Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 5

"Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations"

Index

Fifth In-Person Learning Session: Faculty Biographies

Terrence O'Malley, MD

Dr. Terrence O'Malley works at the intersection of long term care, quality measurement, and electronic health information exchange. He is an internist/geriatrician at Massachusetts General Hospital where he provides clinical care, supervises trainees and conducts research on improving transitions of care and the exchange of clinical information at transitions. At the national level he co-led the Long Term and Post-Acute Care (LTPAC) Transitions of Care and the Longitudinal Coordination of Care (LCC) work groups within the Office of the National Coordinator for Health Information Technology S&I Framework and currently he is the Community Lead on the Electronic Long Term Services and Supports work group (eLTSS) which is developing standards for the exchange of an LTSS care plan. Over the past ten years he has served on many technical expert panels to advise CMS on issues such as quality measures for post-acute care, readmission metrics, development and refinement of the CARE Tool, and establishing a standardized functional assessment tool for PAC. He is currently on the NQF Care Coordination Measure Endorsement Standing Committee, the federal Health Information Technology Policy Committee Advanced Care Models and Meaningful Use Work group, and newly appointed to the federal Health Information Technology Standards Committee representing post-acute care.

Integrated Communities Care Management Learning Collaborative
In-Person Learning Session 5
"Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations"
September 6, 2016 (Holiday Inn, Rutland, VT)
September 7, 2016 (State Office Complex, Waterbury, VT)

AGENDA

08:30 AM – 09:00 AM	Registration and light refreshments
09:00 AM – 09:15 AM	Welcome and opening remarks *Nancy Abernathey, Quality Improvement Facilitator*
09:15 AM – 10:00 AM	Community report out
10:00 AM – 12:15 PM	Where the person is in the system of care: identifying and prioritizing common transitions in care *Terrence O'Malley, MD, Internist and Geriatrician* *Massachusetts General Hospital*
12:15 PM – 01:00 PM	Networking lunch
01:00 PM – 02:00 PM	Determining information each team member needs during a transition of care *Terrence O'Malley, MD, Internist and Geriatrician* *Massachusetts General Hospital*
02:00 PM - 02:30 PM	Afternoon break and light refreshments
02:30 PM – 03:30 PM	Use of electronic tools to facilitate the "connected care community" *Terrence O'Malley, MD, Internist and Geriatrician* *Massachusetts General Hospital*
03:30 PM – 03:50 PM	Shared learning: Communities outline their next steps
03:50 PM – 04:00 PM	Closing remarks and celebration

Keeping the Shared Plan of Care Alive Under Dynamic and Challenging Situations

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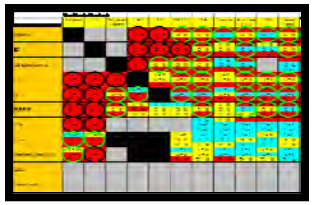
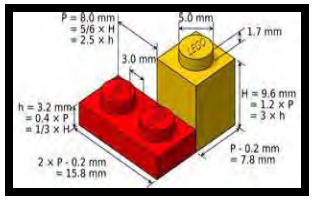
Building a Plan of Care from Bottom Up

- Transitions: the glue that connects us
- Identify and Prioritize Common Transitions in Care
- Determine what each team member needs during a transition of care
- Electronic Tools to Facilitate the "Connected Care Community"





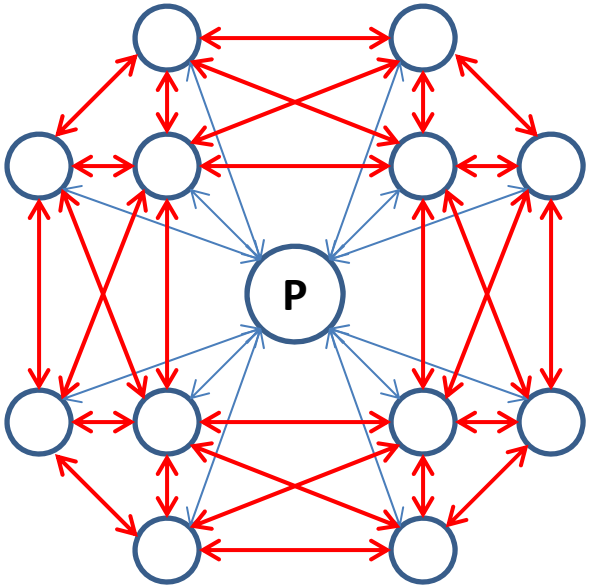
How Care is Delivered

P The Person

Service Provider

Service Connection

Transition



1. Who's on the Team?
2. Who connects with the individual?
3. Which team members need information from another service provider?

Specify the data needed for this transition

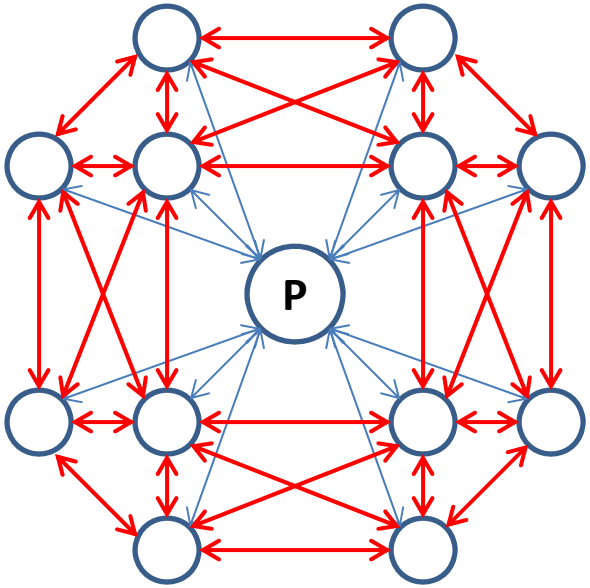
How a Plan of Care Works

P The Plan of Care

Service Provider

Data Connection

Transition
(Information Exchange)



1. Who's on the Team?
2. Who connects with the Care Plan?
3. What information is outbound?
4. What information is inbound?
5. How can we make this information more valuable?

1. Identifying and Prioritizing Common Transitions in Care

Content of this segment

- The relationship between transitions and a Shared Plan of Care
- What's in a shared plan of care?
- What's needed to revise a plan?
- What's needed to share a plan?
- We'll start here
  - Build a transitions grid
  - Prioritize transitions

Transitions of Care

- The exchange of information between two sites, teams or service providers to share the responsibility for care
- They are snapshots at a point in time
- They are “connections” that hold the system together because this is how the parts of the system talk to each other
- The completeness of the information exchanged determines the effectiveness of the transition

Transitions: Basic Content

- Each transition provides the “receiver” with all of the information needed to continue safe and effective care
  - What is being asked of the receiver
  - Goals and priorities of the individual
  - Current active issues
  - Plan for continued management
  - Anticipated outcomes
  - Responsibility for reaching those outcomes
  - Heads-up regarding potential issues
- The individual may or may not move

Shared Plan of Care is Different

- Built from information exchanged during multiple care transitions
- Instead of “point to point” like a transition, the shared plan of care applies to every part of the system. The blueprint of care
- It’s the “movie” made up of all the “snapshots”
- Complex, dynamic, frequently changing

What's in a Shared Plan of Care?

- Comprehensive list of issues
- Prioritized by the individual
- Team roster
- Interventions
- Outcomes assigned to team member
- Plans are unique to each individual but share common components
- Where does the team stop?

What's Needed to Revise a Plan?

- A plan "steward": the Lead Care Coordinator
  - Works with the individual to prioritize issues, interventions and outcomes
  - Reconciles changes in priorities based on outcomes
  - Communicates revisions to the team
  - Maintains current version of plan
- This is important "new" work

What's Needed to Share a Plan?

- Mutually understood and agreed upon vocabulary
- Agreed upon content
- Agreed upon format for the plan
- Agreed upon means for exchanging information
- One source of truth

Before Making the Movie, Frame the Snapshots

- We’re not going to make a shared plan of care today, sorry no movie
- Instead we’re going to look at one transition as the model for all of the snapshots needed to make the movie
- When you think about what to include in the transitions data, think about the movie you want to create
- Think about what is needed in the plan of care

Team Exercise 1: Build a Grid

- Select a high risk population of your choice (e.g. TBI, developmental delay, chronic severe mental illness, homeless)
- Identify the issues common to this population
- Identify the team members needed to address those issues
- Build a grid
- Take a break

Issues Common to These Populations

- Medical
- Behavioral
- Function
- Environmental
- Criminal justice
- Legal
- Educational
- Employment

Who's on the Team?

- Police/Emergency response
- ED
- In patient
- PCP
- Behavioral health providers
- Therapists
- Family supports
- Legal aid
- Medicaid/Payers
- Housing agency
- Transportation
- Home modification
- Respite
- Benefits coordinator
- Vocational education
- Others

Example: Sender-Receiver Grid

	Individual/ Family	Police/EMR	Employment	Housing	Transport	ED	Behavioral health	PCP	Legal aid	Medicaid/ Payers	Family supports	Home modification	Respite	In patient	Therapy	Other	Other
Individual/Family																	
Police/EMR																	
Employment																	
Housing																	
Transport																	
ED																	
Behavioral health																	
PCP																	
Legal aid																	
Medicaid/Payers																	
Family supports																	
Home modification																	
Respite																	
In patient																	
Therapy																	
Other																	
Other																	

Break 1

Team Exercise 2: Prioritization

- How do you know that one transition is more important than another? On what basis will you prioritize them?
  - Frequency
  - Urgency of exchange
  - Content (likely value to others, ease of collection)
  - Barriers (HIPPA, 42 CFR, privacy, security)
  - Others
- Select the top three parameters to use for prioritization

Team Exercise 2: Prioritization cont.

