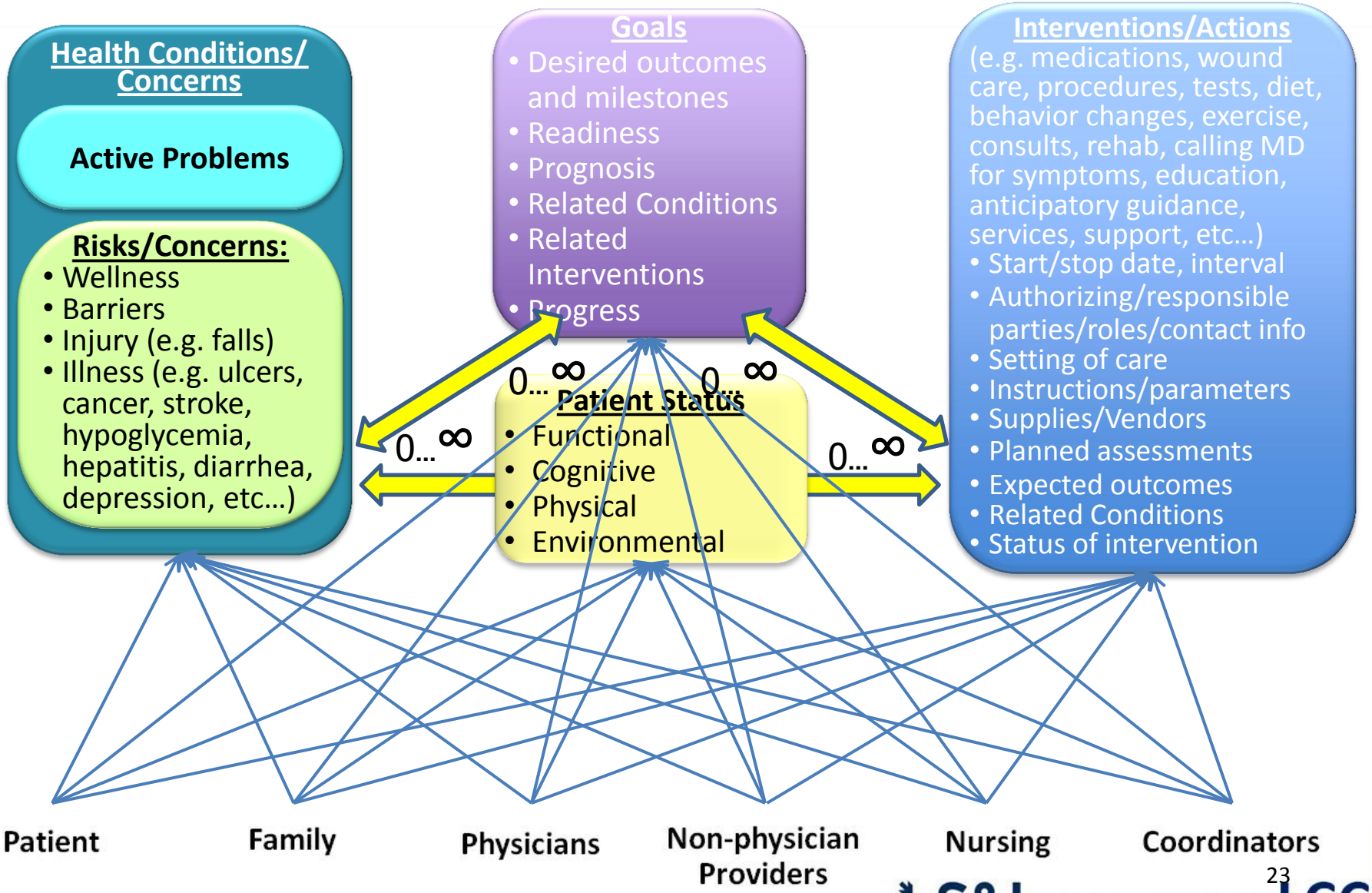

S&I FRAMEWORK LCC

The MAP
Master All-care Plan

Care Plan Decision Modifiers
- **Patient/family preferences** (values, priorities, wishes, adv directives, expectations, etc…)
- **Patient situation** (access to care, support, resources, setting, transportation, etc…)
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Health Conditions/ Concerns

Active Problems

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- Wellness
- Barriers
- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, di… depression, …

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

0… ∞ **Patient Status** 0… ∞

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
- …ed assessments
- …ed outcomes
- …d Conditions
- …of intervention

Master All-care Plan
- **Item #1**
- **Item #2**
- **Relationship** (e.g. Goal-for-Problem, Intervention-for-Problem, Goal-for-Intervention, Performing Team Member-for-Intervention, Performing Team Member-for-Assessment, Team Member Responsible-for-Problem, Team Member Following-Problem, Problem-Problem Causality, etc…)

