NEW YORK STATE | Department of Health | Medicaid Redesign Team

Breakout D:

Piloting Care Plan Exchange

GNYHA DSRIP PPS & QE CARE PLAN COLLABORATION: SUMMARY OF WORK TO DATE

NY DOH DSRIP Annual Statewide Learning Symposium
September 21, 2016

Lindsey Gottschalk
Zeynep Sumer-King

GREATER NEW YORK HOSPITAL ASSOCIATION
Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

GNYHA DSRIP PPS & QE Care Plan Learning Collaboration

What it is:	What it isn't:
Collaboration across PPSs and QEs to minimize duplicative and/or conflicting work	A standard care management solution or software
Recommendations for nomenclature and organizational conventions for core care plan data elements	A template for a standard care plan document with standard, required content
An effort to progress interoperability by recommending standards for care plan exchange across QEs	One-size-fits-all

Care Plan "Translator"

Care Plan Content
Workgroup standards for
core data elements

Content and format vary

Consolidated view of all care plans in a single format

Checking in: Are We Speaking the Same Language?

Care Plan in this Context

- Supports LONGITUNDINAL coordination of care across multiple sites
- Consensus-driven dynamic plan that represents a patient's and care team members' prioritized concerns, goals, and planned interventions.
- Represents synthesis and reconciliation of multiple plans of care; serves as a blueprint to guide the individual's care

Not

- Summary of Care Document
- Transitions of Care Plan
- Transfer of Care Document
- Advanced Care Planning (POLST)
- Treatment Plan
- Plan of Care (Home Health Agency)
- Comprehensive Care Plan (LTC Facilities)

From, Standards and Operability Framework: Longitudinal Coordination of Care WG, ONC

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Collaboration Objectives

Care Plan Content Sub-group

- Identify and recommend set of core care plan data elements
- Recommend nomenclature and structural conventions for care plan organization
- Develop guidelines for care plan governance and workflow

Information Technology Sub-Group

- Identify requirements for existing and new QE functionality to support this exchange
- Develop technical specification guidelines for implementation
- Determine adoption support needs of PPSs and their partners

