Actively Managing Care Transitions

Building the Medical Neighborhood and securing the Patient's Role in it

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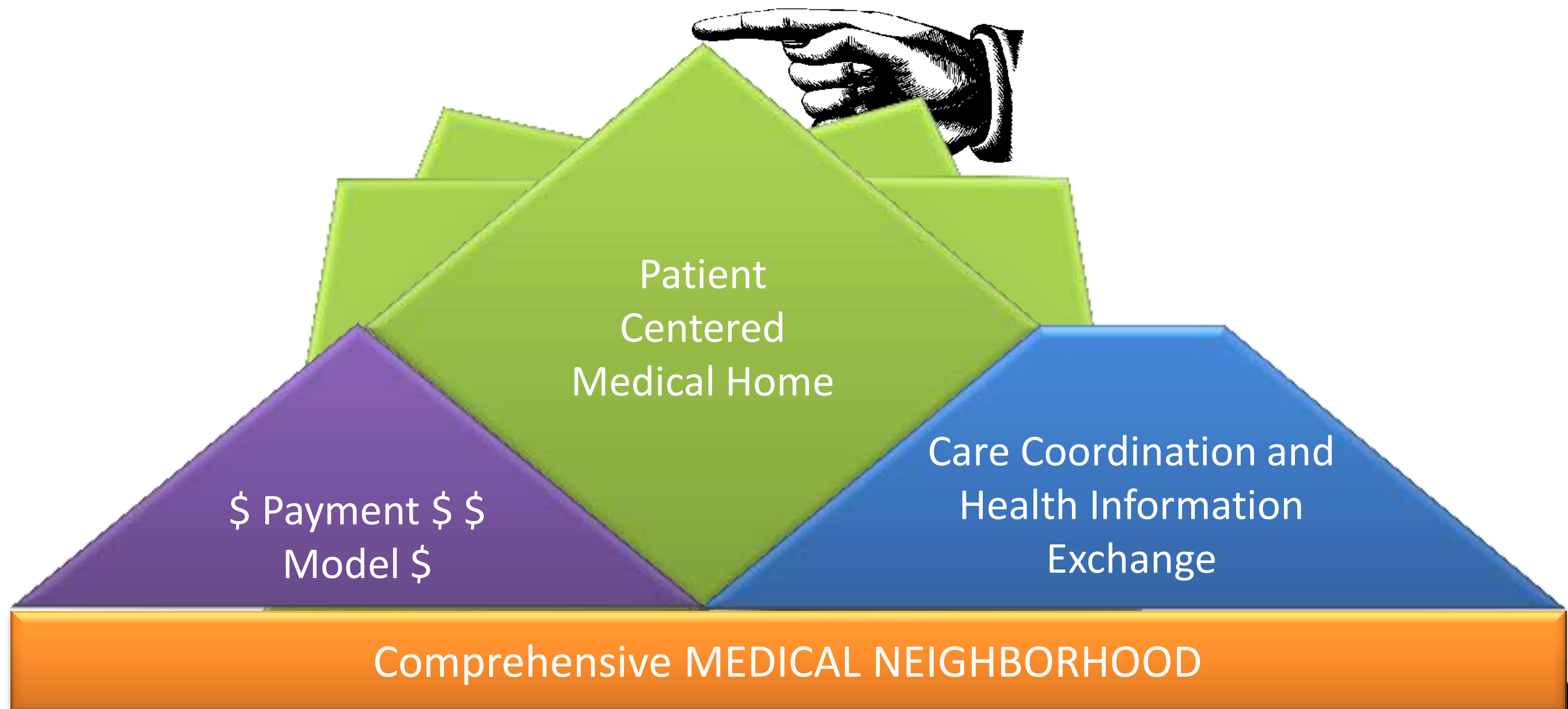
D2D Doc to Doc

Agenda

- Two simultaneous innovations required
- Practical implementation of the concepts
- Results
- Policy challenges
- Implications and Recommendations

Patient Centered Medical Home

- Sounds nice– but what is it really?



