

Briefing on Long-Term and Post-Acute Care

Health IT Policy Committee July 10, 2012

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in collaboration with

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Member, Health IT Standards Committee

Briefing on Long-Term and Post-Acute Care (LTPAC)

- Essential to patient-centered coordinated care
 - Post-Acute Care: healing and rehabilitation after an acute event
 - Long-Term Care: people with disabilities or chronic care needs
 - Interdisciplinary care teams
- Increasingly able to participate
- Aligned with National Priorities for Quality Health Care
 1. Making Care Safer
 2. Ensuring Person- and Family-Centered Care
 3. Promoting Effective Communication and Coordination of Care
 4. Promoting the Most Effective Prevention and Treatment of the Leading Causes of Mortality, Starting With Cardiovascular Disease
 5. Working With Communities to Promote Wide Use of Best Practices to Enable Healthy Living
 6. Making Quality Care More Affordable

Federal Health IT Strategic Plan



U.S. Department of Health & Human Services

The Office of the National Coordinator for
Health Information Technology



OBJECTIVE C

Support health IT adoption and information exchange for public health and populations with unique needs

- Essential partners in care coordination
- Build on Meaningful Use standards for exchange of clinical data
- Leverage State HIEs and Beacon Communities
- Address quality measures and clinical decision support opportunities

Strategy I.C.3: Support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings. Providers working in long-term and post-acute care (LTPAC) and behavioral health settings are essential partners in patient care coordination. ONC, CMS, and the Assistant Secretary for Planning and Evaluation (ASPE) will collaborate to address quality measures and evolving clinical decision support opportunities that will promote appropriate exchange of health information in LTPAC and behavioral health care settings for optimal coordination of care.

HHS will build on meaningful use to adopt electronic standards for the exchange of clinical data among facilities and community-based LTPAC settings, including, where available, standards for messaging and nomenclature. ONC will leverage the State HIE and Beacon Community grant programs in demonstrating methods for which the electronic exchange of information with LTPAC entities can improve care coordination. In addition, HHS will identify opportunities in the Affordable Care Act to support the use of health information exchange technologies by LTPAC and behavioral health providers to improve quality of care and care coordination.

Long Term and Post Acute Care



Health IT Collaborative ■ www.ltpachealthit.org

- Began 2005
- Annual Summits
 - June 18-19, 2012
 - Baltimore, MD
- Roadmaps
 - 2005
 - 2008
 - 2010-2012
 - 2012 -2014