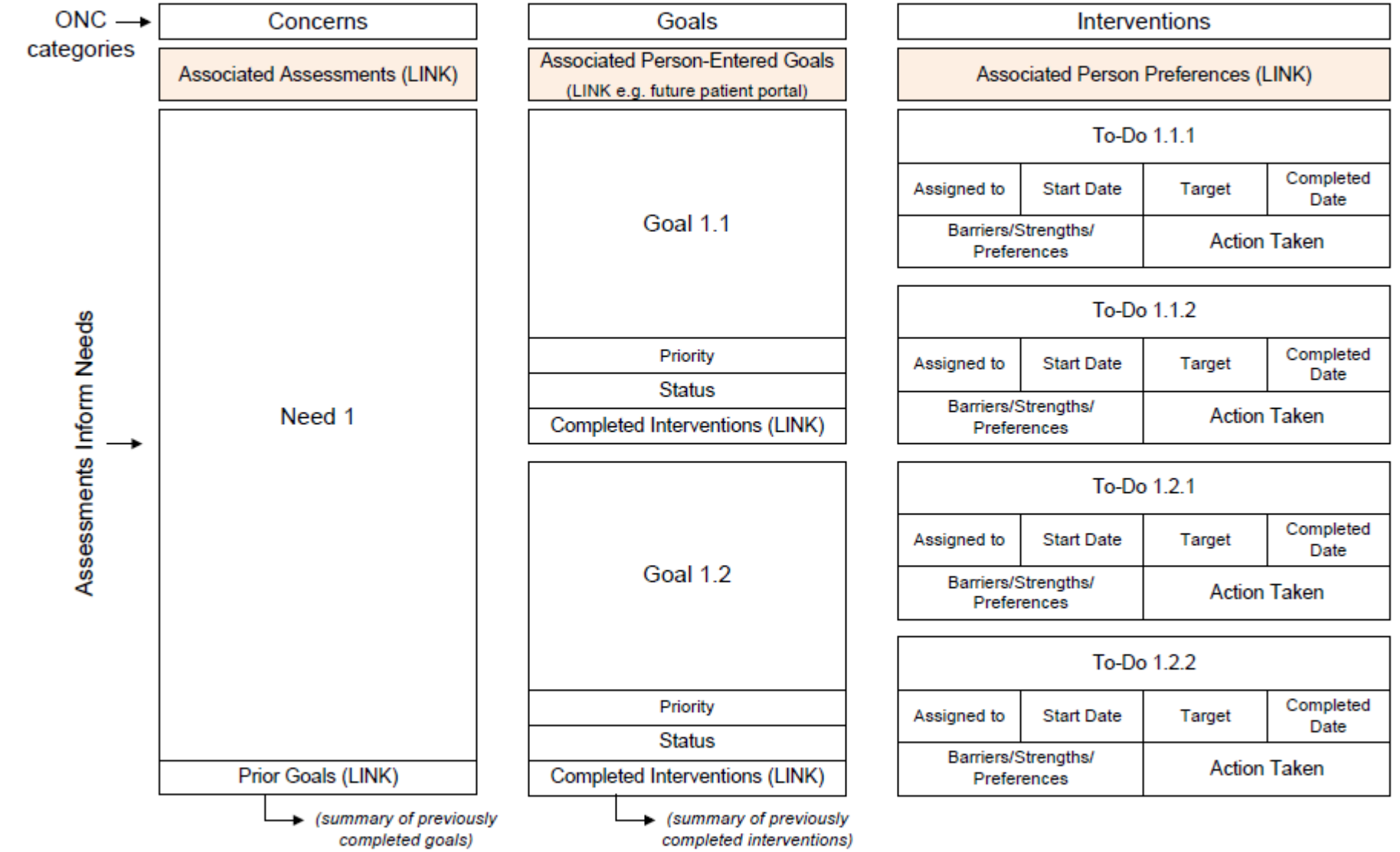
Joint Sub-Groups

- Participate in pilots to test the 3 implementation models of care plan QE exchange identified to address diversity of PPS and QE current state and HIT strategies

Content Sub-Group: Defined and Identified Priority Care Plan Modules (or "Data Sets")

	Module	Status			Module	Status
1	**Patient Information**	Drafted recommendations		7	**Patient Clinical Summary**	Use existing QE information
2	**Care Goals & Status**	Drafted standards and C-CDA Template		8	**Patient-facing Care Plan**	Use existing EMR/CPMS information
3	**Care Team & Programs**	Drafted recommendations		9	**Assessments**	Use existing EMR/CPMS information
4	**Services & Referrals**	Drafted recommendations		10	**Document Repository**	Use existing QE information
5	**Encounters**	Use existing QE information		11	**Screening Tools**	Use existing EMR/CPMS information
6	**Quality of Care & DSRIP Flags**	Identified priority flags				

GNYHA Care Plan and QE Learning Collaborative
C-CDA Template: Containerized Design for Care Goals Module of Comprehensive Care Plan | Version 1.2 | June 6, 2016



Notes:

- Headings align with ONC containerized design concept
- Need to develop design standards to house attestations and provisional updates
- Goals can be personal; can be quantitative or qualitative
- Target can be a date, a numeric value, or continuous

