NQF HIT Critical Paths: Care Coordination

Webinar
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NATIONAL QUALITY FORUM

Speakers

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- **Lipika Samal, MD MPH**
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- **Rosemary Kennedy, PhD RN MBA FAAN**
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Webinar Objectives

- Provide an overview of the Critical Paths: Care Coordination project
- Review the work of the Technical Expert Panel (TEP) to define the requirements for measurement
- Discuss the results from an environmental scan
- Introduce the TEP's recommendations
- Discuss the public comment process for this draft report

http://www.qualityforum.org/HIT/Critical_Paths/Care_Coordination.aspx

Critical Paths:

Project Overview

Critical Paths: Care Coordination Background

- **Scope**
  - Focused on transitions of care and quality measurement using the plan of care
- **Goals:**
  - Assess the readiness of electronic data to support acute care quality reporting of transitions of care using the plan of care
  - Recommend actionable steps to address gaps and barriers
- **Future State:** Enable the use of care plan data communicated during transitions of care for quality measurement

Critical Paths: Care Coordination Project Approach

- **Technical Expert Panel**
  - To define requirements for measurement and evaluation of readiness for measurement.
- **Environmental Analysis**
  - To develop a baseline understanding of the use of health IT to support transitions of care and quality measurement
- **Report**
  - Includes recommendations to advance the ability of existing health IT infrastructure to support quality reporting of care planning during transitions of care
  - Public Comment
  - Webinar

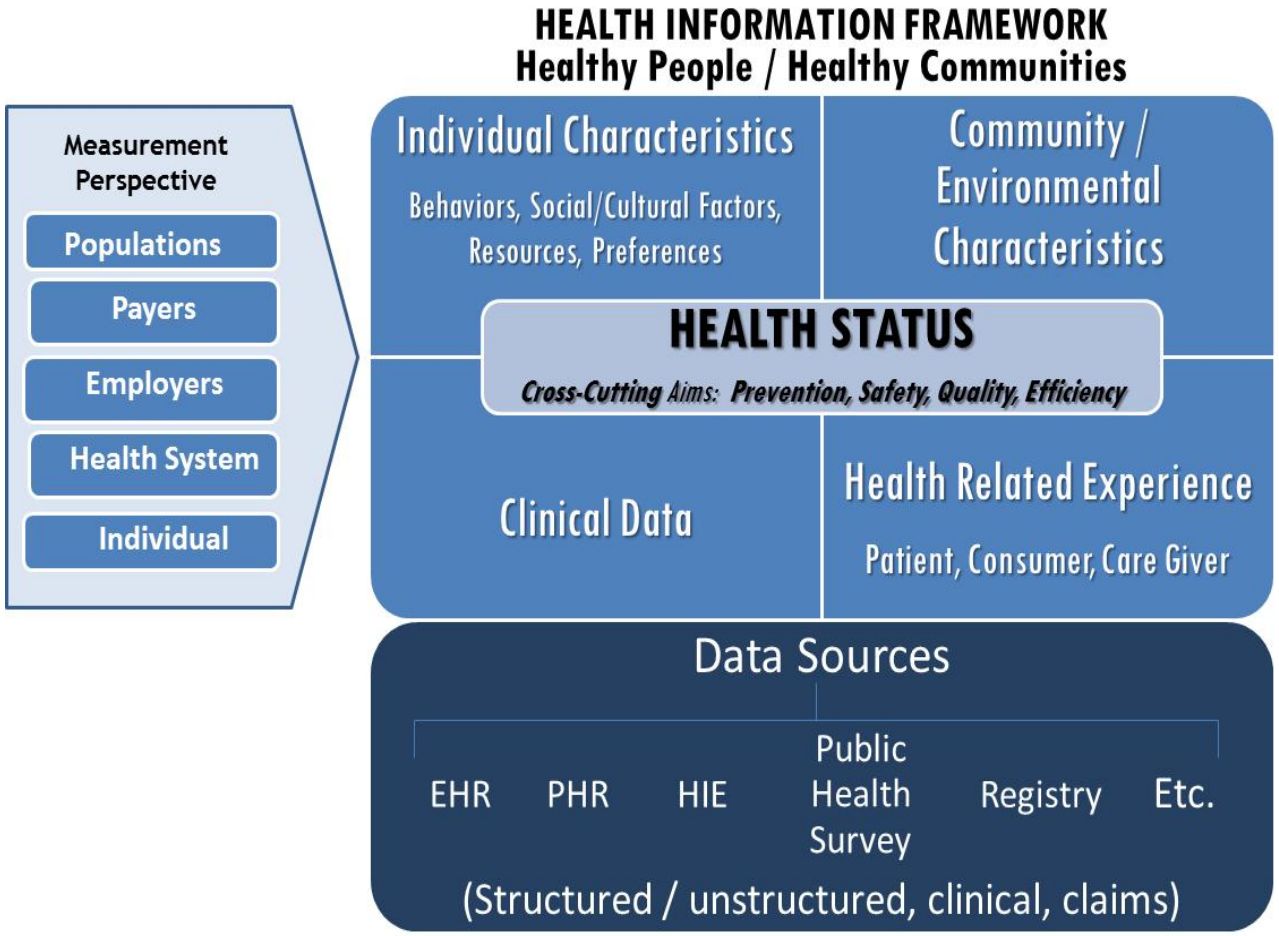
HHS' National Quality Strategy
Aims and Priorities