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D2D Doc to Doc

Beacon Communities

Two things

- **Goals**: **Patient priorities for health should be elicited, documented, and managed.**
- **Transitions**: Process and method for better communication and coordination among providers and patients
  - Relevant data for the recipient
  - In context of patient's goals for care

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D2D Doc to Doc

Current medical record

Problem	Duration	Code	Provider Plans
Congestive Heart Failure	3.5y	I50.1	1. Diuretics titrated to maintain dry weight
Migraine Headaches	6m	G43.1	1. Triptan on person with training
Diabetes	10y	E10	1. HbA1c < 9, 2. Dietary education
Obesity	15y	E66	1. Activity prescription

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D2D Doc to Doc

Patient goals in the medical record

Problem	Duration	Code	Prioritized Patient Goals	Provider Plans
Congestive Heart Failure	3.5y	I50.1	1. Climb stairs at home 2. Sleep through night 3. Wear regular shoes	1. Diuretics titrated to maintain dry weight
Migraine Headaches	6m	G43.1	1. Prevent 100% of headaches	1. Triptan on person with training
Diabetes	10y	E10	1. Off of insulin	1. HbA1c < 9, 2. Dietary education
Obesity	15y	E66	1. Walk around block daily 2. No sodas	1. Activity prescription

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D2D Doc to Doc

CCDA document and section templates (ONC, 2012)

HL7 Implementa
Release 2: I
Consolidation, R

Document Templa
- Continuity of C
- Consultation N
- Diagnostic Ima
- Discharge Summary
- History and Physical (H&P)
- Operative Note
- Procedure Note
- Progress Note
- Unstructured Document

Section Templates: 60

Entry Templates: 82

Need patient goals in this standard document for exchange

Document Template	Section Template(s)		
Continuity Of Care ument	Allergies Medications Problem List Procedures Results Directives Encounters	Family History Functional Status Immunizations Medical Equipment Payers Plan of Care Goals of Care	Section templates in YELLOW demonstrate CDA's interoperability and reusability.
History & Physical (H&P)	Allergies Medications Problem List Procedures Results Family History Immunizations Assessments	Assessment and Plan Plan of Care Social History Vital Signs History of Present Illness History of Present Illness	Chief Complaint Reason for Visit Review of Systems Physical Exam General Status Goals of Care

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D2D Doc to Doc

Two things

- **Goals**: Patient priorities for health should be elicited, documented, and managed.
- **Transitions**: **Process and method for better communication and coordination among providers and patients**
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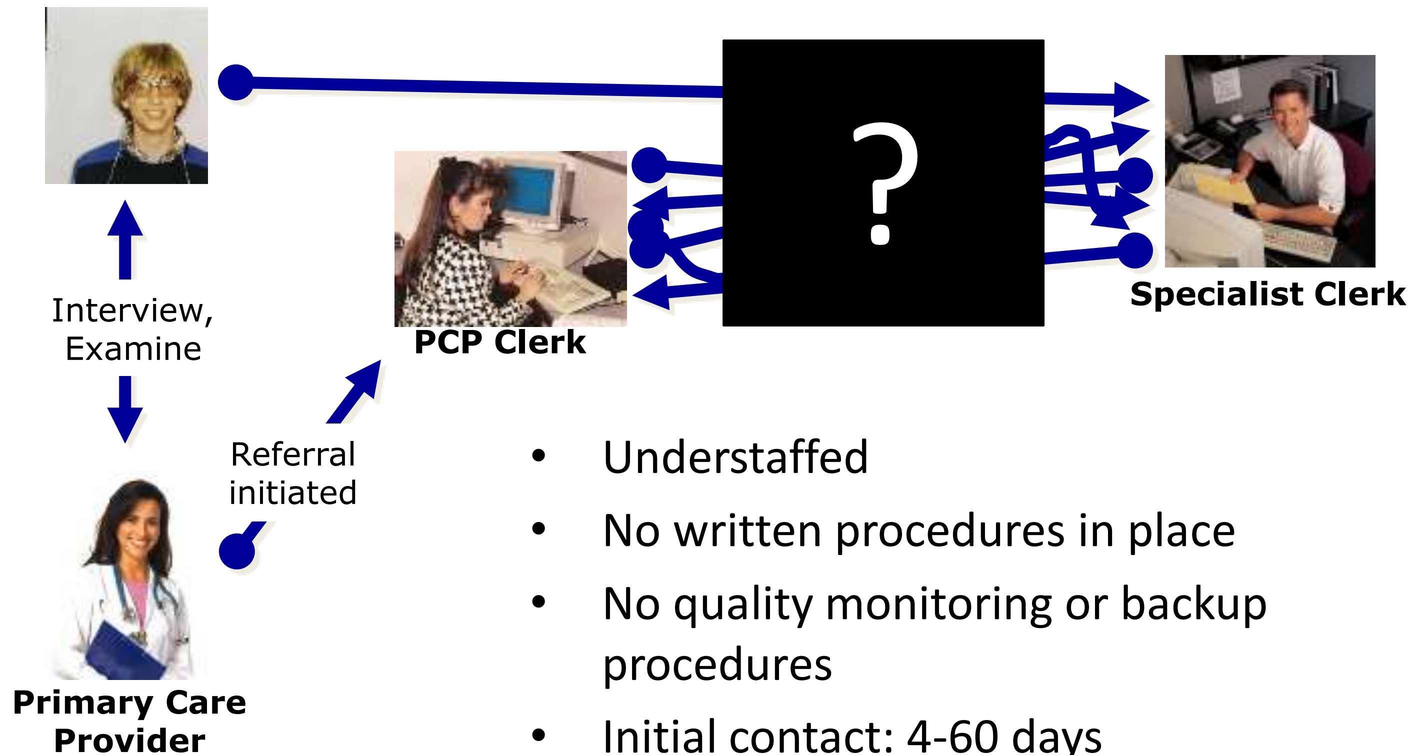
D2D Doc to Doc