www.commonwealthfund.org

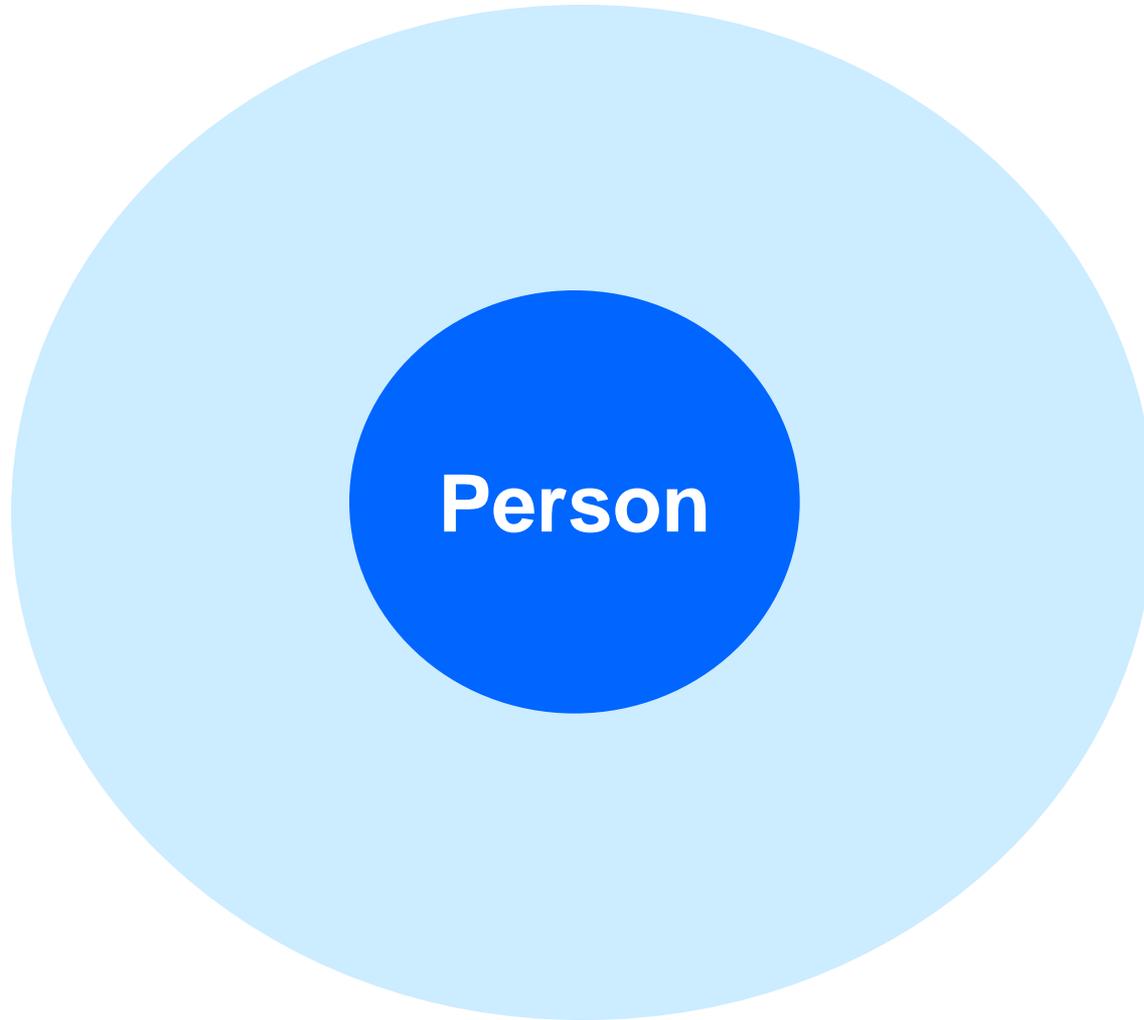


Government Representatives from
ASPE, ONC, CMS, HRSA

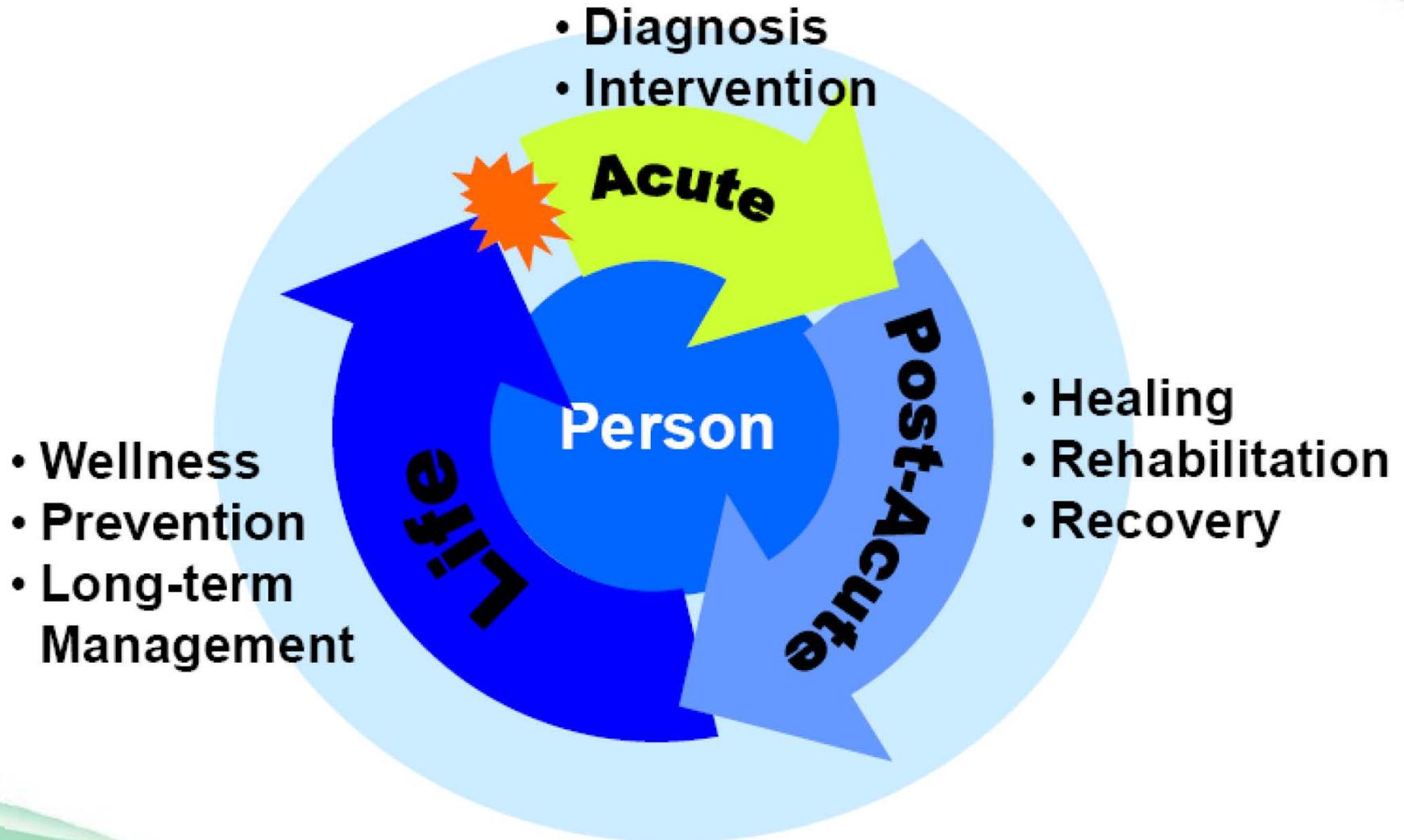
Highlights from 2012-2014 LTPAC HIT Roadmap

- Care Coordination
 - Participate in health information exchange with partners and HIEs/RHIOs
 - Implement Care Summary, CCD, and assess need for CCD+
 - Advance exchange of Care Plans and the work of the S&I Framework, Longitudinal Care Coordination initiative
- Quality and Process Improvement
 - Develop consistent eMeasures for LTPAC settings, directly based on primary documentation
 - Develop measures of longitudinal care outcomes
 - Develop measures of care coordination
- Business Imperative
 - Expand adoption to a broader range of functions
 - Demonstrate clinical and business value
 - Develop national surveys of Health IT adoption
- Consumer and Care Giver Activation and Engagement
 - Expand access by individuals to their own information
 - Engage patients, residents and caregivers as members of the health team
 - Incorporate Patient Generated Health Data in the EHR
- Workforce Acceleration
 - Improve the hands-on technical skills of the workforce
 - Expand the use of clinical informaticists
 - Develop skills to use the information contained in the EHR