Better Care

Healthy People/ Healthy Communities

Affordable Care

Health Information Technology Framework



Care Coordination Technical Expert Panel Member Roster

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Patricia Button, EdD, RN
Chief Nursing Officer, Zynx Health Incorporated, Los Angeles CA

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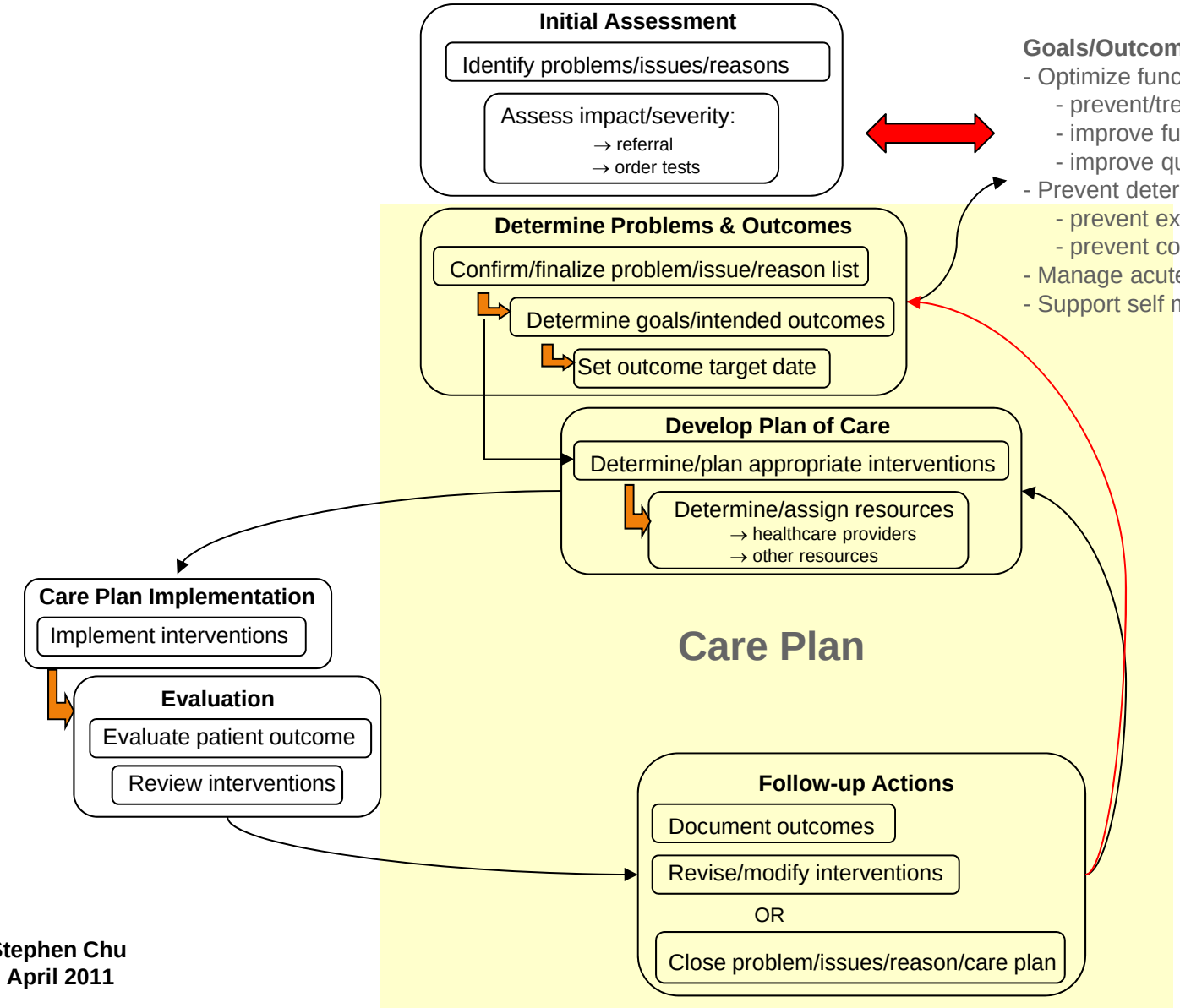
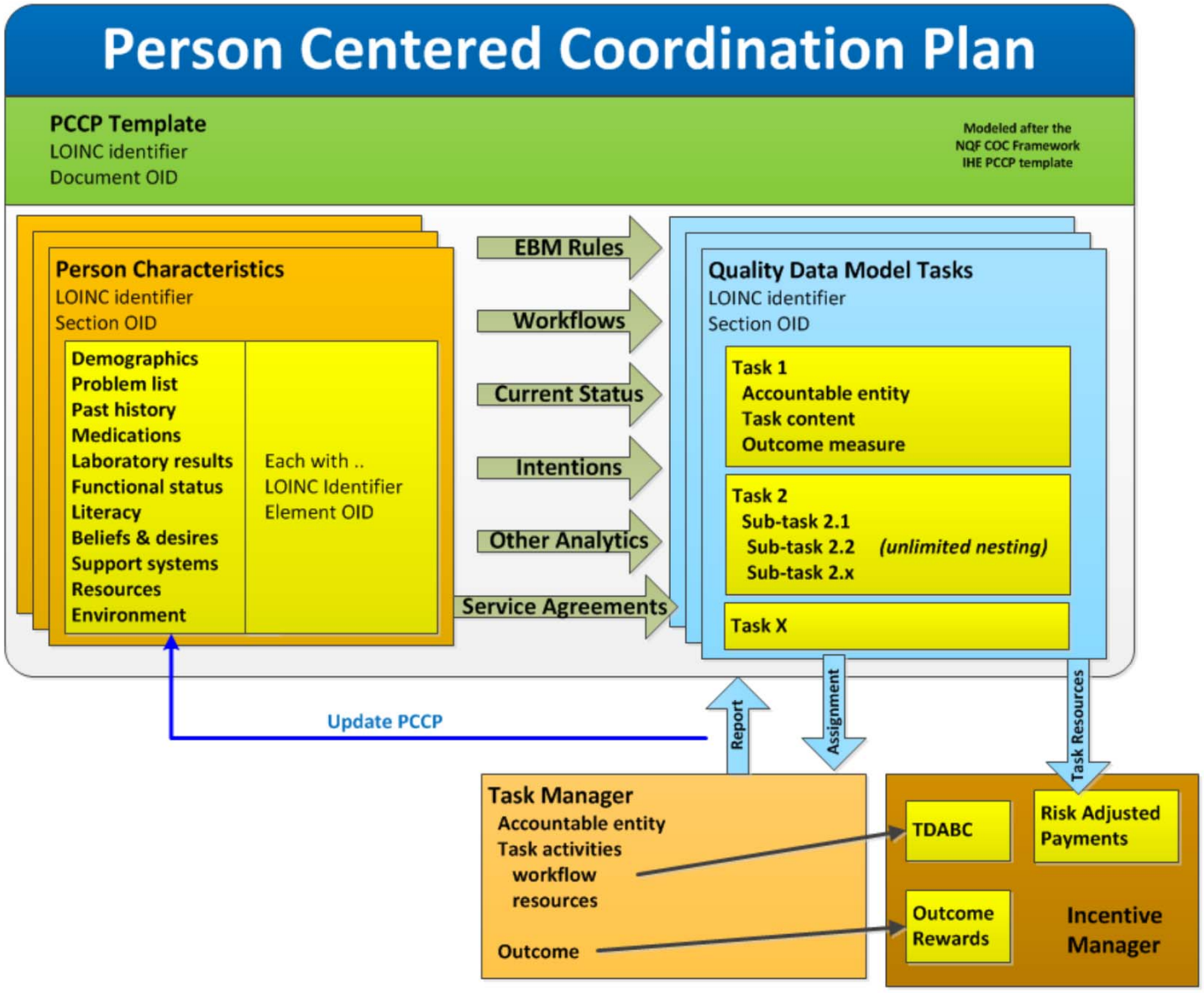
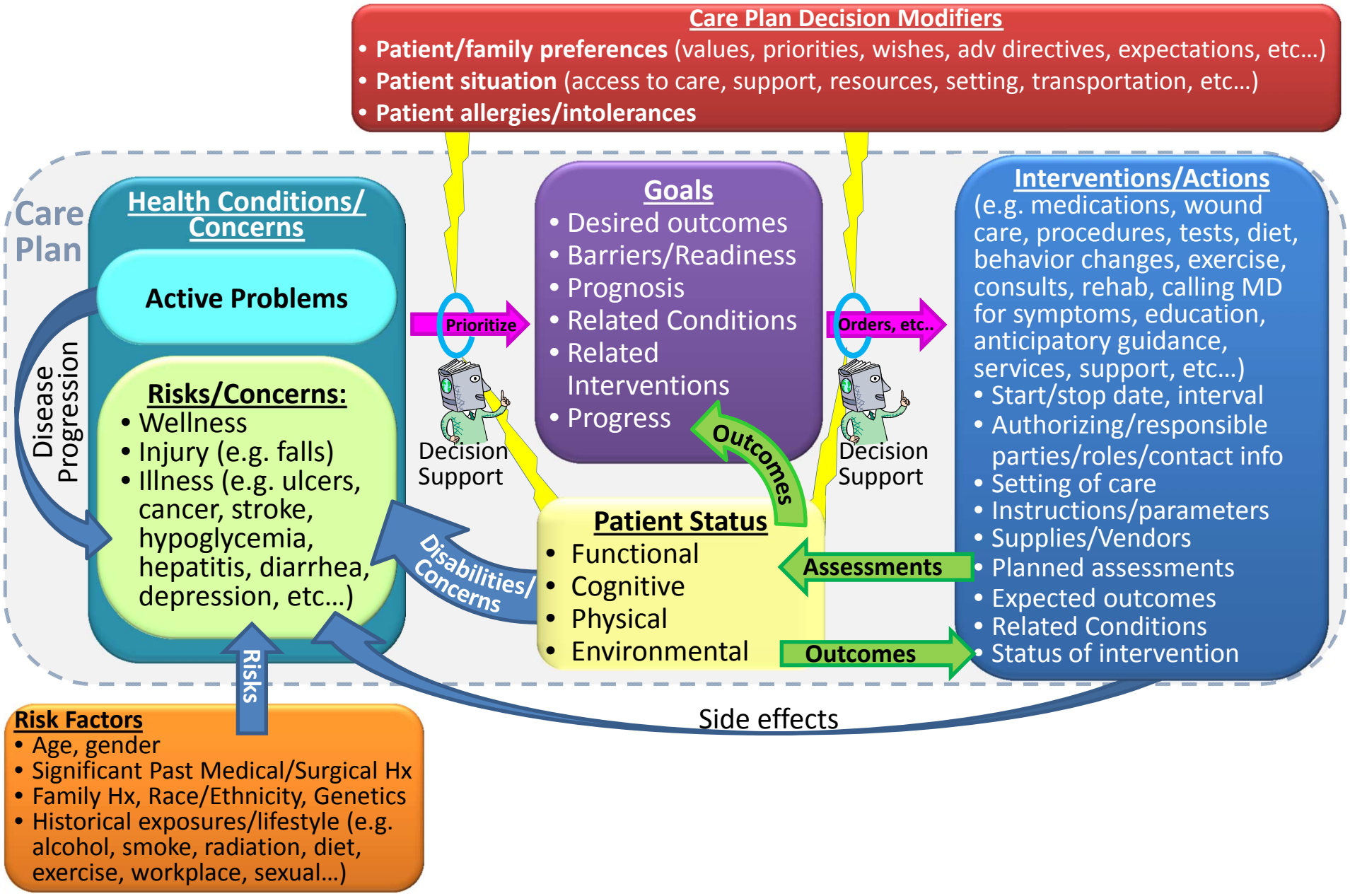
Technical Expert Panel Work to Define Data and Functional Requirements