Pre-Doc2Doc Care Transition Management



- Understaffed
- No written procedures in place
- No quality monitoring or backup procedures
- Initial contact: 4-60 days
- 50 to 3,000 referrals behind
- Many simply dropped

Consultant

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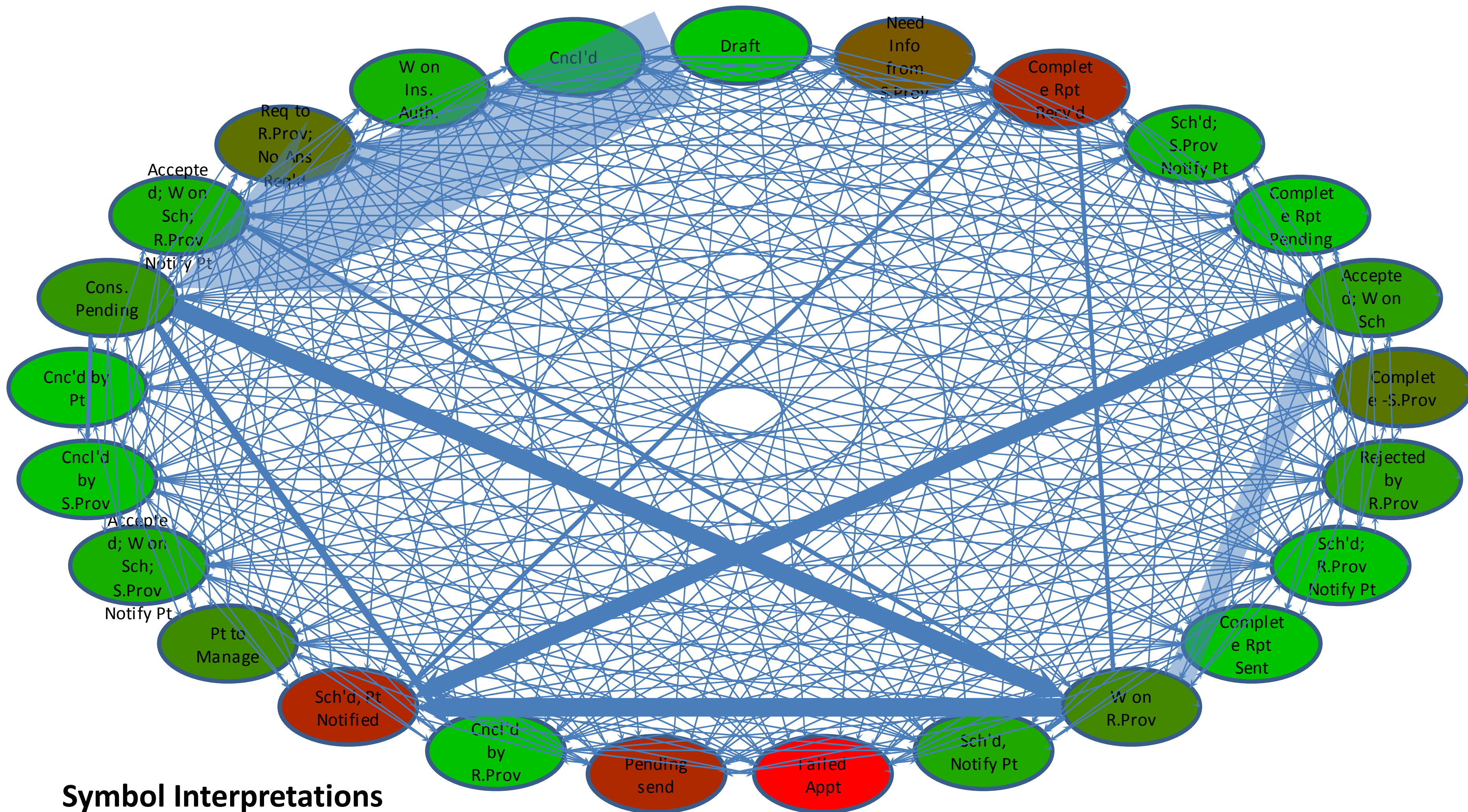
D2D Doc to Doc

