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

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  - 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.

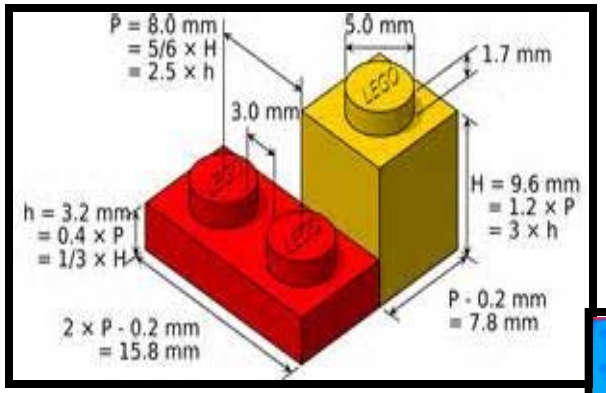
Rate Limiting Step

- 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

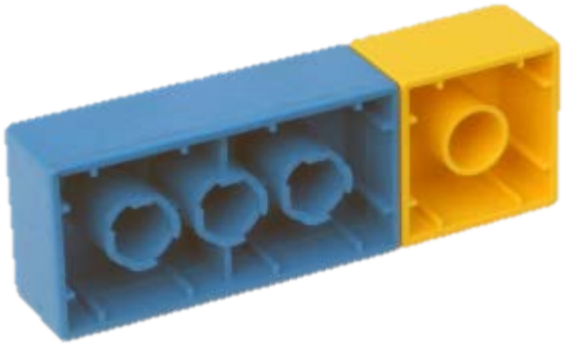
What is a CDA anyway?

- **C**linical **D**ocument **A**rchitecture
- 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