Care Plan – High Level Processes

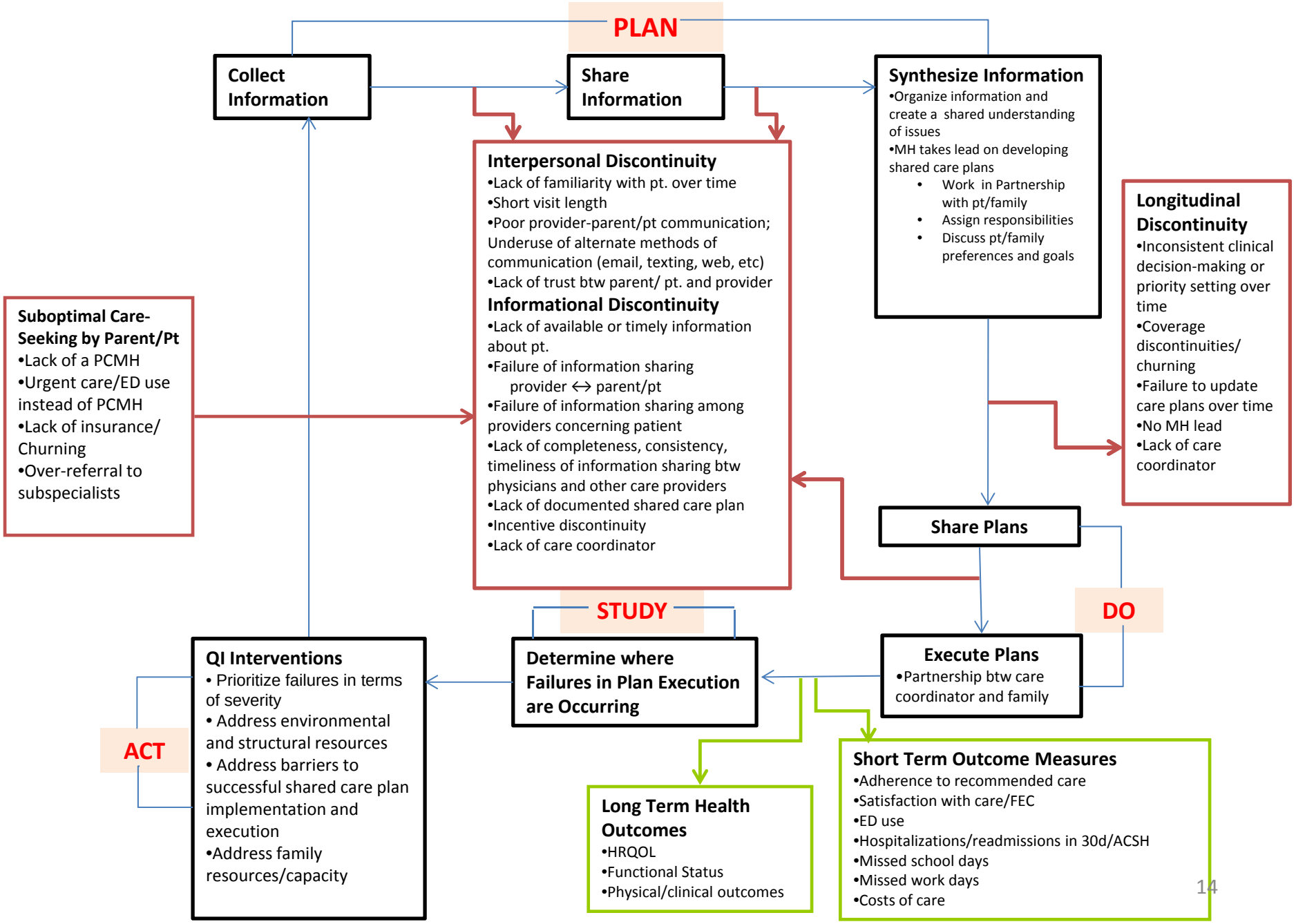


Stephen Chu
5 April 2011


Person Centered Coordination Plan
PCCP Template
LOINC identifier
Document OID
Modeled after the
NQF COC Framework
IHE PCCP template
Person Characteristics
LOINC identifier
Section OID
Demographics
Problem list
Past history
Medications
Laboratory results
Functional status
Literacy
Beliefs & desires
Support systems
Resources
Environment
Each with ..
LOINC Identifier
Element OID
EBM Rules
Workflows
Current Status
Intentions
Other Analytics
Service Agreements
Quality Data Model Tasks
LOINC identifier
Section OID
Task 1
Accountable entity
Task content
Outcome measure
Task 2
Sub-task 2.1
Sub-task 2.2
(unlimited nesting)
Sub-task 2.x
Task X
Update PCCP
Report
Assignment
Task Resources
Task Manager
Accountable entity
Task activities
workflow
resources
Outcome
TDABC
Risk Adjusted Payments
Outcome Rewards
Incentive Manager

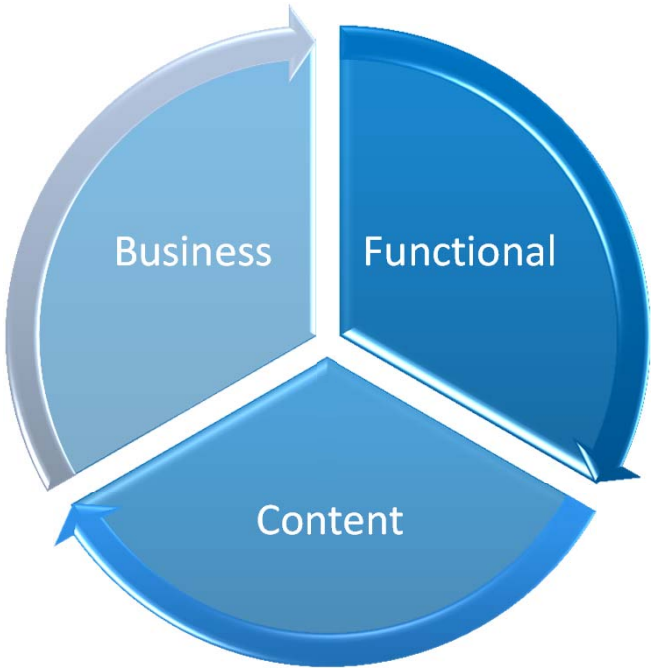

Care Plan Decision Modifiers
• Patient/family preferences (values, priorities, wishes, adv directives, expectations, etc…)
• Patient situation (access to care, support, resources, setting, transportation, etc…)
• Patient allergies/intolerances
Care Plan
Health Conditions/ Concerns
Active Problems
Risks/Concerns:
• Wellness
• Injury (e.g. falls)
• Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc…)
Disease Progression
Prioritize
Decision Support
Goals
• Desired outcomes
• Barriers/Readiness
• Prognosis
• Related Conditions
• Related Interventions
• Progress
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
Patient Status
• Functional
• Cognitive
• Physical
• Environmental
Assessments
Outcomes
Disabilities/ Concerns
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…)

Conceptual Framework for Care Coordination/Fragmentation in the Context of the PCMH for Children with Complex Needs



Care Coordination TEP: Defining Requirements

Characteristics of a Care Plan



- ***Business*** factors include decisions by the organization, policies and procedures, and care coordination practices
- ***Function*** includes human factors that affect how the care plan is developed, used, and evaluated.
- ***Content*** includes those factors
  - *intrinsic* to the plan of care (diagnoses (condition/problem), interventions (orders/services), goals, and outcomes
  - *extrinsic* to the plan of care (environmental factors)

Characteristics of the Care Plan: Business

Business Characteristics

1. **One Patient-Centered Care Plan**
   - The care plan is a "single source of truth" with input from multiple parties
   - All parties need to know "who is doing what," and it will inform the best team mix.