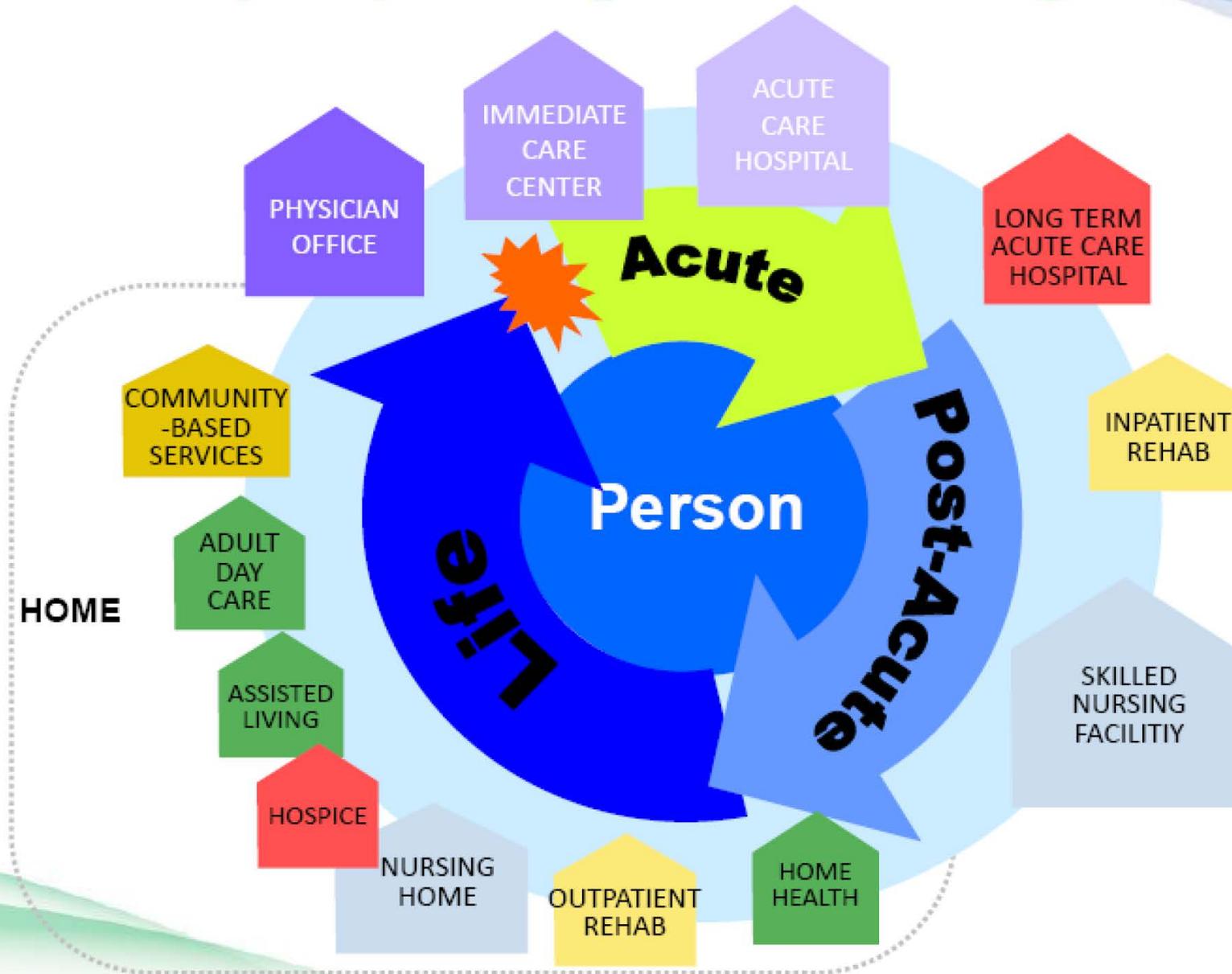
Individual Health



Life Cycle / Care Cycle

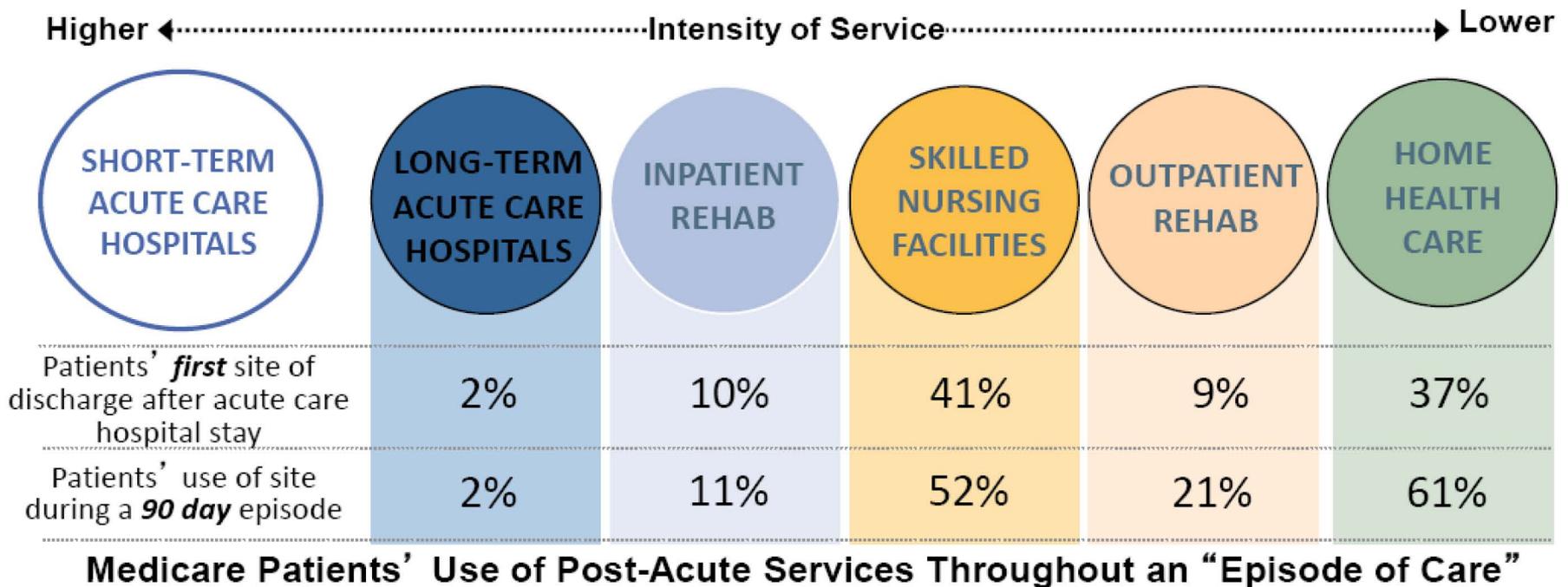


Care Cycle / Example Care Settings



Patients Discharged to Post-Acute Care

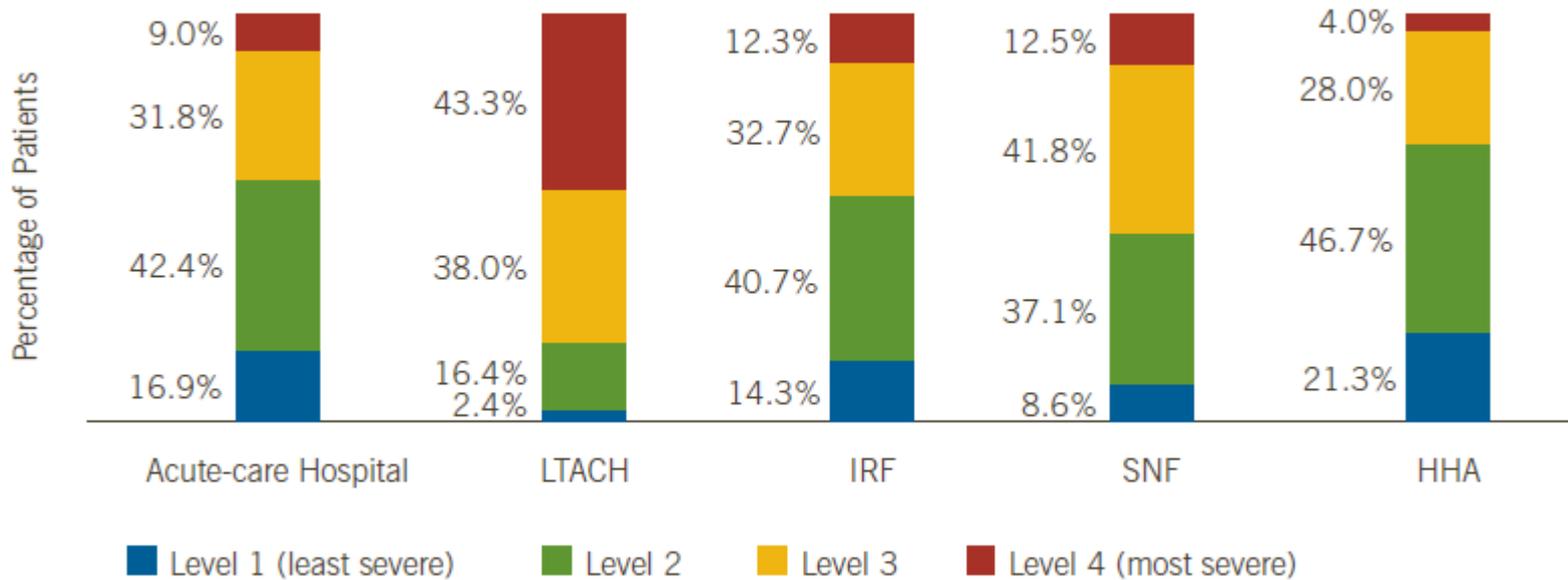
35% of Medicare beneficiaries discharged from short-term acute hospitals receive post-acute care



Source: RTI, 2009:
Examining Post Acute Care Relationships in an Integrated Hospital System

LTPAC - Acuity

Chart 1: Short Term Acute-care Hospital (STACH) and PAC Severity of Illness (SOI), in Prior STACH Stay



Source: Analysis of the 2008 100% Medicare Standard Analytical Files by The Moran Company.