- Go through grid quickly, one square at a time
- For each parameter indicate whether the score is High, Medium or Low (H-M-L)
- Fill in the grid
- Example: one transition might be High volume, Low urgency, and of Medium value to others. That cell would have a score of H L M
- Then go back and mark the transitions
  - H green circle for those with two H's
  - Black circle for those with three H's
- Have lunch

11x11 Sender (left column) to Receiver (top)

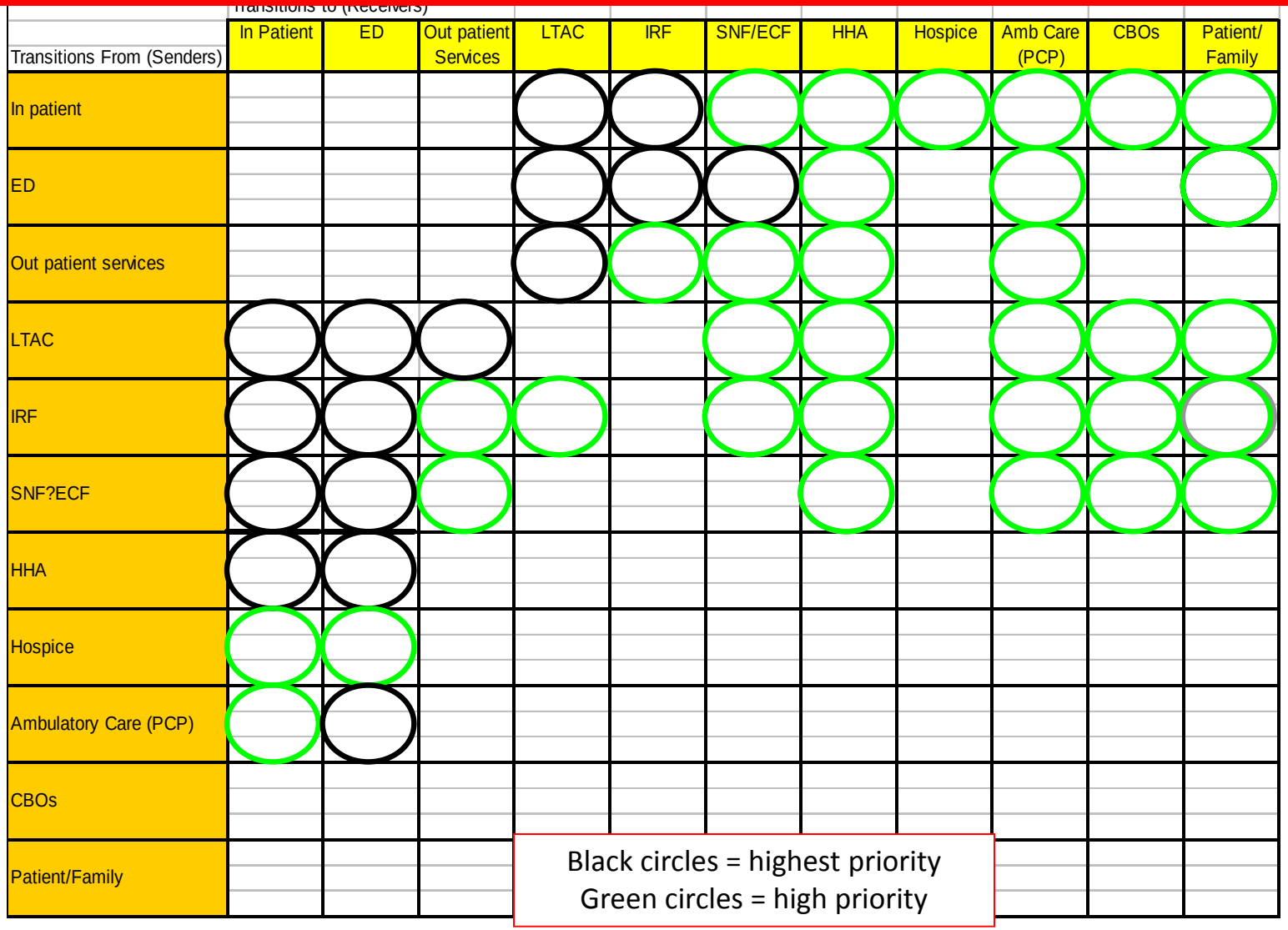
	Transitions to (Receivers)										
Transitions From (Senders)	In Patient	ED	Out patient Services	LTAC	IRF	SNF/ECF	HHA	Hospice	Amb Care (PCP)	CBOs	Patient/ Family
In patient											
ED											
Out patient services											
LTAC											
IRF											
SNF/ECF											
HHA											
Hospice											
Ambulatory Care (PCP)											
CBOs											
Patient/Family											

Prioritized Transitions by Volume (V), Clinical Instability (CI) and Time-Value of Information (TV)

Transitions From (Senders) \ Transitions to (Receivers)	In Patient	ED	Out patient Services	LTAC	IRF	SNF/ECF	HHA	Hospice	Amb Care (PCP)	CBOs	Patient/ Family
In patient				V = H CI = H TV = H	V = H CI = H TV = H	V = H CI = M TV = H	V = H CI = M TV = H	V = H CI = L TV = H	V = H CI = M TV = H	V = H CI = L TV = H	V = H CI = M TV = H
ED				V = H CI = H TV = H	V = H CI = H TV = H	V = H CI = H TV = H	V = H CI = M TV = H	V = M CI = M TV = H	V = H CI = L TV = H	V = M CI = L TV = H	V = H CI = M TV = H
Out patient services				V = H CI = H TV = H	V = H CI = M TV = H	V = H CI = M TV = H	V = H CI = M TV = H	V = L CI = L TV = H	V = H CI = L TV = H		V = H CI = L TV = L
LTAC	V = H CI = H TV = H	V = H CI = H TV = H	V = H CI = H TV = H		V = M CI = M TV = H	V = H CI = M TV = H	V = H CI = M TV = H	V = M CI = M TV = H	V = H CI = M TV = H	V = H CI = M TV = H	V = H CI = M TV = H
IRF	V = H CI = H TV = H	V = H CI = H TV = H	V = H CI = M TV = H	V = L CI = H TV = H		V = H CI = L TV = H	V = H CI = L TV = H	V = L CI = M TV = H	V = H CI = L TV = H	V = H CI = L TV = H	V = H CI = L TV = H
SNF/ECF	V = H CI = H TV = H	V = H CI = H TV = H	V = H CI = M TV = H	V = M CI = H TV = M	V = L CI = M TV = M	V = L CI = M TV = M	V = H CI = M TV = H	V = M CI = M TV = M	V = H CI = L TV = M	V = H CI = M TV = H	V = H CI = L TV = H
HHA	V = H CI = H TV = H	V = H CI = H TV = H					V = L CI = L TV = L	V = M CI = L TV = L	V = H CI = L TV = L	V = H CI = L TV = L	V = H CI = L TV = L
Hospice	V = L CI = H TV = H	V = M CI = H TV = H				V = M CI = M TV = M	V = L CI = L TV = M	V = L CI = L TV = M	V = L CI = M TV = L	V = M CI = L TV = L	V = L CI = M TV = M
Ambulatory Care (PCP)	V = M CI = H TV = H	V = H CI = H TV = H				V = L CI = M TV = H	V = M CI = M TV = M	V = L CI = L TV = H	V = L CI = L TV = M	V = M CI = L TV = M	V = L CI = L TV = L
CBOs											
Patient/Family											

Black circles = highest priority
Green circles = high priority

Prioritizing Transitions by Volume, Clinical Instability and Time-Value of Information

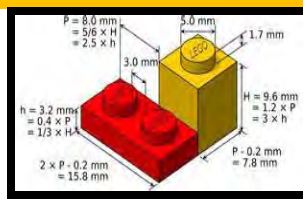


Once You've Built Your Grid

- Select your three highest priority transitions
- Turn them in before lunch
- After lunch two volunteers and I will focus on one or two transitions selected by the majority of teams and identify the data elements required by the receivers
- Then each team will repeat the exercise

Lunch

2. Determining information each team member needs during a transition of care



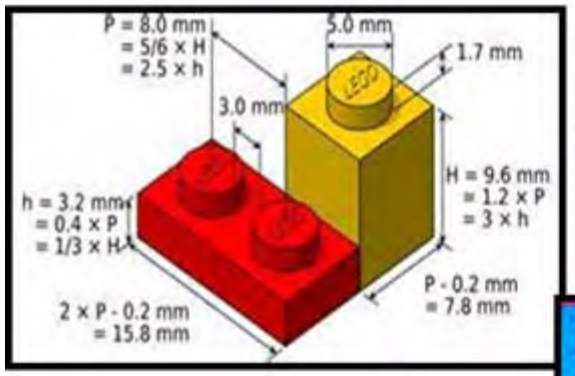
Content of this segment

- Some context: LEGOs and standardized, interoperable data elements
- Analysis of one high priority transition
  - Who are the receivers, what role groups are involved
  - What are the exchanges before, during and after the transition
  - What are the discrete data elements in each exchange
  - Use the Plan of Care examples for possible content
- In the future, select these data elements from national data sets