2. **Belongs to the Patient (Consumer)**
   - There may be a steward who is ensuring that the care plan is executed upon in a timely and safe manner.
   - There is a need for a care coordinator who assumes ownership for updating the plan, with input from all the stakeholders.
   - Successful execution and management requires a single source of responsibility and accountability

Characteristics of Care Plan: Business

Business Characteristics *(continued)*

3. **Needs Structure and Processes (for Execution and Management)**
    - To ensure that all necessary care plan functions are performed across the care continuum
    - The care plan could be informed by service agreements between providers intended to guarantee access to and appropriateness of care.

Characteristics of Care Plan: Function

Function Characteristics

1. **There are multiple input sources, entered once and used many times**
    - Must be current, actionable, dynamic, and iterative with on-going data collection
    - Organized and user-friendly to achieve patient-centered goals
    - May require different views depending on the user role
2. **A key function of the care plan is to enhance the care process and outcomes**
    - Supports episodes of care while also healthcare for life
    - Supports alerting, tracking, and activity/task management
    - Requires clinical decision support

Characteristics of Care Plan: Function

Function Characteristics *(continued)*

6. **Interoperable**
    - Uses industry standards for content, decision support, and messaging between systems.
    - Must be interoperable with external knowledge sources, as well as other systems.

7. **Support Quality Measurement, Safety, and Research**
    - Data must be standardized to support care delivery, clinical decision support, quality measurement, and clinical effectiveness research

Characteristics of Care Plan: Content

Content

1. **The care plan contains core information:**
   - Diagnoses (conditions/problems),
   - Prognosis,
   - Orders (interventions/services),
   - Goals (expected outcomes) and
   - Actual outcomes.

2. **In addition, there are other data elements necessary for interpretation and management of the care plan**
   - Condition specific data elements
   - Contextually driven based on the patient, workflow, setting of care and other variables

Environmental Analysis

Environmental Analysis Conducted by Brigham and Women's Hospital

- **Objective:** to assess the readiness to transmit electronic data, to use HIT systems to perform the data capture, to standardize data, to communicate a patient-centered plan of care, and use data for quality measurement

- **Methodology**
  - Systematic literature review
  - Emailed survey, 6 phone interviews and 2 site visits
    - » Sites represented a diverse range of electronic capabilities and geographic regions
    - » Each site interview was able to provide information on 4 different types of healthcare facilities: ED, ACH, SNF, HHA

Literature Review

- 10 articles included for structured data extraction
- Studies of:
  - Electronic tools for information exchange across transitions
  - Electronic tools for discharge and post- discharge communication
  - Nurse practitioner case management programs

Environmental Analysis: Overview of Results

- Organizations are working to address care coordination demands, but are struggling with a patchwork of systems, few of which connect and exchange data.
- Many organizations are still working to transfer basic discharge summaries electronically between settings.
- Organizations are using multiple methods for communicating and extracting the data
- Comprehensive electronic methods tend to be discipline-specific and focused on high risk patients

Environmental Analysis: Electronic Tools for Care Coordination

- Many sites have electronic discharge summaries implemented in EHRs, but print or fax them to receiving organizations.
- When care team members can access the EHR from another setting, they extract data and then re-enter into their own systems.
- Phone, email, and fax are still common.
- None of the sites have direct electronic transfer of transition of care data elements data; they use view-only or paper-based methods.
- Several sites are developing tools to identify, track and manage high risk patients that require more intensive care coordination.