Note: SOI is measured by the 3M APR-DRG Grouper.

TrendWatch: Maximizing the Value of Post-acute Care
 American Hospital Association, November 2010

<http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf>

LTPAC – Settings and Medicare Beneficiaries

Chart 2: Medicare Patient Volume and Spending for Fee-for-Service Beneficiaries, by PAC Provider Type

Facility Type	Number of Facilities (2009)	Number of Beneficiaries Treated (2008)*	Estimated Medicare Spending (2009)
Long-term Acute Care Hospital	432	115,000	\$4.9 billion
Inpatient Rehabilitation Facility	1,196	332,000	\$5.7 billion
Skilled Nursing Facility	15,053	1.6 million	\$25.5 billion
Home Health Agency	10,422	3.2 million	\$18.3 billion

Post-acute care accounted for approximately 12% of all Medicare spending in 2008.

Source: Medicare Payment Advisory Commission. (June 2010). *Data Book: Healthcare Spending and the Medicare Program*. Washington, DC.

*Data from Medicare Payment Advisory Commission. (March 2010). *Report to the Congress: Chapter 3*. Washington, DC. Includes fee-for-service beneficiaries only.

TrendWatch: Maximizing the Value of Post-acute Care

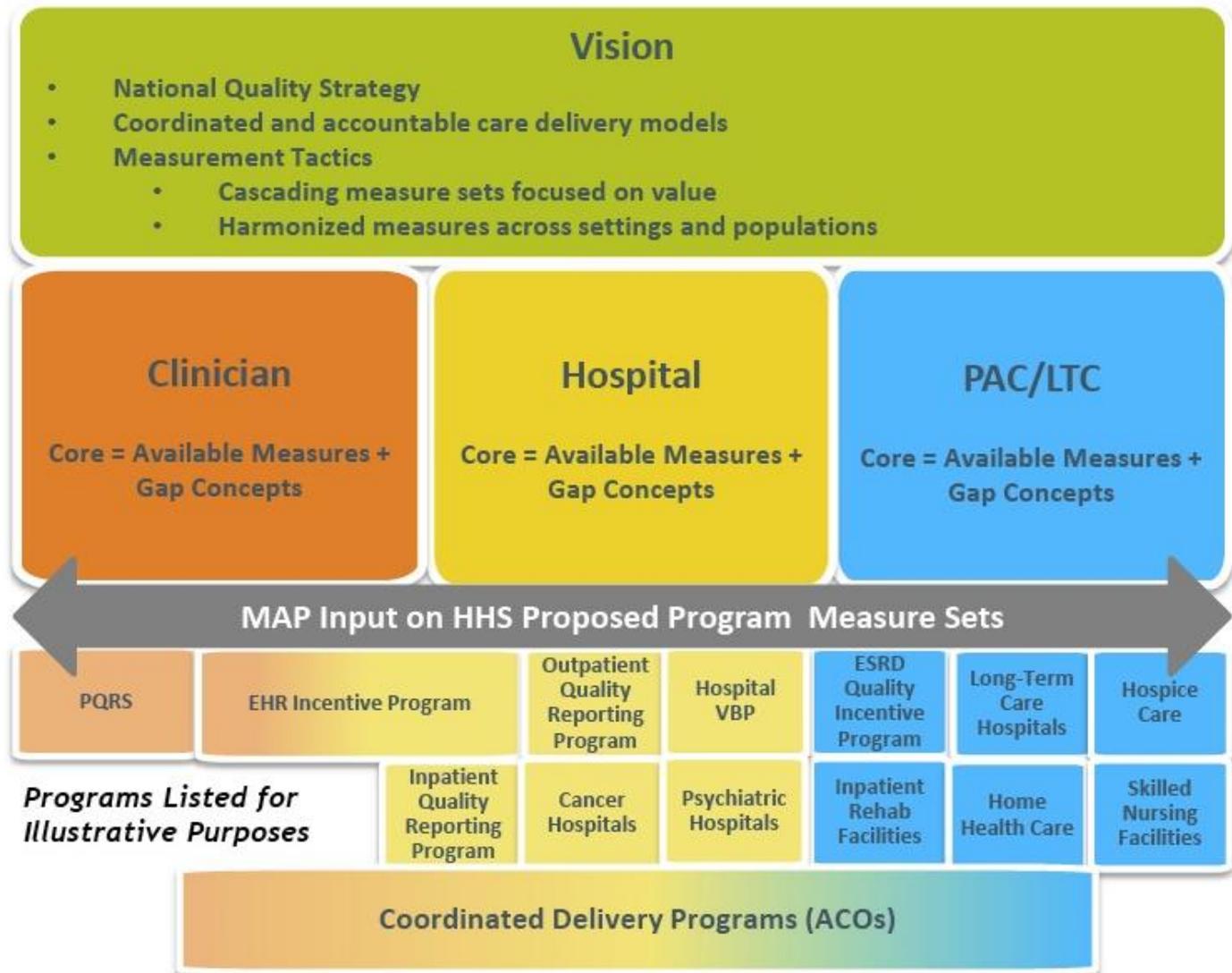
American Hospital Association, November 2010

<http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf>

Required Electronic Assessments

- **Nursing Facility:** Minimum Data Set (MDS 3.0)
- **Home Health:** Outcome and Assessment Information Set (OASIS)
- **Rehab Hospitals:** Inpatient Rehab Facility-Patient Assessment Instrument (IRF-PAI) / Functional Improvement Measure (FIM)
- **Multi-Setting Prototype:** Continuity Assessment Record and Evaluation (CARE)

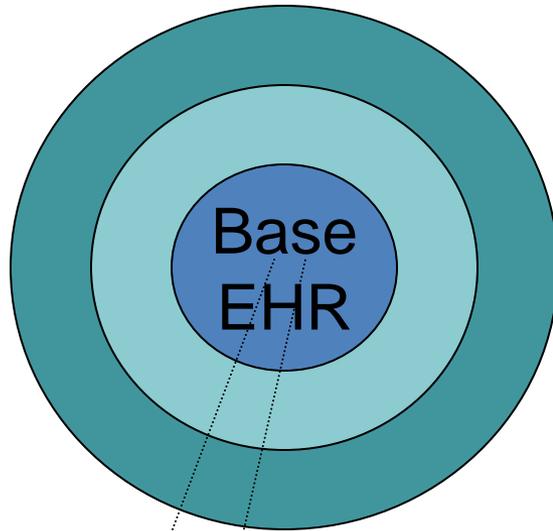
NQF – MAP (Measure Applications Partnership) Harmonize Measures