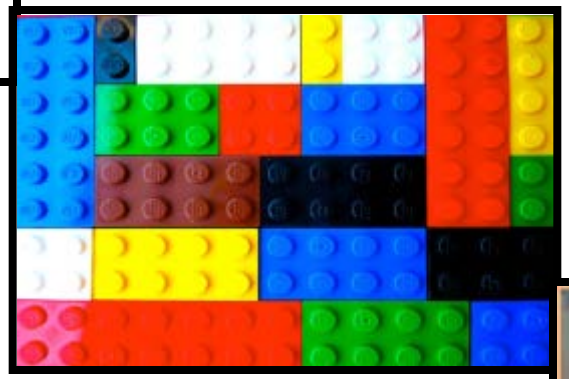
Just like Legos®



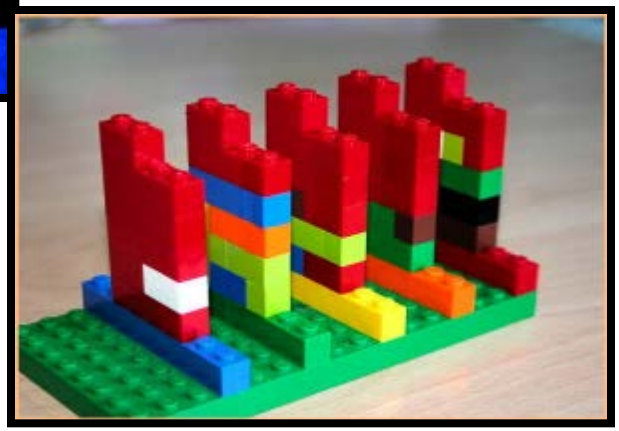
Standardized Containers



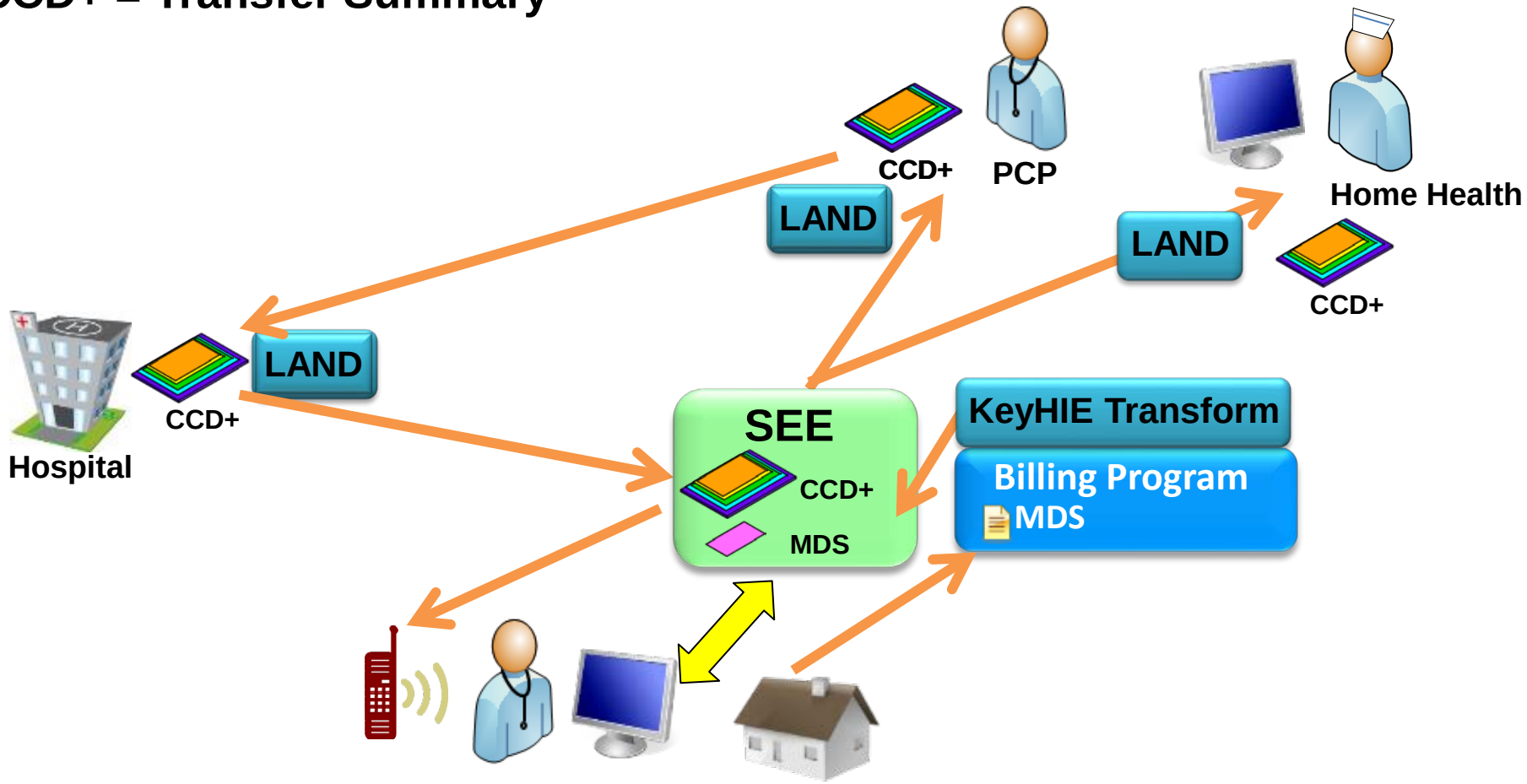
Wide Variety



Reusable



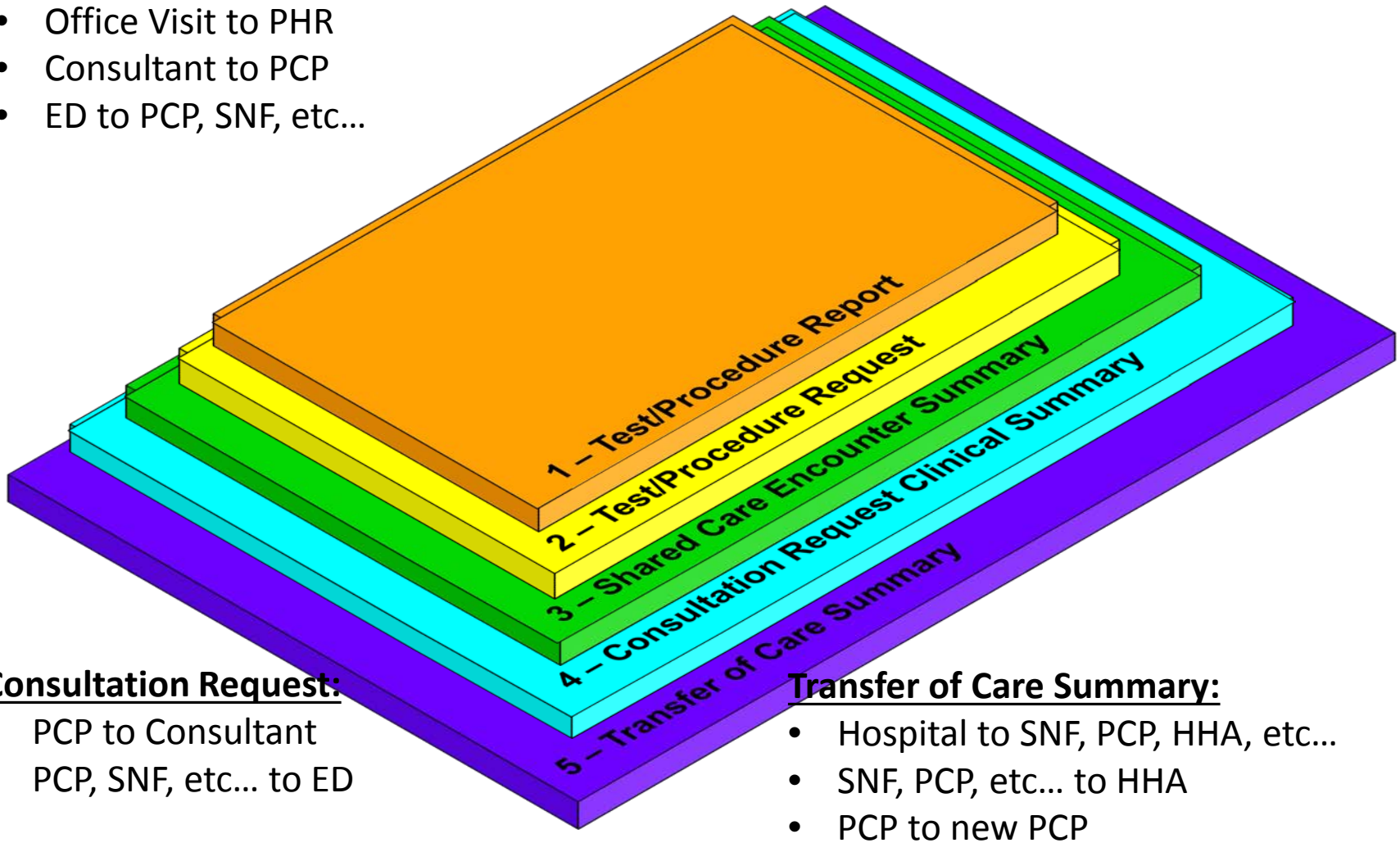
CCD+ = Transfer Summary



Five Transition Datasets

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