Environmental Analysis: Quality Measurement

1. Risk stratification
2. Failures of care coordination
3. Discharge and transition processes
4. Patient Surveys

Environmental Analysis: Future Vision

- Many sites described mixture of verbal and electronic communication solutions
- Electronic Longitudinal Plan of Care = a single, integrated plan that is comprehensive, patient-centered, and reflects patient's values and preferences
  - Barriers to realization of the Longitudinal Plan of Care
  - Uneven readiness for Meaningful Use (MU) Stage 2 criteria

Recommendations

Business Factors: Change Behaviors and Move the Paradigm Forward

- National incentives need to be aligned to change both individual and organizational behavior.
- The MU program is a powerful lever for changing the technical side through ONC certification and the behavioral side through CMS payment incentives.
  - MU Stage 2 addresses technical barriers related to data exchange and the movement towards common data sets.
- Incentives need to expand the scope of a hospital beyond its "walls" to look at how the organization interacts with its environment across the continuum.

Business Factors: Change Behaviors and Move the Paradigm Forward

- With greater adoption of the dynamic, longitudinal plan of care, CDS can play a greater role in the electronic environment.
- Existing CDS tools could support the creation of a dynamic plan of care that displays the most relevant data based on patient-specific characteristics and setting of care.
- CDS includes not only the point of care CDS, but also aggregate analytical tools, which require a robust terminology infrastructure.
- Increased sophistication around data element "attributes" is needed in the CDS system to assign, order, and refer interventions and tasks.

Function: Realizing the Potential of Health IT Tools

- Innovative health information systems and applications are needed that can support care plans across organizations.
- A broad array of health IT can be used that extend beyond the EHR:
  - A plan of care also includes information found in case management systems, home care systems, and financial applications

Function: Realizing the Potential of Health IT Tools

- Data infrastructure can serve as a precursor for automated electronic functional support.
- Use of the Consolidated CDA standard can lead to greater data interoperability, as well as meeting certification criteria and MU objectives.
- Incremental movement is needed from the current state to the end goal: standardization of dynamic longitudinal plans of care that incorporate systems for measuring and improving quality.

Content: Data and Interoperability Standards

- The main data elements (diagnosis, procedure, care goal, outcome) alone are *not* sufficient for either care delivery or quality measurement.
  - Additional data elements include assessment findings, environmental factors, and patient preferences.
- Although MU2 will enhance documentation of common data elements, proposed MU3 measures have an expanded data element list.
  - The common MU data set lacks the necessary granularity for patient-centered, longitudinal care plans.

Content: Data and Interoperability Standards: Minimum "Starter Set"

1. Demographics (name, address, sex, DOB, race, ethnicity, preferred language)
2. Advanced directives
3. Patient preferences
4. Medical equipment
5. Insurance/payers
6. Practice identifier
7. Prior and future encounters (episodes of care)
8. Care team
   a. Roles
   b. Responsibilities
   c. Key owner for the plan of care
   d. Primary contact
   e. Additional contacts
9. Support
10. Special alerts/ heads up
11. Adverse events / unintended events
12. Shared agreement
13. Problems/conditions, Orders/Services/ Interventions, Goals (expected outcomes)
14. Past history
15. Watchful waiting
16. Certification and Certification period for the clinical team
17. Environmental factors
    a. Exposures in environment
18. Observations
    a. Assessment / physical findings / measurement instruments
    b. Actual outcomes
    c. What worked / what didn't work?
19. Results
    a. Allergies
    b. Smoking status
    c. Labs
    d. Diagnostic results
    e. Vital signs
20. Precautions
21. Orders/Services/Interventions
22. Medications (see above categories)

Areas of Future Exploration for Data Elements Related to Electronic Quality Measurement

- Methods for modeling and tracking care plan responsible parties, their roles, and attribution
- Standardization of:
  - Patient, person, or caregiver instructions
  - Representation for encounters, episodes of care, and occurrences
  - Environmental factors
  - Medications
  - Patient reported outcomes and associated attributes
  - Alerts and pending tests

Care Coordination Draft Report
Public Comment Period

October 1, 2012 – October 30, 2012

http://www.qualityforum.org/HIT/Critical_Paths/Care_Coordination.aspx

Questions