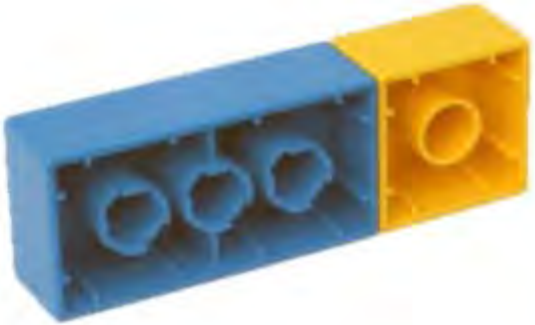
Standardized and Interoperable

- Standardized data elements mean the same thing to everyone that uses them and are collected in the way by everyone
- Data elements are interoperable when they can be exchanged and used without special effort on the part of the user
- Applies specifically to electronic exchange but have value as well when exchanged on paper
- Exchanged electronically in a standardized format called a Consolidated CDA document

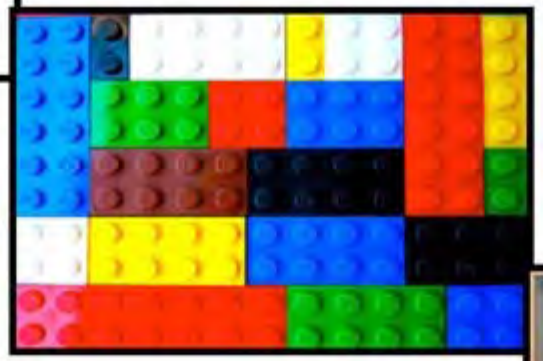
Just Like Legos



Standardized Containers



Wide Variety



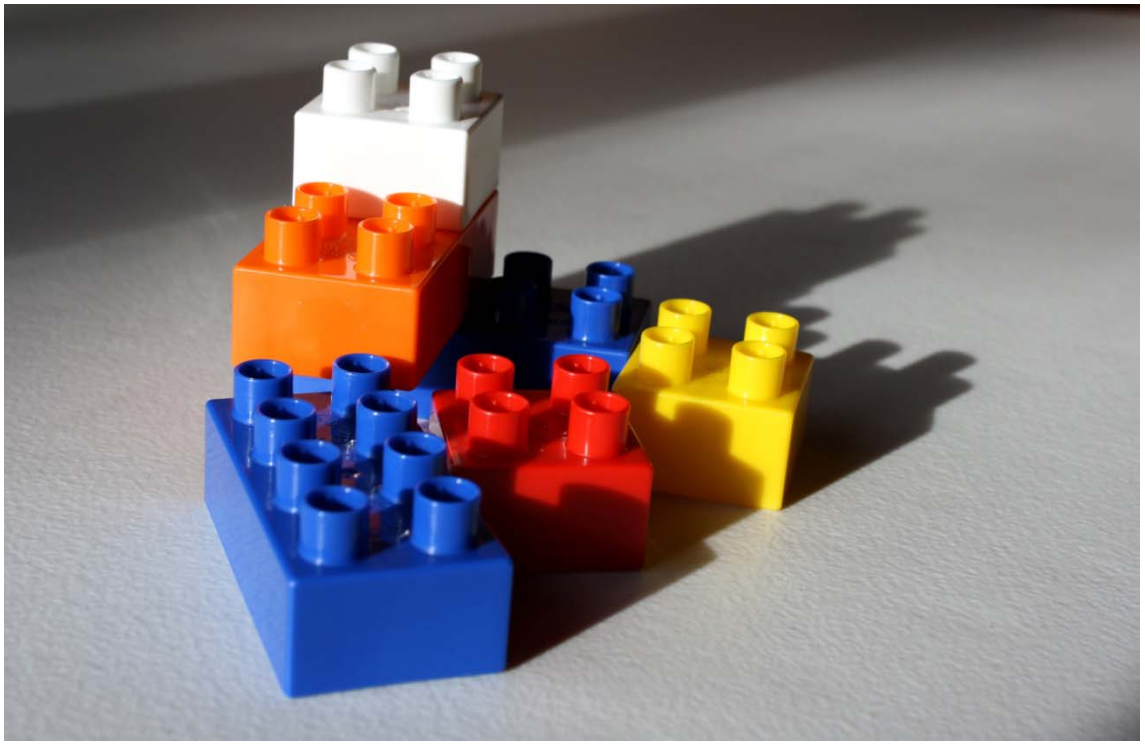
Reusable

Consolidated CDA

- C-CDA documents are constructed from standardized templates and their contents can be reused
- All hospitals and physician practices are using C-CDA for transitions in care
- If you want to communicate with hospitals and physicians it makes sense to adopt the same standards even if your data is exchanged on paper
- Someday you, too, will have electronic exchange so it makes sense to build your shared vocabulary with that goal in mind

Next Step Today

- Define what you need as a receiver in one essential high value exchange

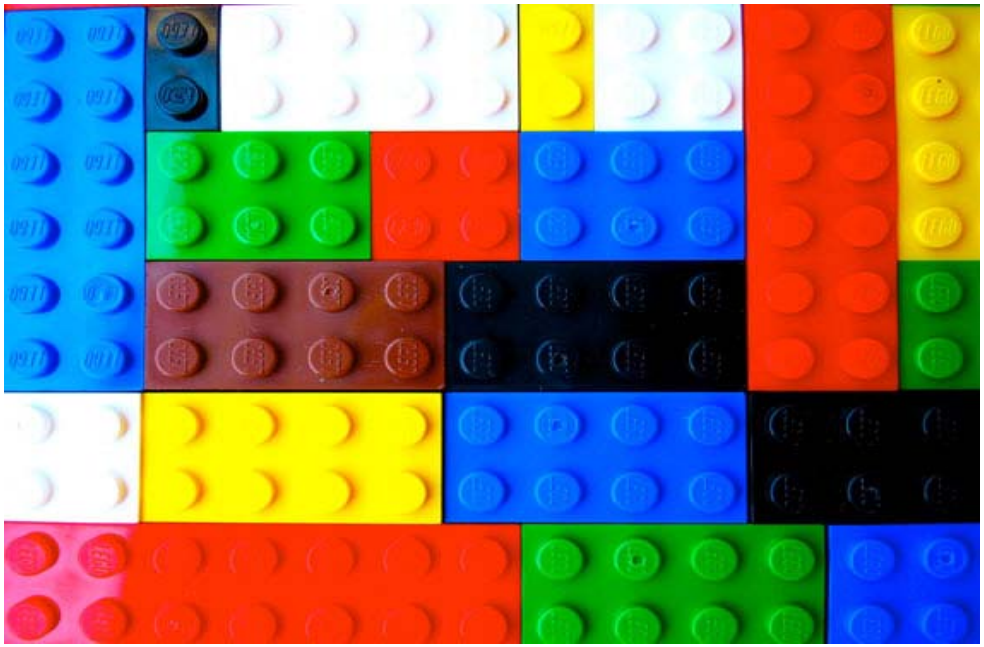


Many Standardized Data Elements

- Define what you need to know

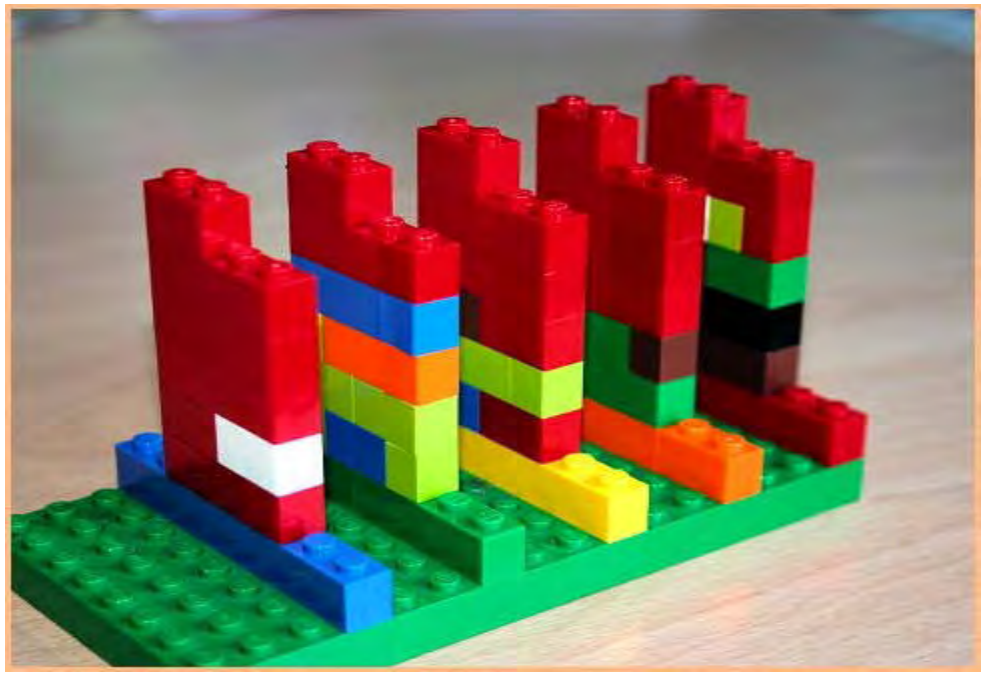
What Your Partner Needs to Know

- The key is to insure that both you and your partner receive the required information



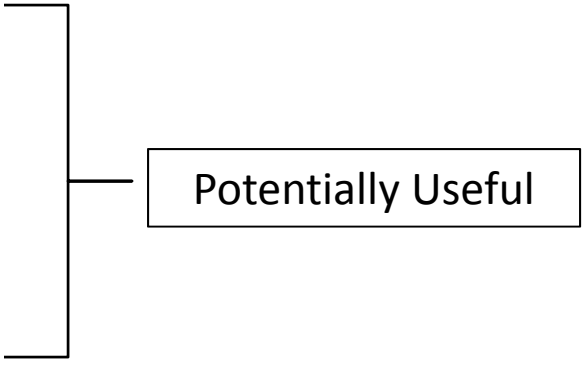
What Do Your Other Partners Need?