Home Health Plan of Care

Care Plan

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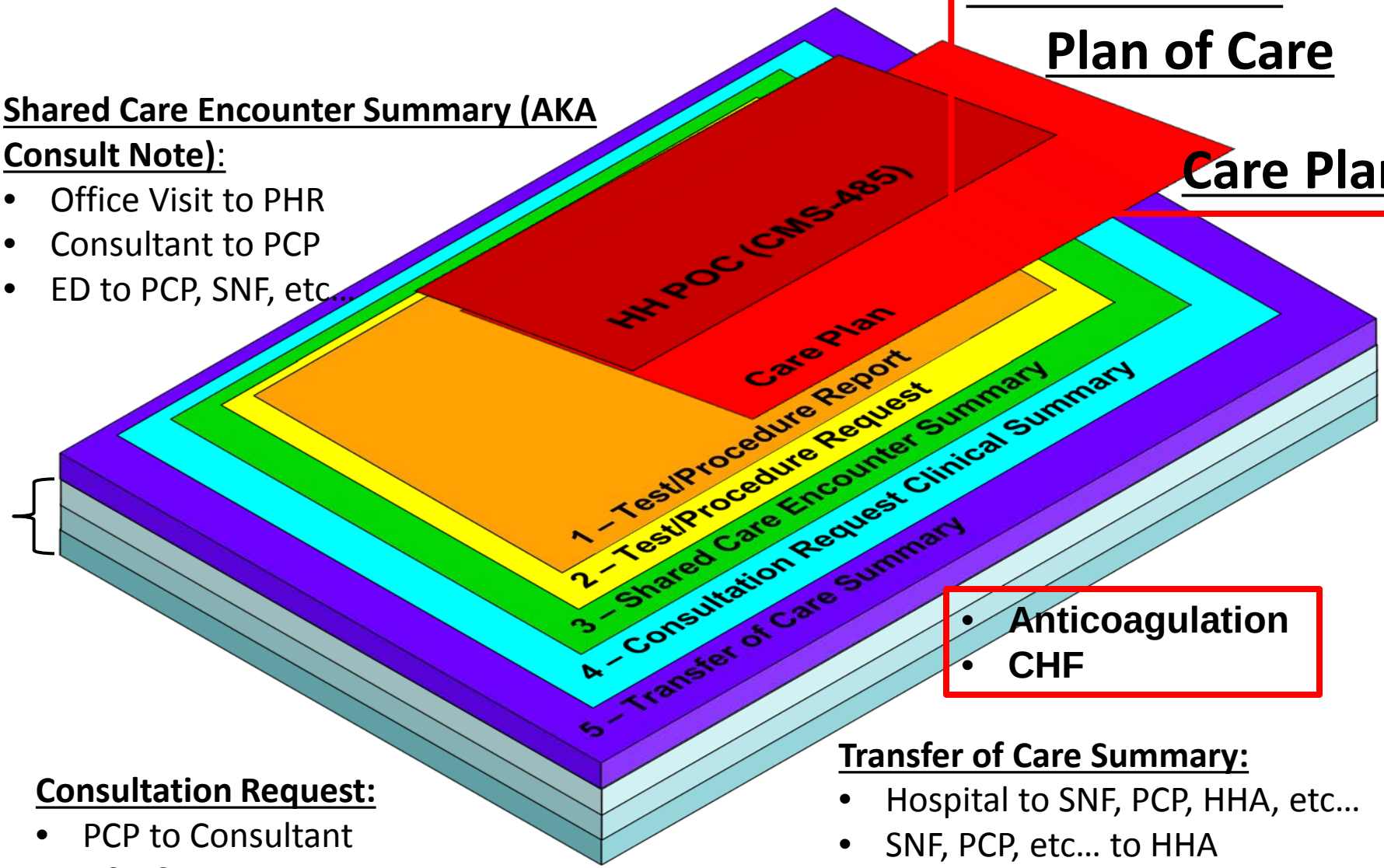

- **Anticoagulation**
- **CHF**

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Transfer of Care Summary:

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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) 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:

  – consult note, summary note, transfer note and care plan/home health plan of care

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Care Plan Glossary

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.