Patient | Family | Physicians | Non-physician Providers | Nursing | Coordinators

The MAP

Master **A**ll-care **P**lan enables many views

Care Plan Decision Modifiers

- **Patient/family preferences** (values, priorities, wishes, adv directives, expectations, etc…)
- **Patient situation** (access to care, support, resources, setting, transportation, etc…)
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Health Conditions/ Concerns

Active Problems

Risks/Concerns:

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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
- uthorizing/responsible
- ties/roles/contact info
- ng of care
- uctions/parameters

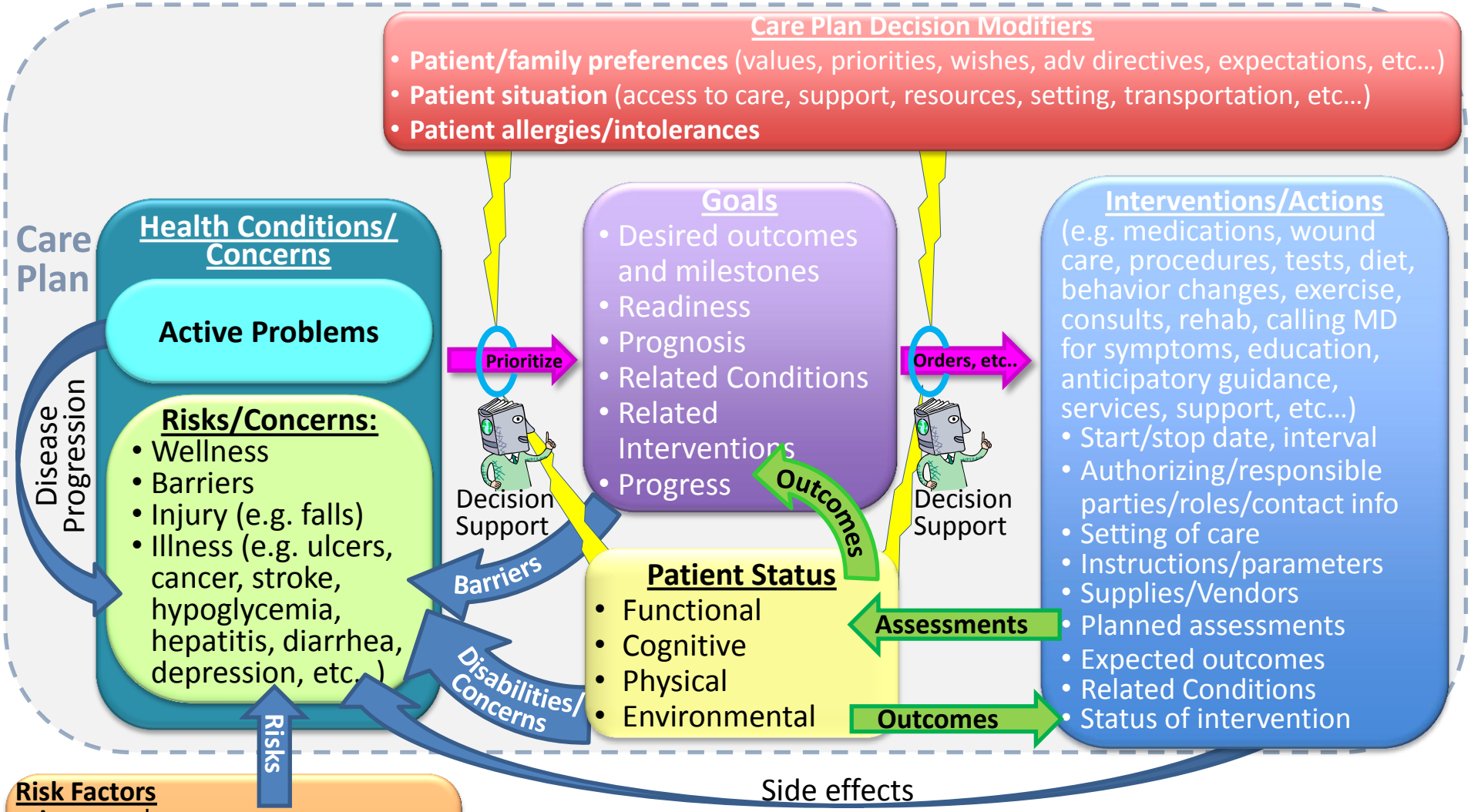
Who on my Care Team is taking care of my wound?

Which problems am I responsible for?

What problems are treated by this intervention and what are the goals of treatment?

What interventions are in place for this health concern?

Patient | **Family** | **Physicians** | **Non-physician Providers** | **Nursing** | **Coordinators**


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
Prioritize
Goals
• Desired outcomes and milestones
• Readiness
• Prognosis
• Related Conditions
• Related Interventions
• Progress
Decision Support
Barriers
Outcomes
Patient Status
• Functional
• Cognitive
• Physical
• Environmental
Assessments
Disabilities/ Concerns
Outcomes
Orders, etc..
Decision Support
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
Risks
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…)

Questions?

Part 2:

Alignment to HL7 Domain Analysis Model (DAM)

To be continued …