- It is likely that your other partners will need basically the same information



Consolidated CDA Release 2.1 Documents

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



Team Exercises 3 and 4: Build a Data Set

- Two volunteers to work with me to develop a data set (20 min)
- Each team repeat the process and identify the information needed in one priority transition (20 min)
- Compare data sets as a group, identify common elements
- Ultimate goal: make movies out of LEGOs

Role Groups by Receiving Site

Transitions to (Receivers)													
Received By (Role)	In Patient Acute Care Hospitals	ED	Out patient Services	BH In patient Facilties	LTAC	IRF	SNF/ECF	HHA	Hospice	PCP PCMH	BH Community Services	Community Based Organizations	Patient/ Family
Admissions/ Scheduler	X	X	X	X	X	X	X	X	X	X	X	X	
Care Manager	X			X	X	X	X	X		X	X	X	
EMTs	X	X	X	X	X	X	X	X	X				X
MD/NP	X	X		X	X	X	X			X	X		
OT					X	X	X	X					
PT					X	X	X	X					
RN	X	X	X	X	X	X	X	X	X	X	X	X	
Social Worker				X			X				X		
Speech Therapy							X	X					
Technician			X										

Example: SNF to ED Data Set

- Demographic information- Patient
- Sending Site
  - Clinician at "Sending" site who is available to answer questions (with contact info)
  - Clinician(s) if different from above to call for each active problem (with contact info)
- Patient Specific Medical Information
  - Reason for Transfer
  - Chief Complaint
  - Allergies (name of inciting agent, type of reaction, severity)
    - Medications
  - Current Active Clinical Conditions
  - Past Medical History
  - History of Present Illness
- Medications
  - Current Active Medications on Transfer or Discharge
    - Indication
    - Route
    - Dose
    - Frequency
    - Date and time last dose administered
- Advance Directives
  - Code Status
  - Orders for Life Sustaining Treatment (POLST or MOLST Form) attached (Y/N)
- Physical Findings (with time recorded)
- Functional Status at Discharge/Transfer
  - Activities of Daily Living (ADLs)
  - Transfers
  - Ambulation
  - Eating
- High risk lines, drains, catheters
- Alerts, Restrictions
- Known limitiations or Disabilities
  - Cognitive
  - Ability to consent to treatment
- Major Psychiatric Conditons
  - Psychosis
  - Severe depression
  - Bipolar

- Heart rate
- Resp Rate
- Pulse
- Oxygen Saturation
- Temperature
- Blood Pressure
- Mental status at discharge/transfer

- Devices, drains
- Pacemaker
- Foley
- IR drains
- Internal defibrilator (AICD)
- Drains
- High risk lines
- Hemodialysis
- Ports
- Epidural catheters
- Total Parenteral Nutrition (TPN) Line
- PICC
- Dialysis
- Total Parenteral Nutrition (TPN)

- Fall Risk Y/N interventions
- Aspiration
- Limited/non-weightbearing left/right, Upper/Lower
- Violent behavior
- Infection precautions
  - Methicillin-resistant *Staphylococcus aureus* (MRSA), VISA
  - Vancomycin-resistant enterococci (VRE)
  - Clostridium difficile
  - ESBL
- Pregnant, Y/N

Team Exercise 4- Data Set for One Transition

- List the ways the “Sender” and “Receiver” interact, e.g.
  - Preparation
    - Send a query to find an available service provider
    - Respond to query
  - Formally request services or exchange the responsibility for providing care
  - Ongoing interchange around clarification, new issues, outcomes and interventions
- Identify which role groups are involved with each interaction
- Identify what data each role group needs

Summary of Work

- A list of elements common to several high priority transitions
  - Demographics
  - Issue being addressed
  - Interventions
  - Identity of service provider
- These are some of the LEGOs that make a snapshot
- How many snapshots to make a movie?
- Start with identifying what you need

Next: Map to National Data Sets

- Use national data sets as a “menu” from which to select the data elements you need
- Don’t reinvent the wheel, use someone else’s if it works
- National data sets:
  - Are mapped to widely accepted data standards (LOINC Codes and SNOMED)
  - Have established meaning and standardized collection processes
  - Convert easily to electronic exchange when and if that is desired
- There is value to building towards the electronic future using these data elements

Homework

- PDSA cycles to refine
  - Priority exchanges
  - Essential data elements
  - Information exchange process
- “N of 1” to test system
- Select data elements from standardized national data sets for electronic exchange (even if exchange is not electronic)
- Repeat for next high risk population

Break 2

3. Using Electronic Tools to Facilitate the "Connected Care Community"

Goals of this segment

- Overview of changing health care payments and the impact of community based services
- Case Study: Worcester, MA
- Why standardized, interoperable data elements are important now and for the future

Three Dramatic Changes

- New payment models based on the total cost of care across an episode
- New focus on individuals with the most complex and costly needs
- New ways to exchange information

“Out With the Old, In With the New!”

Old: Fee for Service (FFS)

- More services generate more payments.
- Payment can expand, just add more services.
- Information exchange driven by special incentives

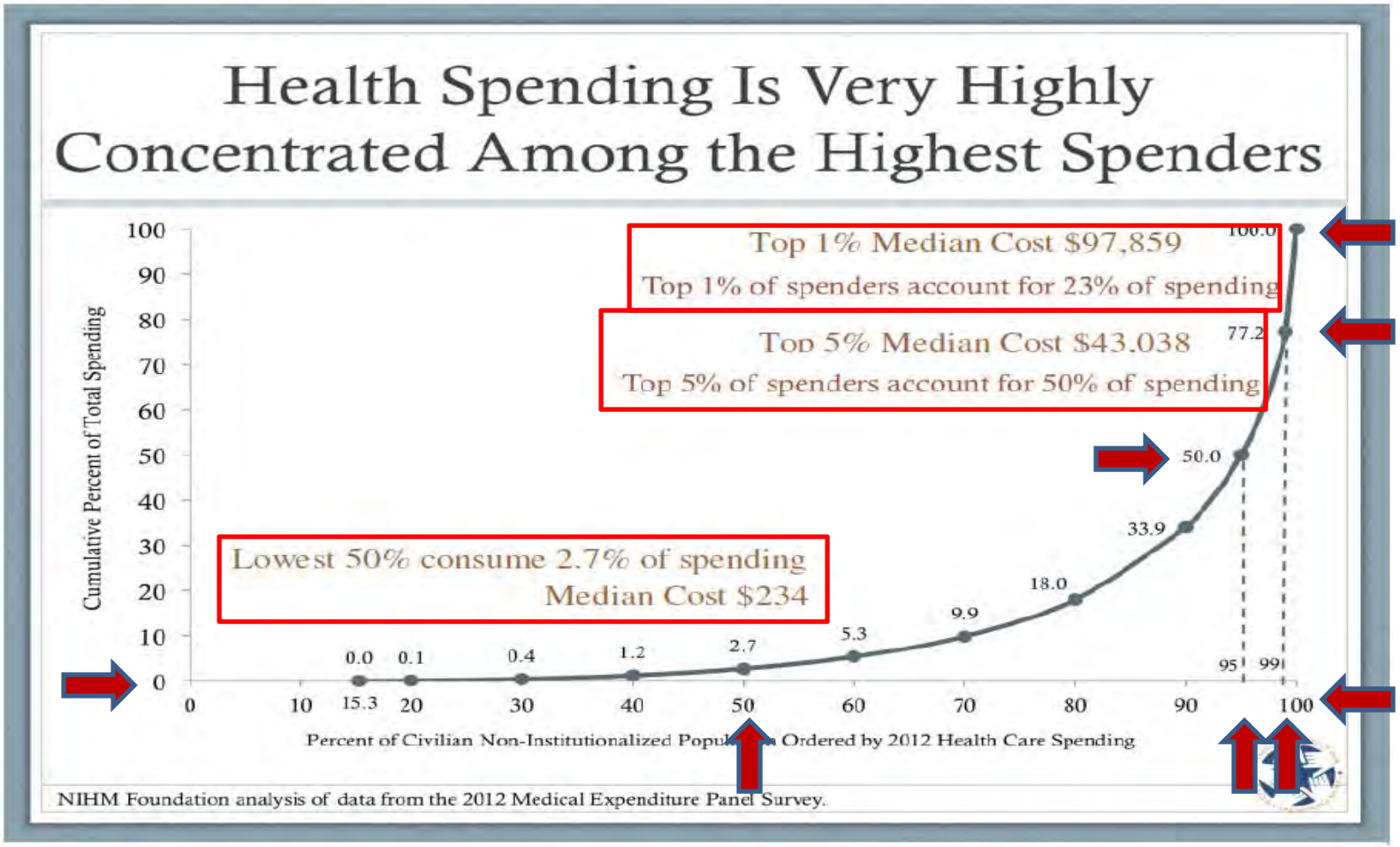
New: Payment Based on Outcomes/Quality

- Responsible for the outcomes of an entire population
- Outcomes = Quality and Cost.
- Payment based on meeting outcomes, not just on providing services.
- Requires attention to individuals with the most complex issues and highest costs