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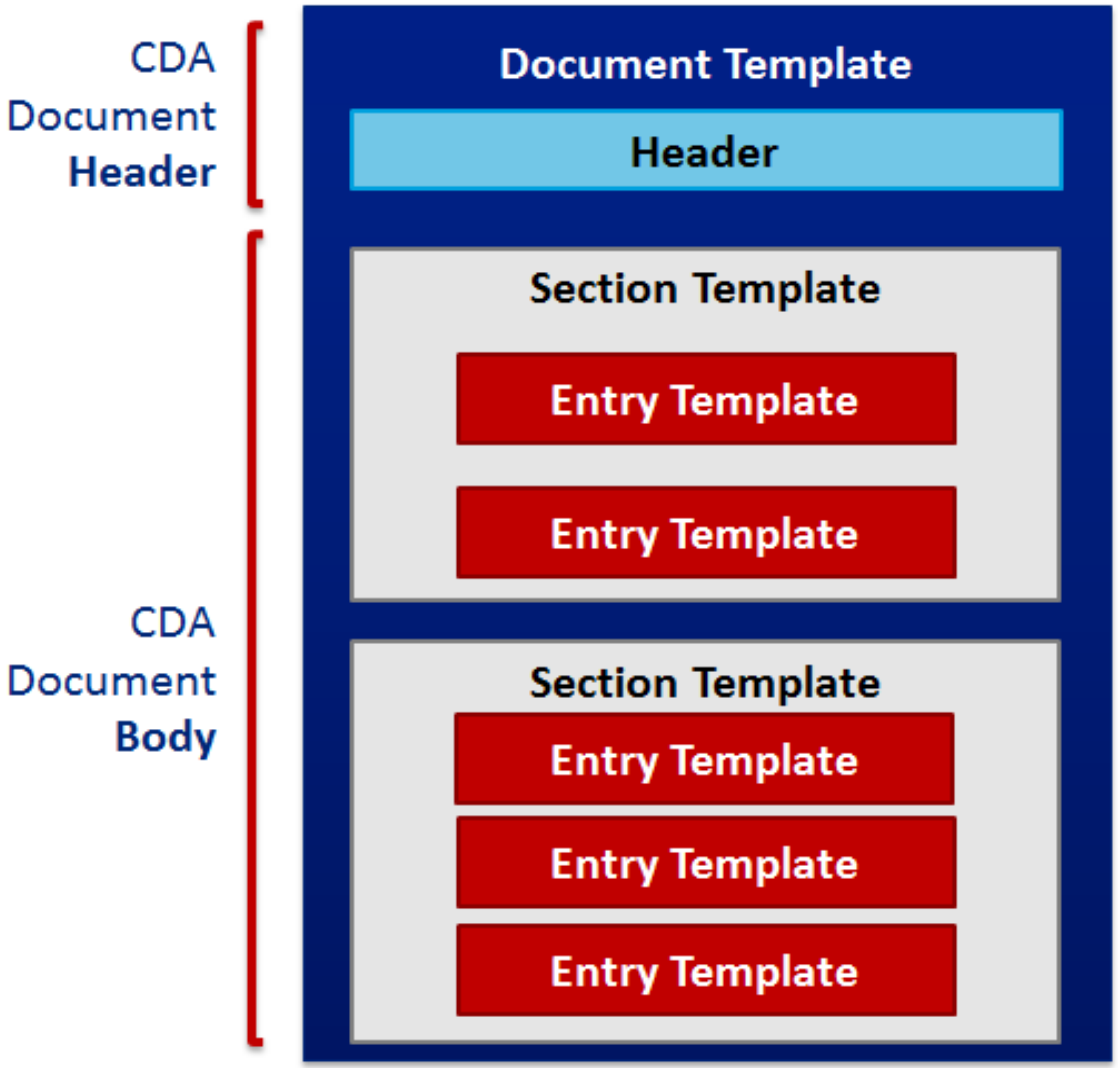