NQF MAP – Post-Acute Measures

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	<ul style="list-style-type: none">• Functional and cognitive status assessment• Mental health
Goal Attainment	<ul style="list-style-type: none">• Establishment of patient/family/caregiver goals• Advanced care planning and treatment
Patient Engagement	<ul style="list-style-type: none">• Experience of care• Shared decision-making
Care Coordination	<ul style="list-style-type: none">• Transition planning
Safety	<ul style="list-style-type: none">• Falls• Pressure ulcers• Adverse drug events
Cost/Access	<ul style="list-style-type: none">• Inappropriate medicine use• Infection rates• Avoidable admissions

Certified EHR Technology



1. Includes patient demographic and clinical health information, such as medical history and problem lists; and
2. Has the capacity:
 - i. To provide clinical decision support;
 - ii. To support physician order entry;
 - iii. To capture and query information relevant to health care quality;
 - iv. To exchange electronic health information with, and integrate such information from other sources;
 - v. To protect the confidentiality, integrity, and availability of health information stored and exchanged

Micro Kernel

What is the minimum necessary for all settings to

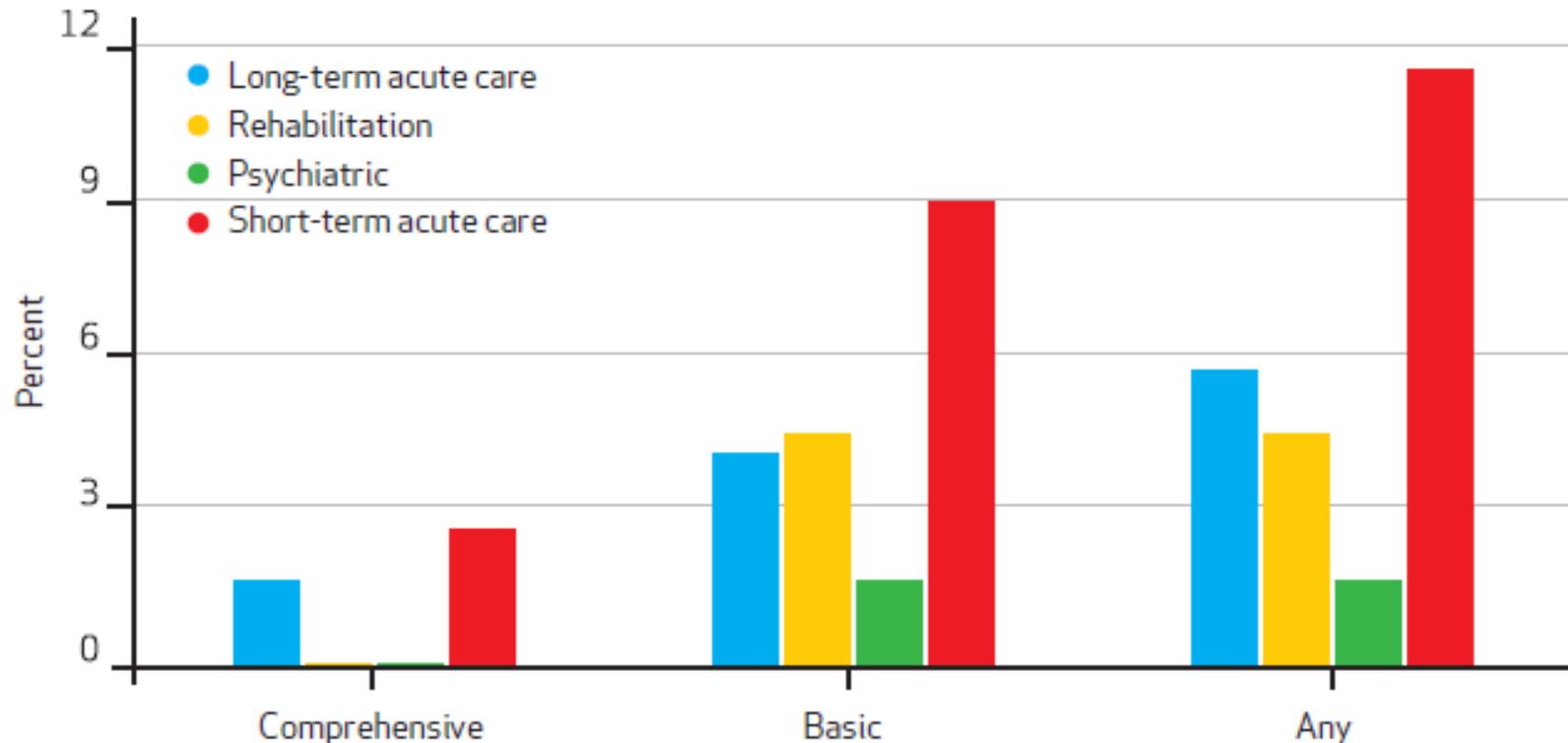
- Provide a base for process and quality improvement?
- Ensure a legal medical record?
- Improve care coordination? Standards and Interoperability?
- Measure and report quality?
- Enable a Learning Healthcare System?

Software Certification

- **ONC-ATCB – Modular Certification**
 - Potential for a common core
- **CCHIT – LTPAC Certification**
 - Specialized needs of these settings

HIT Adoption – LTACH, IRF, Psych (2009)

Electronic Health Record (EHR) System Adoption Rate Among Hospitals, By Type Of Hospital And EHR System Capability, 2009