New Payment-New Care System

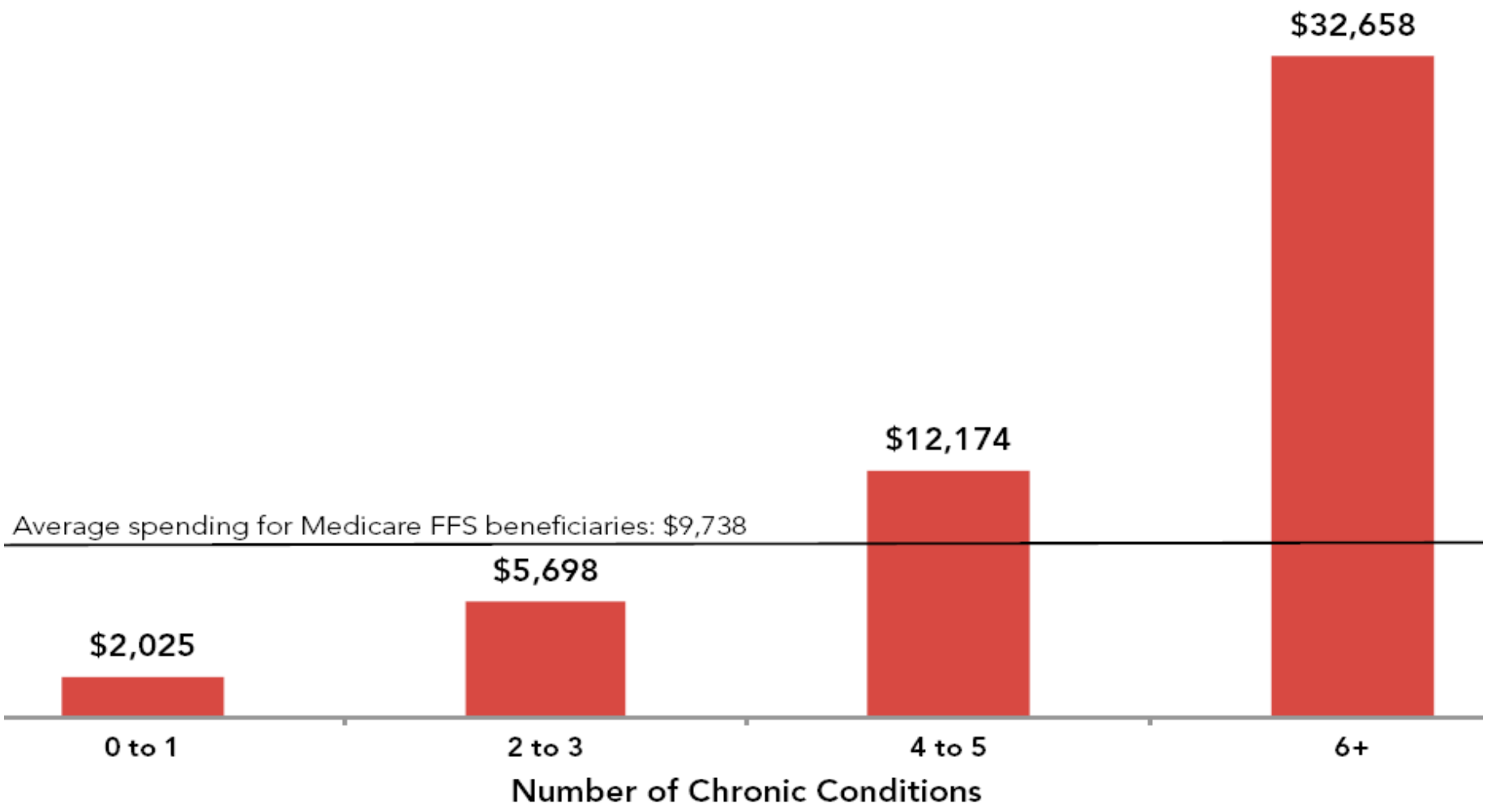
- **Alternative Payment Models include:**
  - Medicare Advantage
  - Accountable Care Organizations
  - Bundles
    - **Elective**: voluntary sign up
    - **Mandatory**: Comprehensive Care for Joint Replacement (CCJR)
      - Hospital responsible for all costs for 90 days
      - Top 75 metropolitan regions
      - Started 4/1/16
    - **Followed by:** two cardiac measures (heart attack and bypass graft) and a new Surgical Hip/Femur Fracture Treatment July 2017
- **Outcomes Based FFS Payment 2018 to include:**
  - SNF, IRF, LTAC 30 Day Readmission Reduction Program
  - Total cost of care
  - Discharges to the community