Transfer Summary

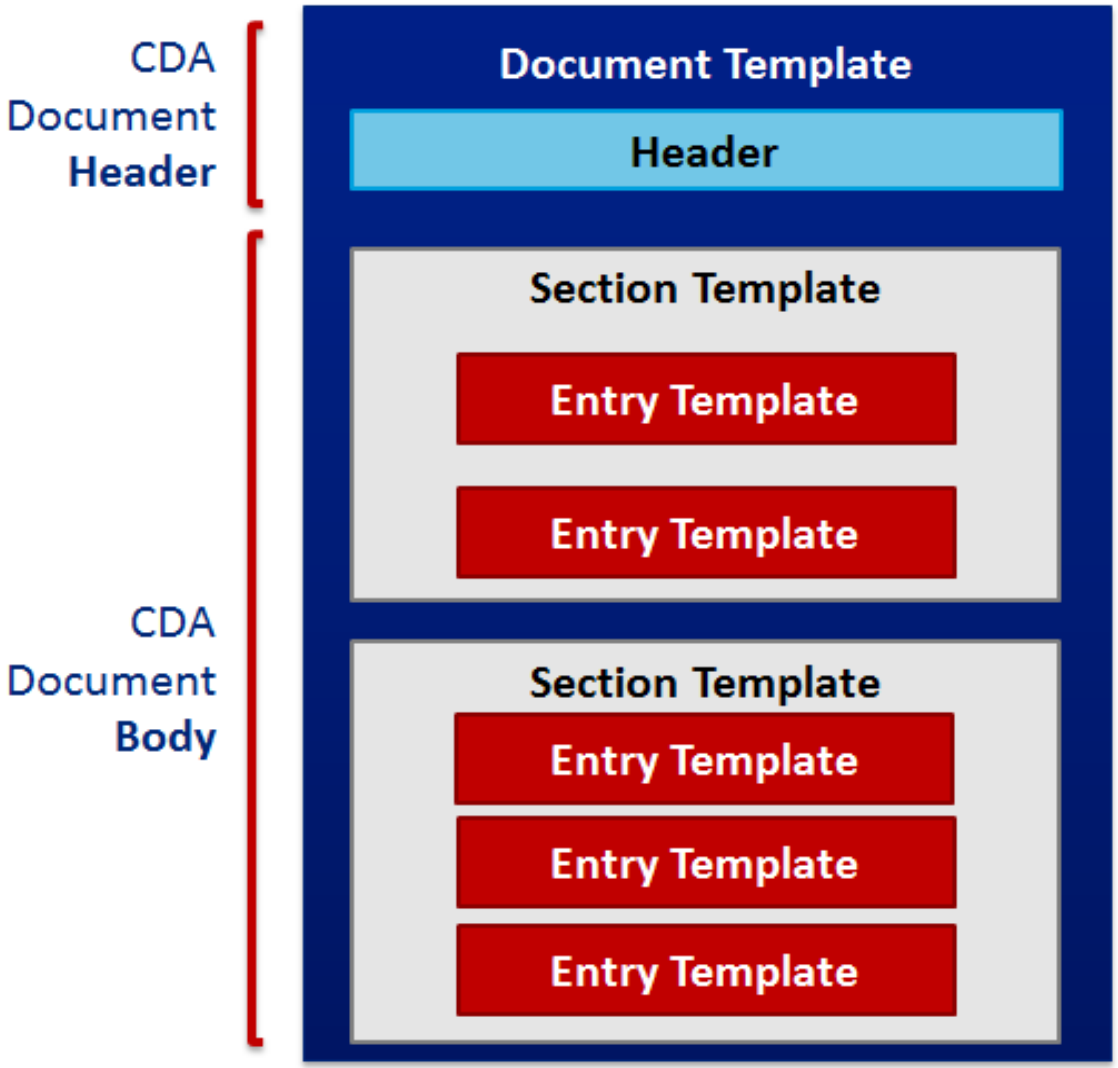
- Patient

Physical Exam

- Pressure Ulcer Stage
- # of Pressure Ulcers

Plan of Treatment

- Instructions
- Procedures
- Nutrition Recommendations