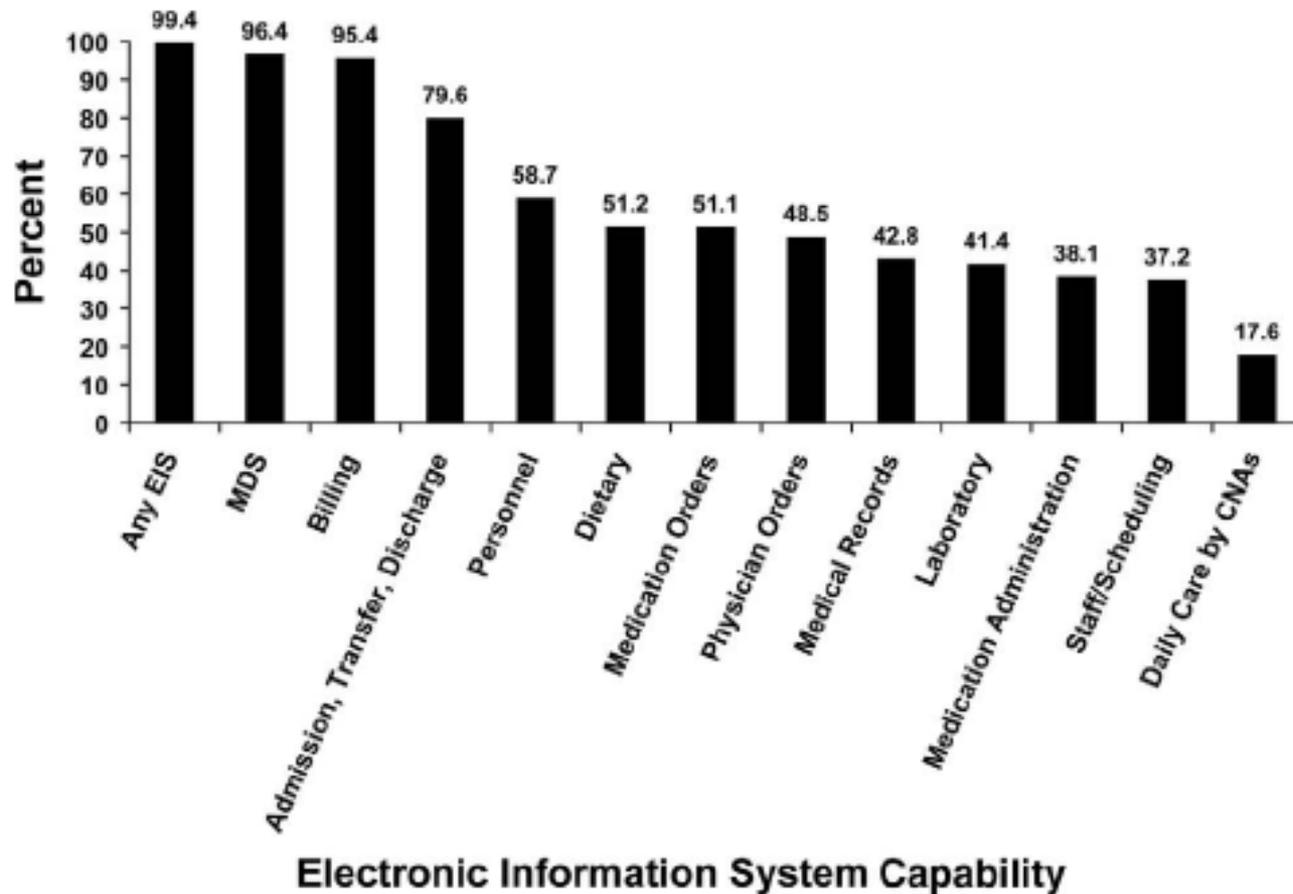


Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates Of Adoption Of Electronic Health Records

Larry Wolf, Jennie Harvell, Ashish K. Jha

Health Affairs, Vol 31, No 3 (2012)

HIT Adoption – Nursing Facilities (2004)



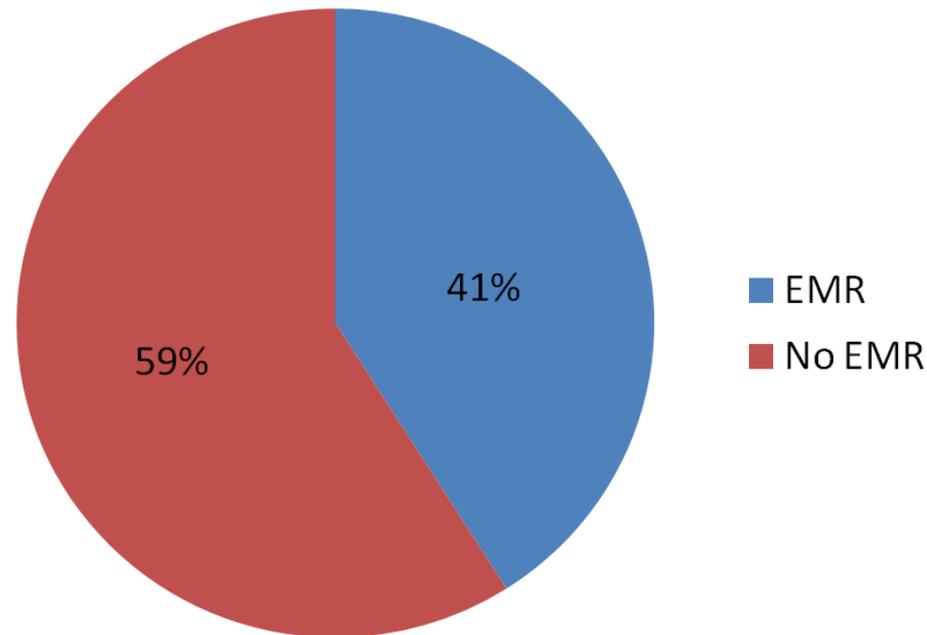
Use of Electronic Information Systems in Nursing Homes, United States, 2004

Helaine E. Resnick, Barbara B. Manard, Robyn I. Stone, Majd Alwan

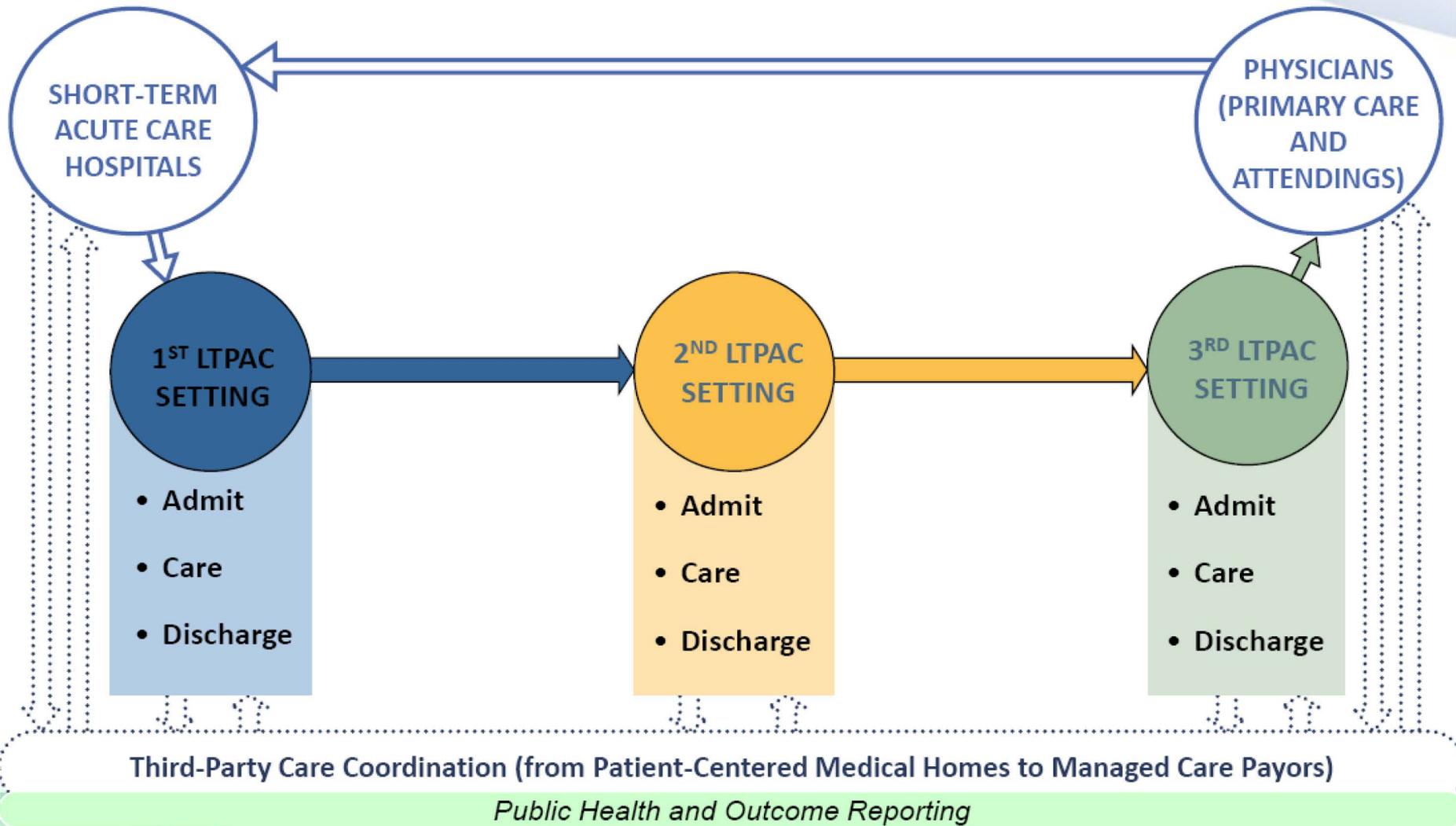
Journal of the American Medical Informatics Association, Vol 16, No 2, March/April 2009