Focus on the 5%

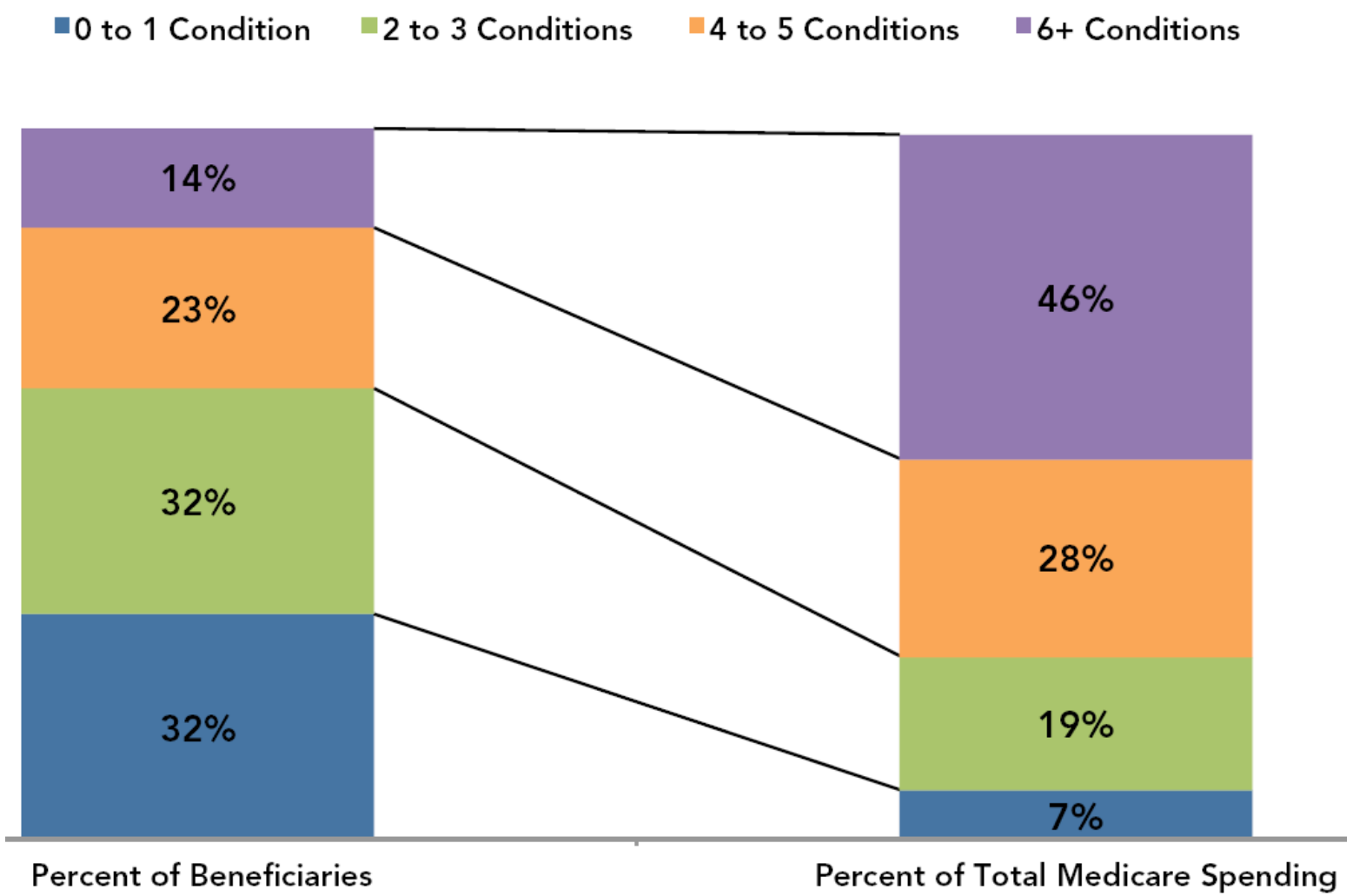


http://www.nihcm.org/concentration-of-health-care-spending-chart-story

Per Beneficiary Medicare Spending



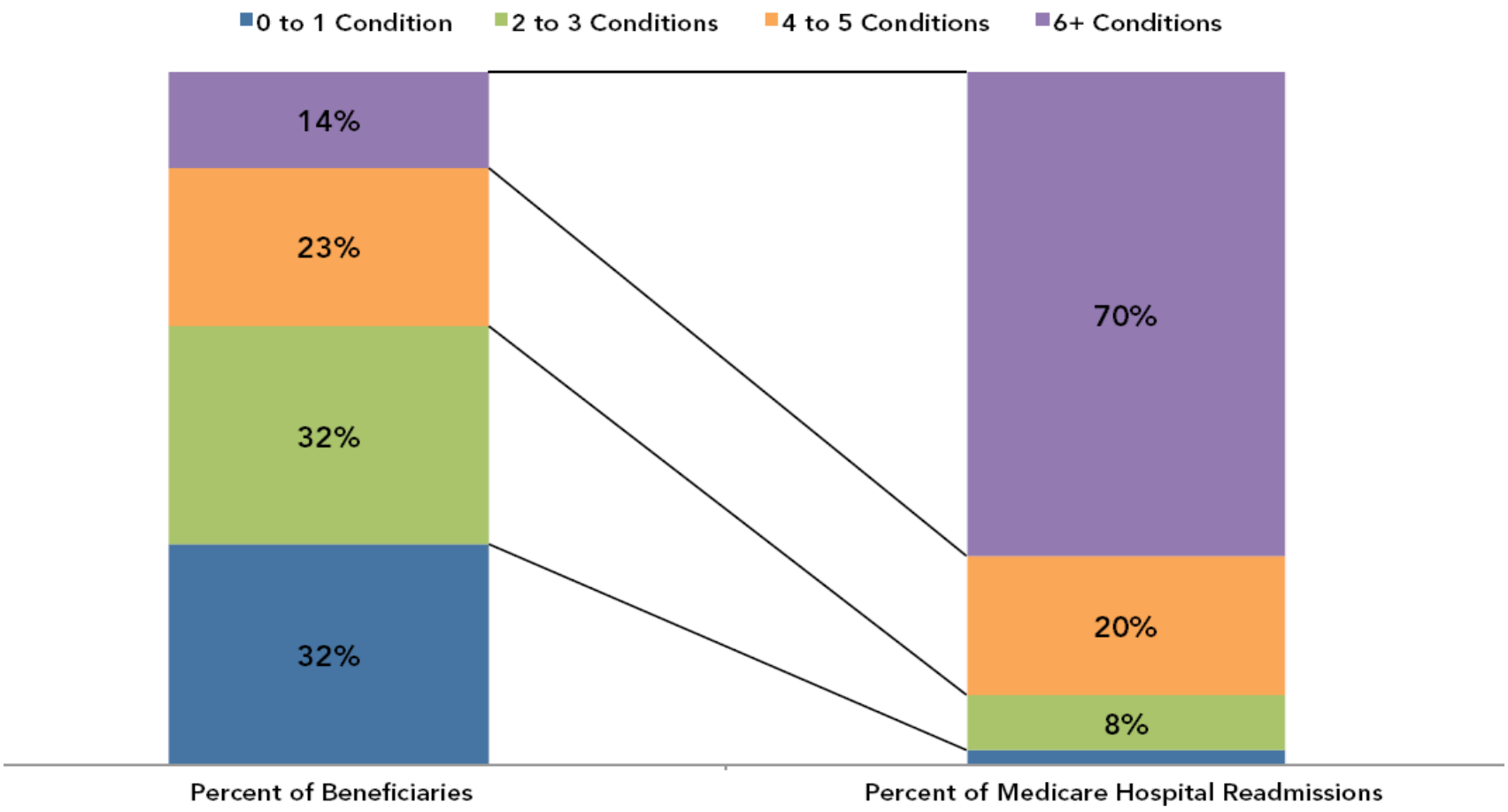
Proportion of Medicare Spending



Source: 2012 Medicare Chart Book: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/2012ChartBook.html

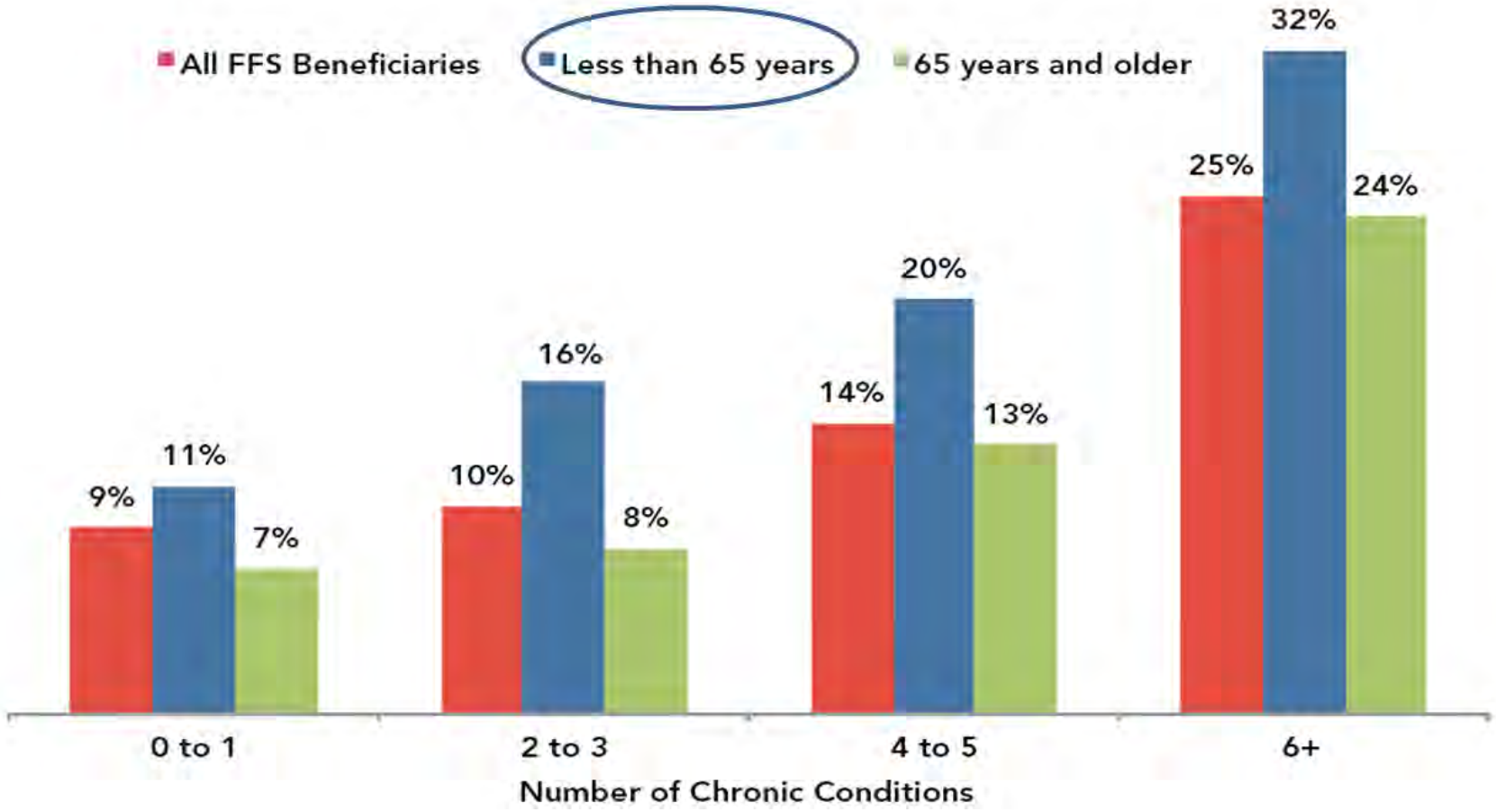
Medicare Readmissions by Number of Chronic Conditions

Figure 2.7 *Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Hospital Readmissions: 2010*



Readmissions: Greatest Among Younger Persons with Disabilities

Figure 2.6a *Percentage of Hospital Admissions with a Readmission within 30 days by Number of Chronic Conditions and Age: 2010*