Care Transitions = Physician Orders

- Philosophy: To achieve quality, important processes must be:
  - standardized into common steps which
  - must be tracked for performance monitoring
- Reality:
  - Pharmacy orders are tracked with statuses from 1) order initiation through 2) delivery to pharmacy, 3) dispensing of the medication, and in some cases, 4) even the medication administration
  - Lab orders are tracked with statuses from 1) specimen collection, 2) sample arrived at lab, 3) testing in progress, 4) preliminary results, 5) final results, 6) results accepted and acknowledged by the provider
- Why are referrals and care transitions any different?

Care Transition Workflows: A Mess



Symbol Interpretations

- Arrows represent transition from one referral status to another
- Arrow thickness is proportional to # of transitions
- Status color represents relative length of time consults remain in each status (compared to others in this subset): red = longest; green = shortest
- Status states are abbreviated

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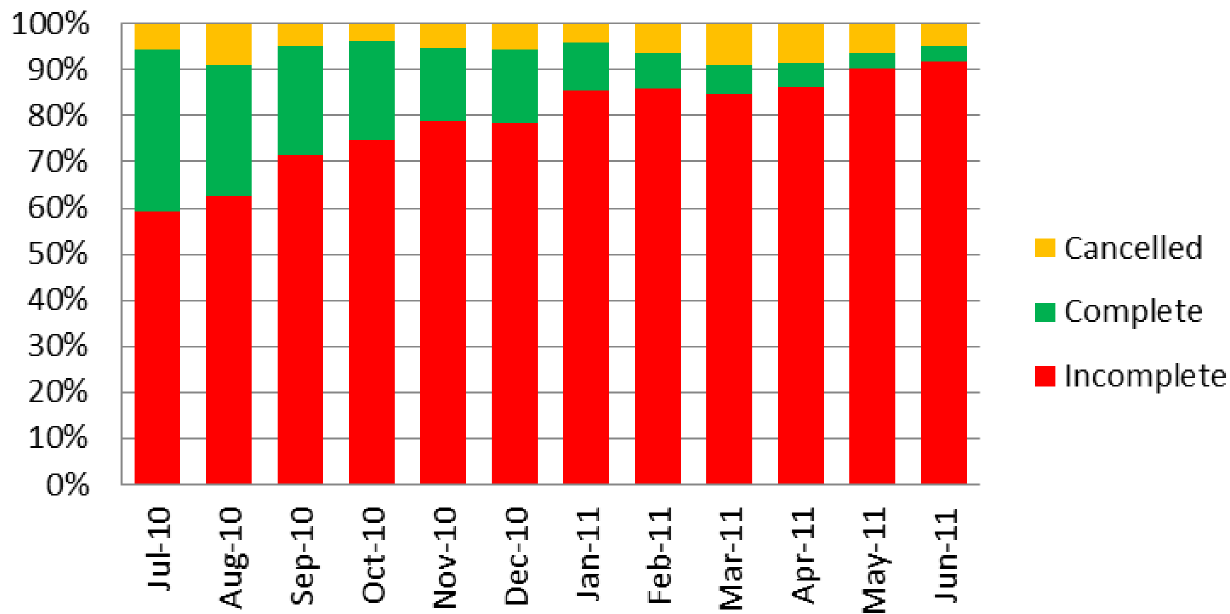
D2D Doc to Doc

Care Transitions Measured

- 1 clinic, 12 months of experience

Visit Request Status as of August 31, 2011 by Month Initiated:

	JAN 2011		FEB 20
	N	%	N
Total Number Initiated	**325**		**285**
Pending Appointment	211	64.9%	199
Scheduled	57	17.5%	37
Consult in Progress	2	0.6%	0
Visit Occurred: Report P	8	2.5%	9
Visit Occurred: Complet	33	10.2%	22
Cancelled	14	4.3%	18
Cancelled by Patient	1	0.3%	2
Cancelled by Receivir	2	0.6%	2
Cancelled by Sending	5	1.5%	2
Failed Appointment	5	1.5%	4
Rejected by Receiving	1	0.3%	8
Not Specified	0	0.0%	0



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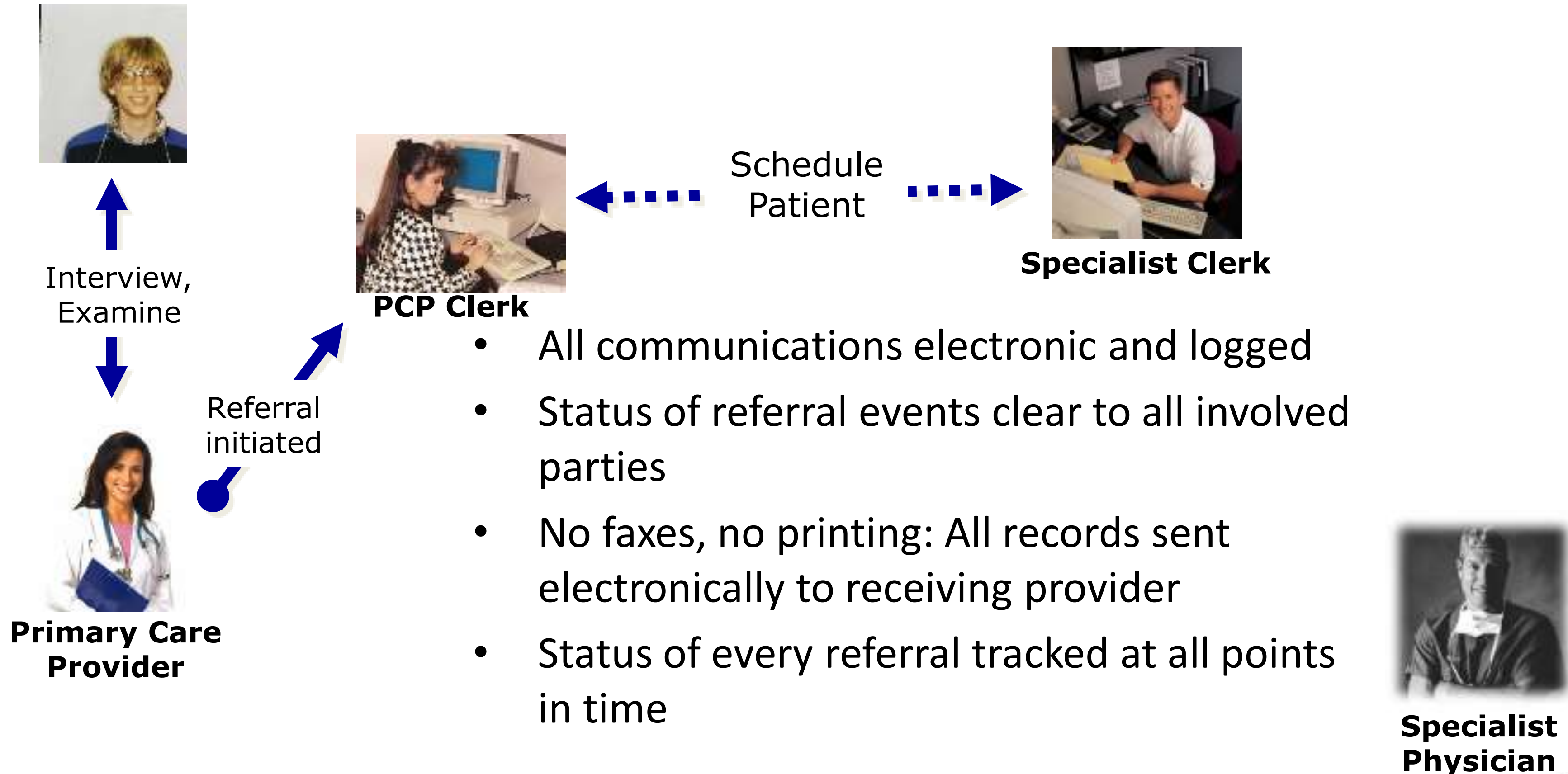
Doc to Doc