HIT Adoption - Home Health & Hospice Agencies (2010)

Home Health and Hospice EMR Adoption

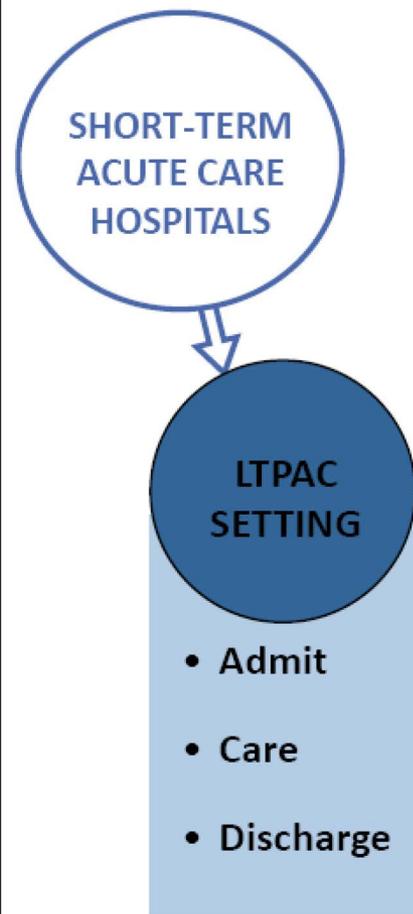


Care in Multiple Settings



Note: Often physician, pharmacy, laboratory and other services are fragmented among the settings and care may bounce back to an earlier setting.

Care Coordination Is Multi-Step – Needs of Receiver



- At Referral
 - Admission Decision
- At Discharge
 - Current Status
- At Admission
 - Physician: Admission Orders, Admission History and Physical
 - Nursing/Therapy: Initial Assessments
 - Reconciliation processes
 - Problems
 - Allergies
 - Medications
- During Admission
 - Coordination across an interdisciplinary team
 - On-site and off-site resources/services

Note: Each setting has its own perspective, payor and regulatory requirements. The needs of sender and receiver are different.

HIE Challenge Grants: Improving Long-Term and Post-Acute Care Transitions

- Colorado
 - Community-based care management with focus on reducing hospital readmissions
 - Address developmentally disabled populations
 - 160 organizations in four communities to use results delivery, community record, CCD
- Massachusetts
 - Learning Collaborative to improve care transitions
 - Universal Transfer Form
 - Hybrid tools to bridge different technology levels
- Maryland
 - Building on work of three early adopter LTPAC providers
 - Portal access for those with limited technology
 - Registry of Advance Directive documents
- Oklahoma
 - Two-way communication between nursing facilities and hospitals
 - Include information from INTERACT (Interventions to Reduce Acute Care Transfers)
<http://www.interact2.net/>
 - Also Advance Directives, ADLs, MDS
- National Governors' Association workshops on HIE and LTPAC:
Alaska, Arkansas, Indiana, Michigan, North Dakota, Pennsylvania, Rhode Island and Washington + HIE Challenge Grantees for LTPAC
- Delaware HIN
 - 100% of acute hospitals, 100% of SNFs and other LTC providers
 - 88% of medical providers

Reusing Existing Assessments

- Transform MDS and OASIS to CCD/C-CDA
 - Select components for inclusion
 - Re-code and format for CCD



MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
ALL ITEM LISTING

Section A Identification Information

ADMR - Facility Provider Number

ADMR - Type of Provider

ADMR - Type of Assessment

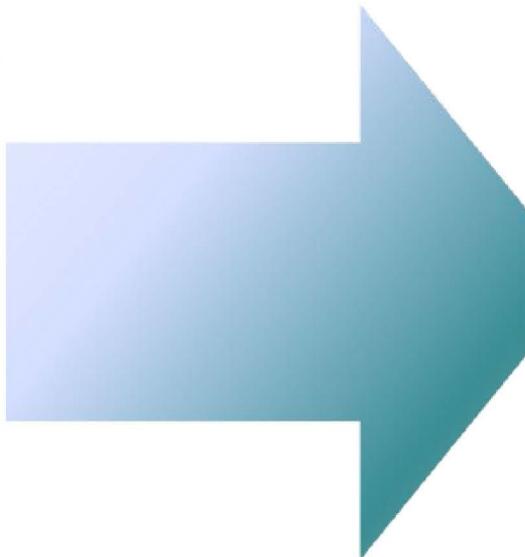
ADMR - Reason for Assessment

ADMR - Scheduled Assessments for a Medicare Part A Stay

ADMR - Scheduled Assessments for a Medicare Part A Stay

ADMR - Other Medicare Required Assessments - OASIS

MDS 3.0 Item Listing Section A.00.2 10/01/2010 Page 1 of 38



Russell Robinson
MRN: HA-87-0087 Gender: Male Date of Birth: March 8, 1914
Internal Health Record Powered Up

Continuity of Care Document (CCD) for Russell Robinson

Problems

Problem	Date	Comments
HYPERTENSION, ICD-901.1	09/17/2004	Stable, J&J.
HYPOLIPIDEMIA, ICD-272.2	02/07/2003	Stable, J&J.
DIABETES NON-IN-SULIN DEPENDENT, ICD-250.00	09/17/2004	Monitoring weight.

Problems

Problem	Date	Comments
BLOCK HEART, ICD-435.9	11/26/2005	Surgery Planned.
DYSRHYTHMIA, SUPraventricular, ICD-432.2	06/12/2005	Resolved with antiarrhyth.
HEARTBLOCK (HEART TIC), ICD-435.81	06/04/2005	Resolved with antiarrhyth.