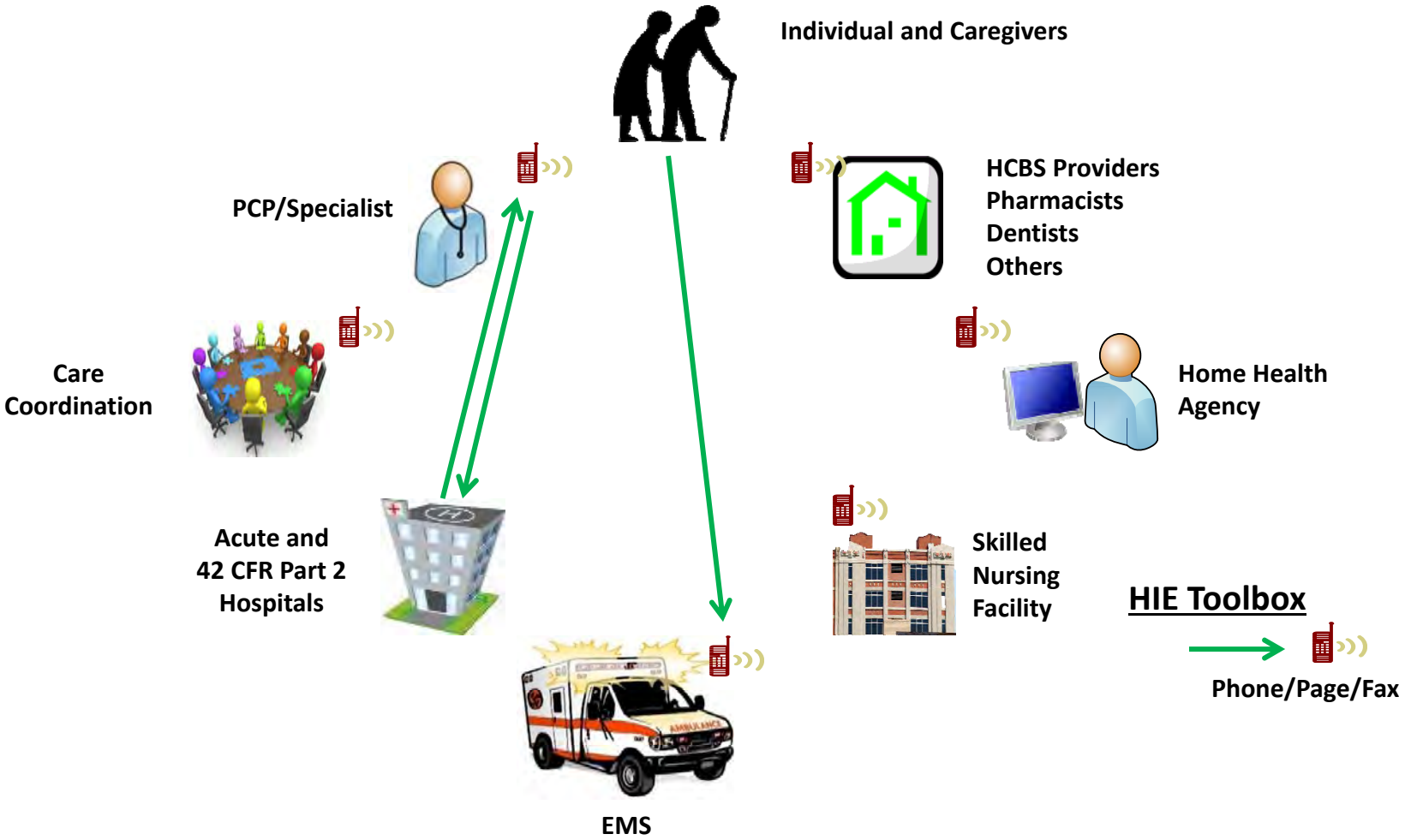
Responsible for the 5%

- Complex medical, behavioral, functional and environmental issues including social determinants
- Care from multiple providers
- Care in multiple sites
- High utilization of emergency responders, emergency departments, hospitals, nursing facilities and home based services
- Experience multiple transitions and need an overall care plan

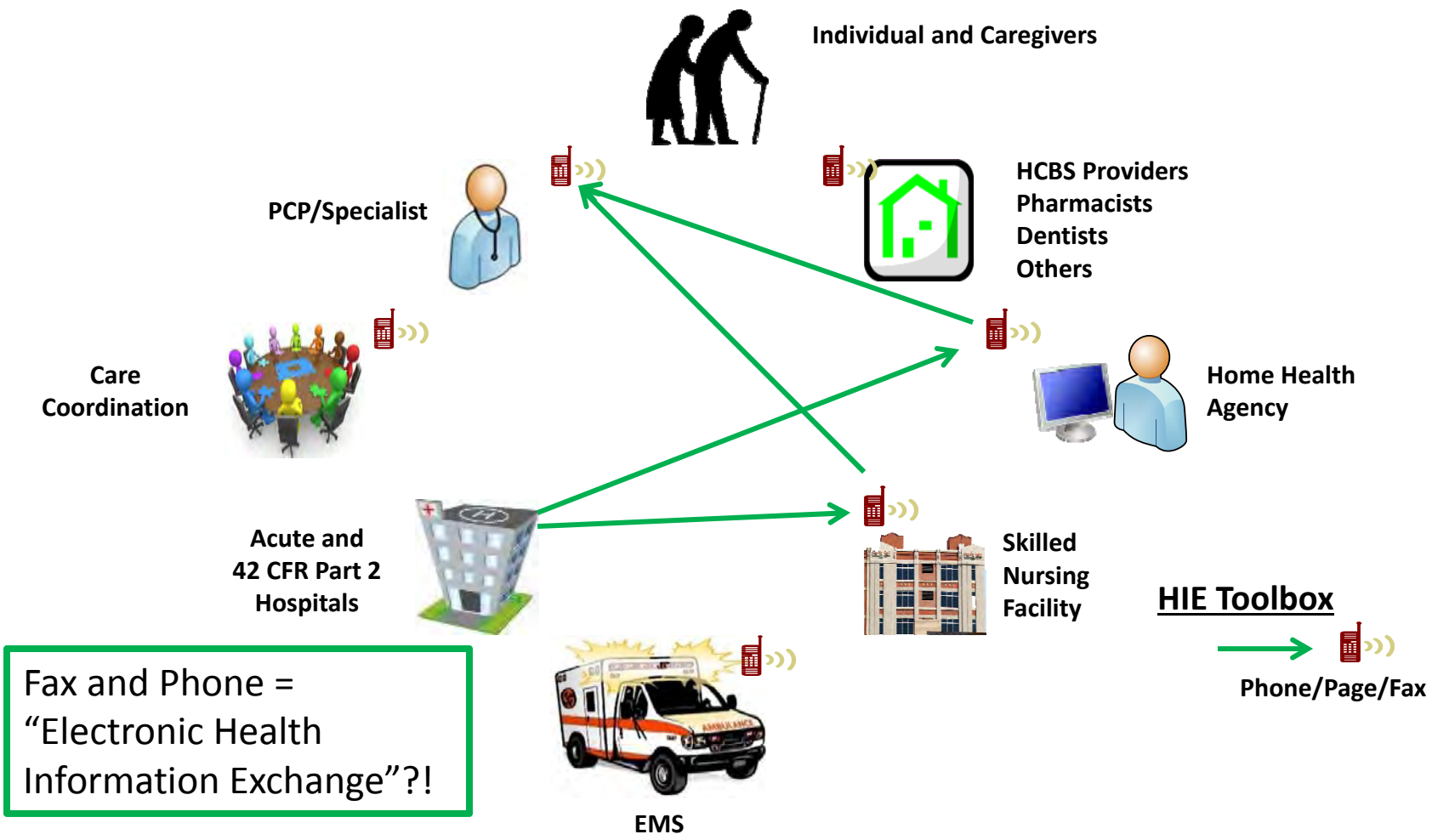
Population Management

- Responsible for “attributed” population
- Significant change: no longer able to exclude high cost/high risk patients from management
- This shifts the focus of the system to the highest risk, highest cost patients
- More complexity, more sites, bigger teams
- Need a new system of care

The Current Care Community



The Current Care Community



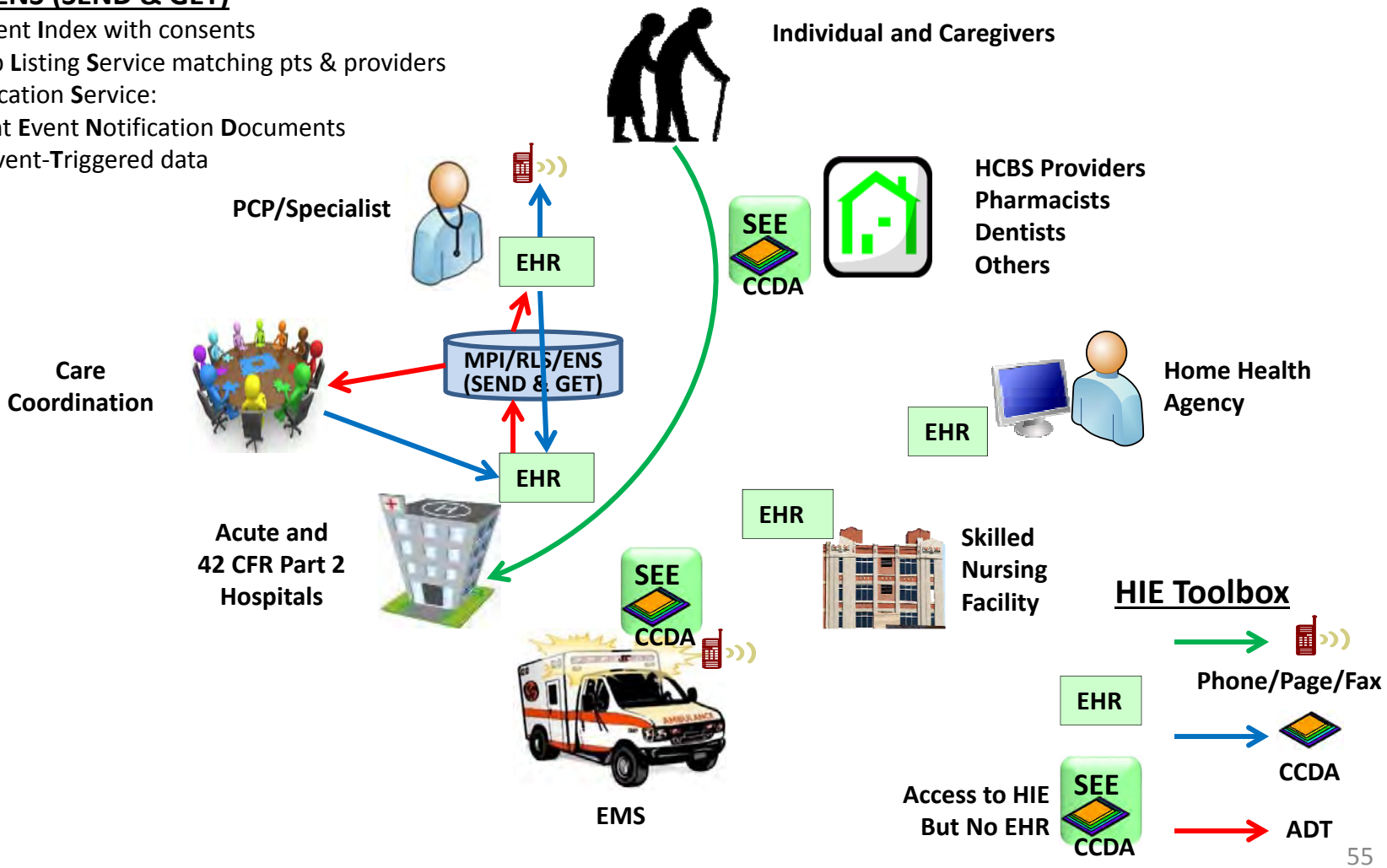
Fax and Phone = "Electronic Health Information Exchange"?!