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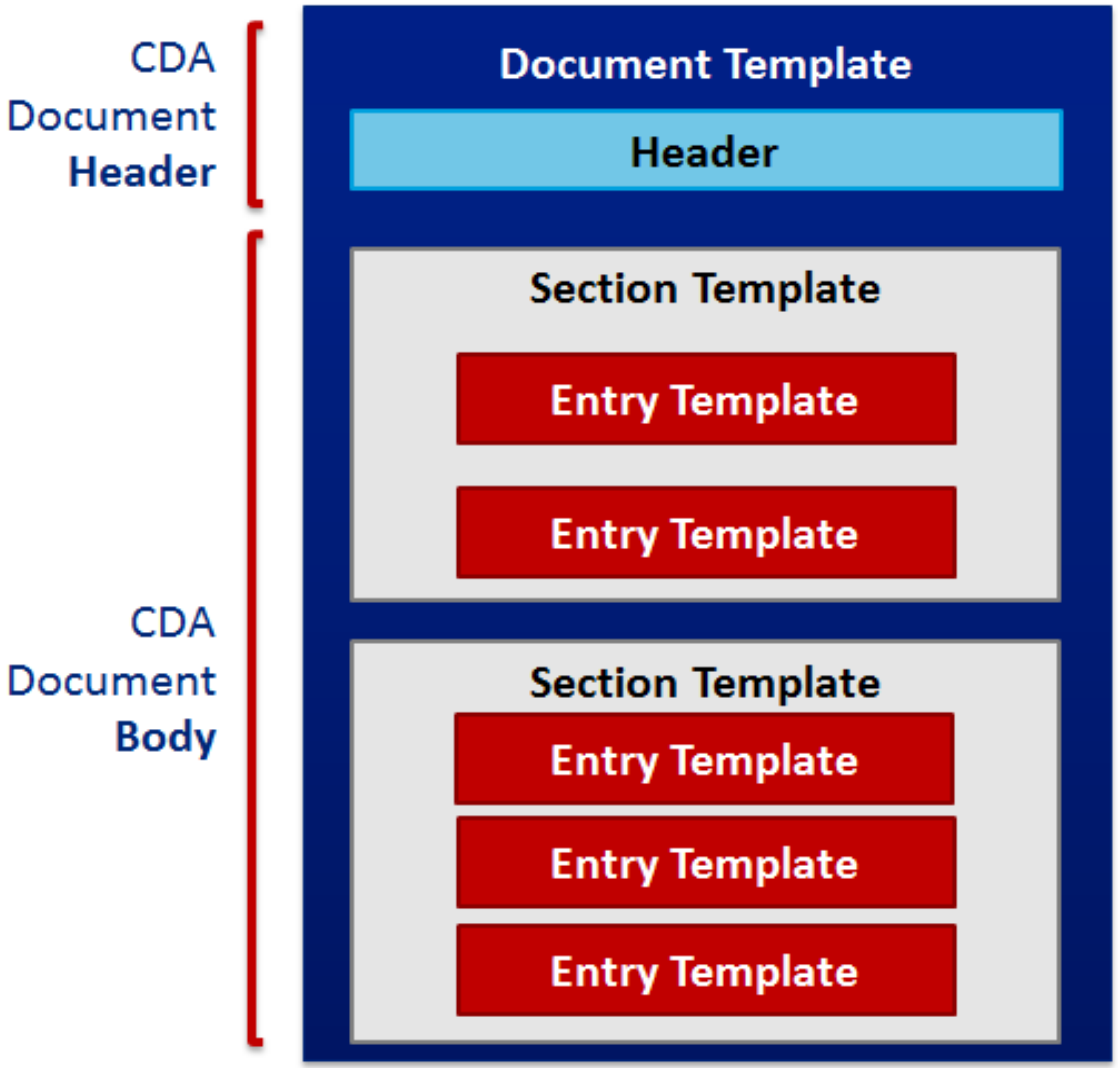

Consult Note

- Patient

Nutrition

- Nutrition Assessment

Plan of Treatment

- Instructions
- Procedures
- Nutrition Recommendations