Linking Home Health to the Larger Health Ecosystem

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The Health Ecosystem

• At the center, the individual with personal priorities and caretakers
• All parts funded by Medicare and Medicaid
• Community based services that address the social determinants of health
• Health and wellness service providers
• Their connections with each other
Outline

• Some observations from previous presentations
• New tools to link the health ecosystem
  – Transitions of Care
  – Longitudinal Coordination of Care
  – Referral management
  – Outcome reporting
• How these tools might support new roles for home care as service integrator, coordinator and manager of high risk populations
The Future is Now

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  – Address the needs of the “5%ers”
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  – Integrate aspects of social and medical models
  – Produce credible metrics demonstrating significant improvements in satisfaction, outcome and cost
  – Interventions from low to high complexity
  – Require effective communications across teams, sites and organizations
No IT, No Coordination

• A critical issue: lack of shared IT platform
• VA has one, national, standardized
• Large systems have one (EPIC for example) but can’t communicate as easily off the platform
• CBOs, HHAs, SNFs and Patient and Family are not on these platforms
Building a common IT platform

• IT integration across the ecosystem requires five components:
  – A compelling business case for this exchange
  – An electronic highway that connects all parties
  – Low cost access ramps to the highway for those without EHRs and millions to spend
  – Trucks to carry the information reliably between sites
  – Cargo to put in the trucks, ie information, that is valuable to the sites and standardized so it can be used everywhere.
Rate Limiting Step

• Information exchange, Informatics

• Use Cases:
  – HHAs with other “health care sites”
    • Hospitals
    • EDs
    • PCMH
  – HHAs with Long Term Support Service providers
  – Patients and Families to everyone else

• Requirements
  – Easy, reliable, low cost
  – Standardized interoperable data: CDA documents
What is a CDA anyway?

• **Clinical Document Architecture**

• International standard to communicate patient data

• “Consolidated CDA” is a library of standard reusable data element “templates” that are combined to form CDA documents

• Incorporates the old standard, the CCD
Just like Legos®

Standardized Containers

Wide Variety

Reusable
CCD+ = Transfer Summary

Hospital

CCD+ to LAND

SEE

CCD+

LAND

PCP

Nursing Facility

KeyHIE Transform

Billing Program

MDS

Home Health

CCD+
Shared Care Encounter Summary (AKA Consult Note):
- 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 Summary:
- Hospital to SNF, PCP, HHA, etc...
- SNF, PCP, etc... to HHA
- PCP to new PCP
Datasets include Care Plan

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Home Health Plan of Care

Care Plan

Anticoagulation
- CHF
Consolidated CDA R2.0 Documents

- History and Physical Note
- Progress Note
- Diagnostic Imaging Report
- Operative Note
- Procedure Note
- Discharge Summary
- Continuity of Care Document (CCD)
- Consultation Note
  - Referral Note
  - Transfer Summary
- Care Plan
Sections of Summary Document

- Demographics
- Advance Directives
- Chief Complaint
- History of Present Illness
- Encounters
- Problems
- History of Past Illness
- Family History
- Social History/Risks
- Allergies
- Medications

- Immunizations
- Medical Equipment
- Vital Signs
- Physical Exam
- Functional Status
- Procedures
- Results
- Assessment
- Discharge Diagnoses
- Care Plan
- Payers
Putting the Pieces Together

• Highways: HIE build-out continues across the country
• On and Off Ramps: free, open source, Java based software which allows non-EHR users to send and receive standardized messages
• New trucks: Consolidated CDA, the required health care data exchange standard stipulated in MU 2. A significant improvement in flexibility
• High value cargo: standardized demographics, functional status, cognitive status, nutritional needs, treatment plans, medication lists, care plans
• The business cases: what does LTSS know that “health care” providers need to know? What do they know that LTSS needs? The patient and family need?
The Future: Novel uses of C-CDAs

- Home Health Plan of Care
- Signed F2F (!)
- Suggest changes to care plan
- Transmit orders/instructions
- Convey Advance Directives
- Request appointments/referrals/procedures
- Request information (e.g. questionnaire)
- Quality reporting
The Future: Novel uses of C-CDAs

• Put in the hands of others that don’t have EHRs:
  – Behavioral health
  – Ancillaries (pharmacies, labs, imaging)
  – Long-term Support Service providers
  – Other Community-Based Organizations
  – Patients

• Enhancements to manage care planning
• Smartphone-compatible version
• Patient-friendly version
• Technology interface
So What?

- Foundation of a low cost, shared IT infrastructure
- For individuals, caretakers and service providers
- Supports high value functions
  - Transitions
  - Coordination
  - Referrals
  - Event notification
For Home Care

- Enables “cross episode” utilization, cost and outcome studies
- New business lines
  - Urgent response
  - Increased clinical intensity
- A path away from selling a commodity
- Shift to value added service model
  - Aggregator
  - Integrator
  - Coordinator
  - Manager
  - Guarantor
No One Does
What Home Care Does

• Provide services in the home
• Bring services to the individual not the individual to services
• Address directly the impact of function on health
• Address the social determinates of health
• Support those who support the individual
No One Knows
What Home Care Knows

• Care is not just about the individual, it is about the individual and their immediate supports
• The individual and supports are in charge
• What matters most to them determines the care plan
• Addressing what matters most to them is the key to negotiating what matters most to the care team
No One Can Do What Home Care Does

- Unique platform: Geographically distributed
- Multiple services
- Connects with all aspects of the “Health Care” system
- Connects with the “LTSS” system
- Connects the two
- Keeps the individual safe and at home
Summary

- A common connection between diverse service providers across the ecosystem
- Standardized process and data
- Agnostic
- Useful both within and between sites of care
- A connection to patients and families
- Steadily expanding
Appendix
LCC Scope Statement

• To define the necessary requirements that will drive the identification and harmonization of standards that will support and advance patient-centric interoperable health information exchange, including care plan exchange, for medically complex and/or functionally impaired individuals across multiple settings.
It’s not about data standards...

...it’s about aging and thriving in place
Collaborated with the Keystone Beacon Community, HL7, and Lantana to develop and ballot the [HL7 Implementation Guide for CDA® Release 2: Long-Term Post-Acute Care Summary, DSTU Release 1 (US Realm)](http://hl7.org) to support the interoperable exchange of summary MDS and OASIS content across Nursing Homes and Home Health Agencies.
LTPAC Transitions SWG (cont’d)

• In collaboration with the Longitudinal Care Plan SWG, and working with public and private partners in the development and balloting of the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use, Release 2 (Sept 2013) which provides new templates and requirements for the HL7 C- CDA standard for the exchange of data elements for:
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## Care Plan Glossary

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Transfer Summary

- Patient

Physical Exam

- Pressure Ulcer Stage
- # of Pressure Ulcers

Plan of Treatment

- Instructions
- Procedures
- Nutrition Recommendations
Consult Note

• Patient

Physical Exam

• Pressure Ulcer Stage
• # of Pressure Ulcers

Plan of Treatment

• Instructions
• Procedures
• Nutrition Recommendations
Consult Note
• Patient

Nutrition
• Nutrition Assessment

Plan of Treatment
• Instructions
• Procedures
• Nutrition Recommendations