Medications

Medication	Prescription or Dose	Instructions	Start Date
GLUCOPHAGE (METFORMIN) HCL	1000 MG TABS	2 PO BID	09/17/2004
MEDROL (METHYLPREDNISOLONE)	4 MG TAB	1 PO Q AM	04/26/2005
ASPIRIN	81 MG TAB	2 PO BID (PRN)	01/26/2006
AVASTIN	150 MG TAB	1 PO Q AM	04/26/2005
COURADIN	2.5 MG TAB	1 PO BID -MED PRN	04/26/2005
COURADIN	2 MG FOR SOLU	1 PO QID -TUE-THU	04/26/2005

Allergies

Allergen	Reaction	Severity	Comments	Onset	Stop Date
Met mycin	Severe	allergic to penicillin		200412	
ASPIRIN	Severe	allergic to aspirin		200508	
ASPIRIN	Severe	allergic to aspirin		200512	200408
ASPIRIN	Severe	allergic to aspirin		199805	200408

Reasons for Referral

Reason	Comments
Diagnosis	Not in control

Discharge

Discharge	Comment	Start Date
No artificial IV support	No artificial IV support	200412

MDS 3.0

KEYSTONE
BEACON COMMUNITY

CCD (C32)

S&I Framework: Community-Led Initiative

0  larrywolf51 | My Wikis | Help | Sign Out



- Wiki Home
 - Pages and Files
 - Members
 - Recent Changes
 - Manage Wiki
-

Home | Calendar | Contact



General Information

(Click '+' to Expand)

+ Getting Started

April Face to Face (F2F) Info

Initiatives

(Click '+' to Expand)

+ Community-Led Initiatives

- Public Health Reporting
- Longitudinal CC WG

+ Cross-Initiative Functions

☆ Longitudinal Coordination of Care WG

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Longitudinal CC
WG Home

Longitudinal Care
Plan SWG

LTPAC Care
Transition SWG

Patient Assessment
Summary SWG

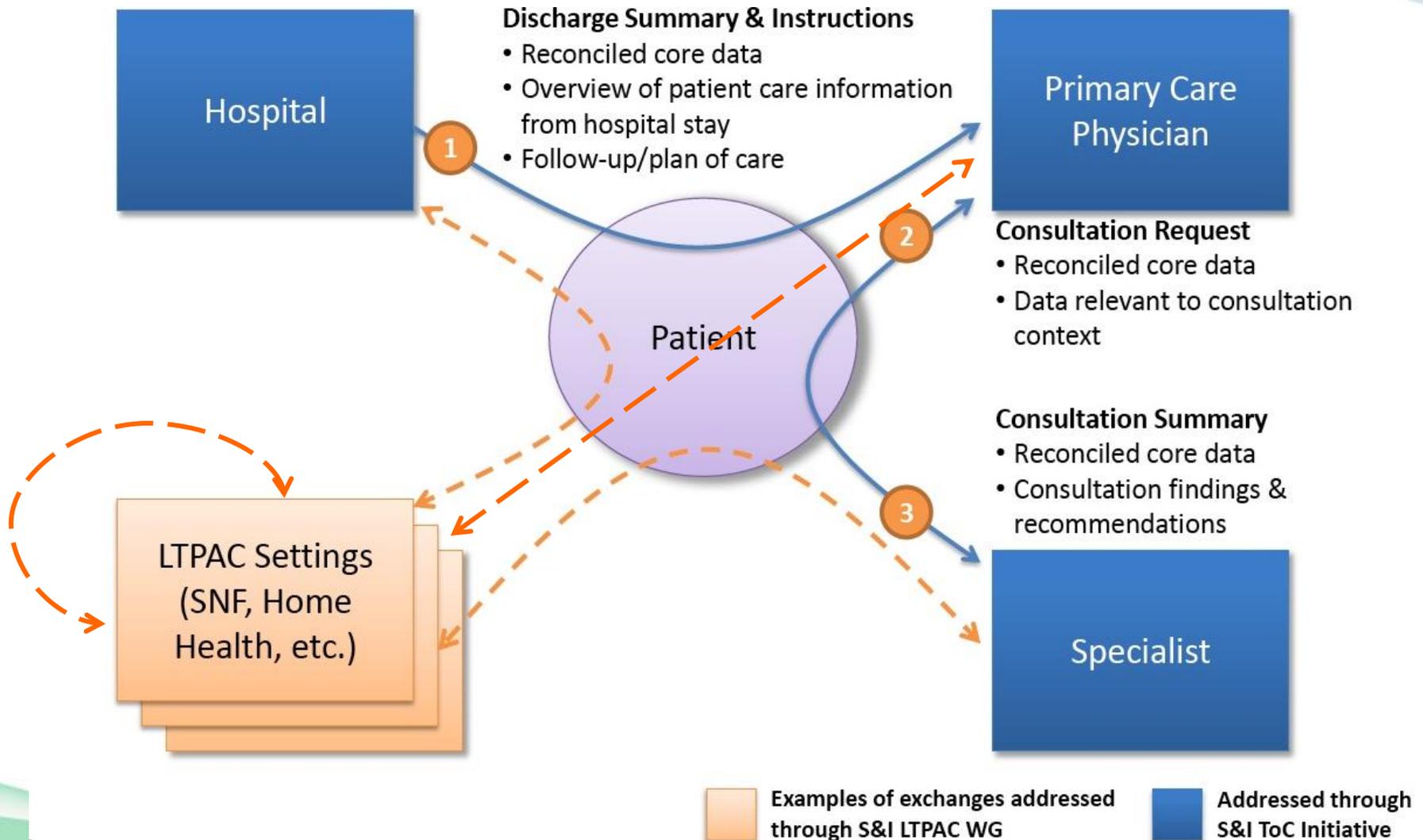
Meeting Schedule

To add these meetings to your calendar, subscribe to the [Longitudinal Coordination of Care Calendar](#).

LCC WG Monthly All Hands Meeting	LCC WG Leads Meeting
Date of Next Meeting: Thursday, Apr. 5, 2012	Date of Next Meeting: Thursday, Apr. 12, 2012
Recurring Meeting: First Thursday of Every Month from 9:00-10:00am ET	Recurring Meeting: Second Thursday of every Month from 9:00-10:00am ET
Webinar: siframework1.webex.com	Webinar: siframework1.webex.com
Dial-in: 1-408-600-3600 Passcode: TBA	Dial-in: 1-408-600-3600 Passcode: TBA
LCC Use Case Extension Working Session (Link to Wiki Page)	
Next Meeting: Thursday, Mar. 22, 2012	
Recurring Meeting: 3rd, 4th & 5th Thursday of each month from 9:00-10:00am ET	
URL: siframework1.webex.com	
Dial-in: 1-408-600-3600 Passcode: 669 990 773	

Note: Meetings will have streaming web audio for those unable to access the meeting using the phone dial-in information. Please plan to

Building on the S&I ToC Framework



Helping people live their lives