The Connected Care Community

MPI/RLS/ENS (SEND & GET)

Master **P**atient **I**ndex with consents
Relationship **L**isting **S**ervice matching pts & providers
Event **N**otification **S**ervice:

- **S**ignificant **E**vent **N**otification **D**ocuments
- **G**ather **E**vent-**T**riggered data



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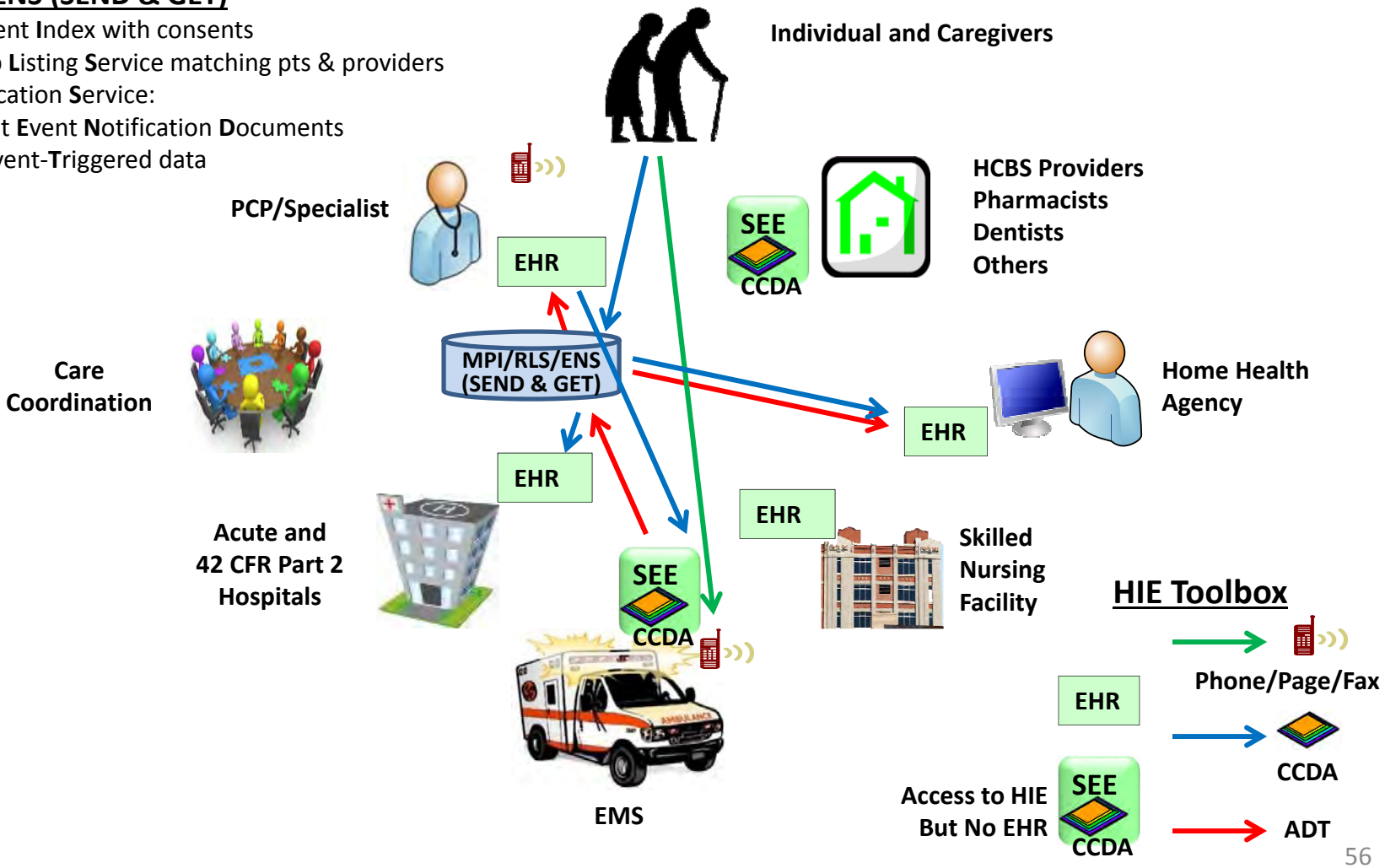

The Connected Care Community

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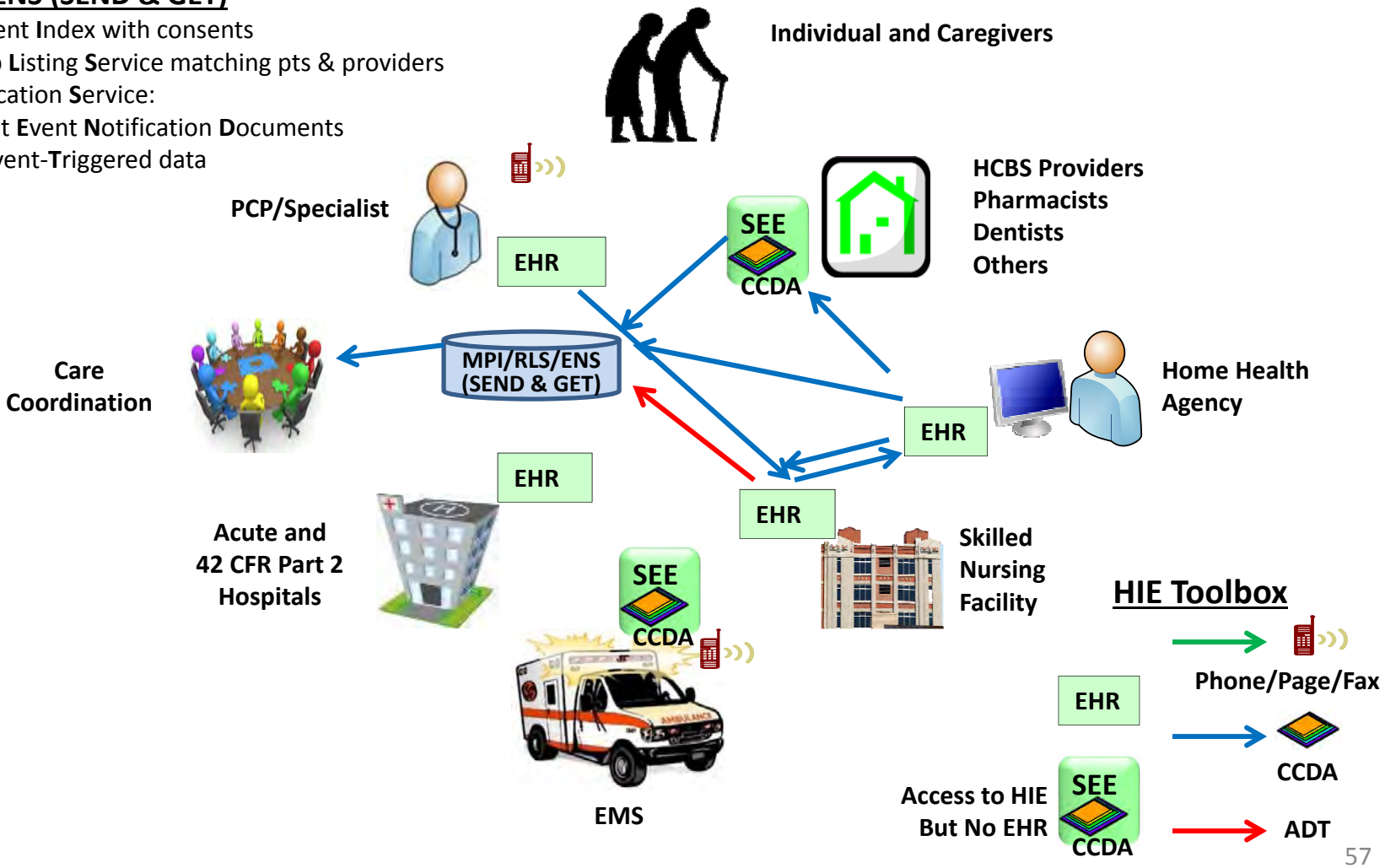

Summary

- Start with good transitions
- Pay attention to what you need to build a shared plan of care
- Select data elements from national data sets of standardized, interoperable data elements
- Test and improve processes on paper
- Look to acquire electronic exchange incrementally

Integrated Communities Care Management Collaborative: September 2016 Learning Session Evaluation

Thank you so much for your participation in today's Learning Session. We would like your opinion about today's agenda and presentations. Please complete the following evaluation and leave this form in the designated box on the registration table.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. Terrence O'Malley's morning presentation, "Where the person is in the system of care: identifying and prioritizing common transitions in care" was useful to me and my work.					
2. Terrence O'Malley's afternoon presentation, "Determining information each team member needs during a transition of care" was useful to me and my work.					
3. Terrence O'Malley's afternoon presentation, "Use of electronic tools to facilitate the connected care community" was useful to me and my work.					
4. I feel confident in implementing the tools we learned about today.					
5. Hearing from other communities about their progress since the last Learning Session was a beneficial learning opportunity.					
6. Today's agenda provided ideas and strategies to continue working together to improve care management in my community.					
7. For the future I would recommend the following improvements:					
8. Other comments:					