Doc2Doc Care Transitions Process



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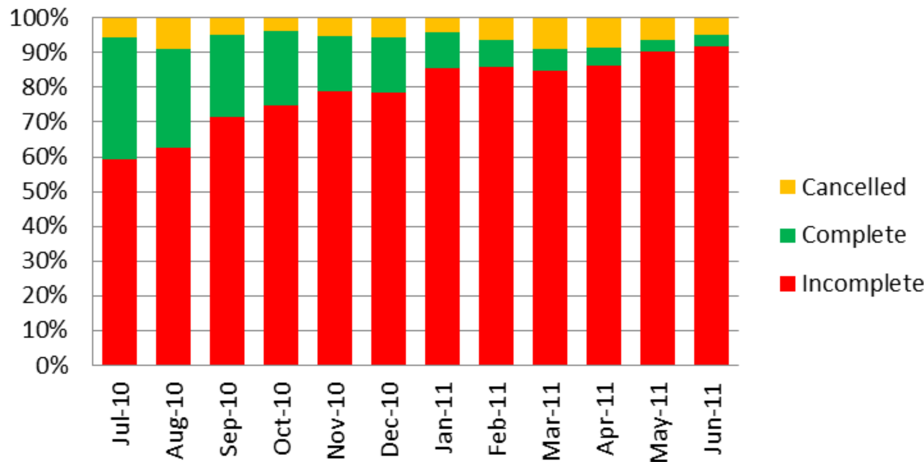
D2D Doc to Doc

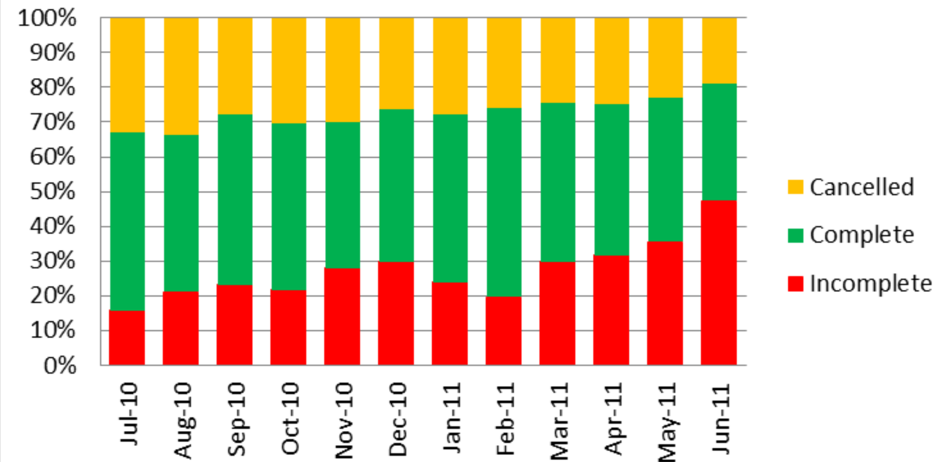
Results: A Tale of Two Clinics

Clinic 1:

Visit Request Status as of August 31, 2011 by Month Initiated:

	JUL 2010		AUG 2010		SEP 2010		OCT 2010		NOV 2010		DEC 2010		JAN 2011		FEB 2011		MAR 2011		APR 2011		MAY 2011		JUN 2011		JUL 2011		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Number Initiated	**409**		**361**		**442**		**363**		**362**		**324**		**325**		**285**		**438**		**426**		**433**		**457**		**392**		**5,017**	
Pending Appointment	154	37.7%	172	47.6%	227	51.4%	210	57.9%	165	45.6%	171	52.8%	211	64.9%	199	69.8%	296	67.6%	272	63.8%	306	70.7%	314	68.7%	280	71.4%	2,977	59.3
Scheduled	79	19.3%	49	13.6%	71	16.1%	55	15.2%	99	27.3%	65	20.1%	57	17.5%	37	13.0%	61	13.9%	75	17.6%	67	15.5%	90	19.7%	71	18.1%	876	17.5
Consult in Progress	4	1.0%	2	0.6%	3	0.7%	3	0.8%	4	1.1%	4	1.2%	2	0.6%	0	0.0%	2	0.5%	8	1.9%	9	2.1%	10	2.2%	6	1.5%	57	1.1
Visit Occurred: Report Pending	5	1.2%	3	0.8%	14	3.2%	4	1.1%	18	5.0%	14	4.3%	8	2.5%	9	3.2%	12	2.7%	13	3.1%	9	2.1%	5	1.1%	9	2.3%	123	2.5
Cancelled by Receiving Provider	31	3.8%	49	5.6%	34	3.7%	34	4.7%	30	3.6%	22	3.3%	18	3.0%	14	2.6%	32	3.4%	25	2.8%	42	5.1%	26	3.5%	14	1.6%	371	3.6
Cancelled by Sending Provider	77	9.5%	77	8.7%	58	6.3%	44	6.1%	37	4.5%	32	4.9%	54	8.9%	46	8.7%	50	5.3%	56	6.3%	43	5.3%	36	4.8%	25	2.9%	635	6.2
Failed Appointment	93	11.4%	96	10.9%	92	9.9%	82	11.4%	90	10.9%	70	10.7%	51	8.4%	28	5.3%	84	9.0%	76	8.5%	51	6.2%	37	4.9%	29	3.4%	879	8.6
Rejected by Receiving Provider	10	1.2%	22	2.5%	24	2.6%	14	1.9%	23	2.8%	8	1.2%	11	1.8%	10	1.9%	9	1.0%	13	1.5%	15	1.8%	20	2.7%	33	3.9%	212	2.1
Not Specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0





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D2D Doc to Doc

Generic Processes to Support Many Transition Types

- Gather data specific to each care transition:
  - PCP to Specialist
  - ER to PCP or Specialist
  - Doctor to ancillary care
  - Hospital to PCP, home health, DME, Transportation, long term care, etc.
  - And any others needed

Cost Analysis

- Medicaid cost assessment performed
- 4 years of comprehensive claims data available
- Conducted analysis on PMPM basis

Care Transition Results

- Patients receiving an online consult had a significant reduction in PMPM cost of care when compared with themselves as historical controls:
  - *$140.53 Pre Consult vs. $78.16 Post Consult*
  - *Net savings of $62.37, p=0.021*
- Compared with patients who received a re NOT a consult:

Cost Type	Mean PMPM Cost Change	Mean Percentage Change
Facility Costs (UB92)	-$13.00	[illegible]
Professional Costs (HCFA 1500)	-$108.04	-34%
Pharmacy Costs (PBM)	-$9.14	-14%
Total Costs	-$130.18	

$117M in potential savings for OK Medicaid program

High Value Care Coordination Collaborative

ALLIANCE FOR ACADEMIC INTERNAL MEDICINE (AAIM)

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HVCC Joint letter to HHS and ONC:

We are concerned that current efforts to expand EHR implementation (Meaningful Use) are unintentionally serving as a barrier to our ability to provide effective and efficient coordinated care to our patients throughout the medical neighborhood.

High Value Care Coordination Collaborative,
February 3, 2014

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D2D Doc to Doc

Challenge:

- ONC's Meaningful Use program rules out these innovations:
  - Requires that email be used instead
  - No reporting or tracking
  - Each Electronic health record vendor implementing differently
- Represents significant regression in capability and worse . . .
- Potential harm to patients.

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D2D Doc to Doc

HVCC Joint letter to HHS and ONC:

- High Value Care Coordination (HVCC) project:
  - develop recommendations and tools to facilitate more effective and efficient **patient-centered referral and referral response** interactions between primary care and specialty/subspecialty practices.
- Care coordination among providers within the medical neighborhood, requires standards that:
  - allow **bi-directional dialogue** among practices;
  - provide a framework allowing **e-consultations**; and
  - require communication of acknowledgements regarding clinical information provided, appointments being kept and referrals being completed. These "**closing the loop**" requirements would mitigate a number of safety and liability concerns.

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D2D Doc to Doc

Conclusions & Recommendations

1. ONC should add Patient Goals of Care to standard document types for Meaningful Use
   – CCD/CCDA with a Patient Goals section and taxonomy and terminology for representation
2. ONC should suspend the current Transitions of Care requirement in MU stage 2 until appropriate study can be performed and clinicians can address the process. Allow innovation to proceed.
3. CMS should pay for eConsults which have a proven return on investment.

Discussion

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