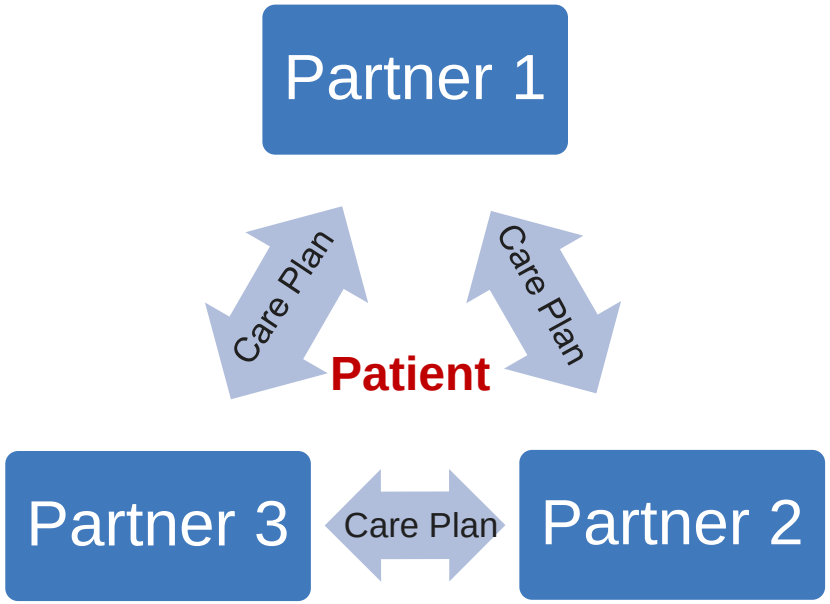
= Does not exist yet

Pilot Approach to Implementation

Identify PPS Specific Use Cases

- Target populations
  - High utilizers; chronic disease management; linkage to care
- Variety of partners
  - Clinical Sites; CMAs; MCOs; social services; other
  - Variety of electronic capabilities
- Variety of sites of care
  - Primary Care; ED; Hospital; CBO; BH

Test Concept of "One Patient, One Care Plan, Many Team Members"



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How Do We Define Pilot Success?

- Phase 1 Objectives
  - Test Model A (PDF document) bi-directional care plan exchange
  - Identify care plan exchange workflow and governance guidelines
  - Obtain partner and care team buy-in and feedback for care plan exchange using QEs
- Phase 1 Participation Expectations
  - PPS identify at least 2 partner sites with QE connections
  - Pilot teams complete “Pilot Implementation Worksheet” PPS and partners exchange at least 20 care plans for targeted use case
  - Pilot teams participate in 4 bi-weekly check-in calls and report out on experience to group
- Phase 2 Objectives
  - Test Model B and/or C (C-CDA document) bi-directional exchange using content and standards developed by group

Pilot Phase 1 - Participation

	PPS	Partners	QE	Use Case
1	**Staten Island PPS**	Richmond University Medical Center; Community Health Center of Richmond (PCMH); Metro Community Health Centers (PCMH); RUMC Primary Care (PCMH); Coordinated Behavioral Care (HH)	**Healthix**	MAX Series Super-utilizer project. Exchange ED generated care plans of BH populations presenting to ED with primary care and health home services.
2	**New York Presbyterian**	NYP Comprehensive Health Program (HIV/AIDS Clinic); ASCNYC (CBO);	**Healthix** (ASCNYC not yet connected)	Exchange ASCNYC generated care plans of HIV+ Health Home enrollees with clinical team
3	**Bronx-Lebanon**	Bronx Lebanon Hospital; Boom Health (CBO)	**Bronx RHIO**	Health Home at Risk project
4	**NQP/ Northwell**	*Health Home partners TBD*	**Healthix**	*Health Home in preparation for Phase 2*
5	**Mt. Sinai Health System**	VIP Community Services, Betances Health Center, Phoenix House New York, Bedford Medical Family Health Center, The Bridge, Visiting Nurse Service of NY	**Healthix; NYCIG; Bronx RHIO**	*Chronic Disease Management*

Where Are We Now: Collaboration Phases and Timelines

Phase	Timeline
Planning and PPS Engagement	Jan - Feb 2016
Content and Standards Development	Feb - May 2016
Phase 1 Pilot Planning	May – June 2016
Phase 1 Pilot Implementation • PPS identify at least 2 partner sites with QE connection committed to participating in pilot • PPS/partners commit to exchanging at least 20 care plans • Pilot participants commit to joining hour-long bi-weekly check-in calls during pilot period and reporting out on experience to group.	*July – Nov 2016*
Phase 2 Pilot Planning • Develop technical specification guidelines and business requirements to support C-CDA exchange	*July – Dec 2016*
Phase 2 Pilot Implementation	*Jan 2017 +*

Realizations Along the Way

- Need for pilot approach to work through unanswered questions
  - Concerns around care plan governance, ownership, and reconciliation
  - Workflow should dictate design not the other way around
- Focus on shared learning
  - Call #1: Use cases and initial challenges
  - Call #2: Consent frameworks and workflows
  - Call #3: Provider engagement strategies
  - Call #4: Pilot metrics and care plan user reports
  - User focus group to provide feedback on QE care plan interface
- Incorporate PPS variation
  - Content: Care plan modules and containerized C-CDA
  - Technology: Implementation models and vendor participation
  - Don’t let consensus/perfection get in the way of iteration

Staten Island
Performing Provider System, LLC

Plan of Care Pilot : Phase 1

SEPTEMBER 21ST

Goals of Phase I Pilot

Identify Participating Partners

- Focus on partners connected to Healthix

Explore Partner Specific Workflows

- It’s imperative to follow the care plan

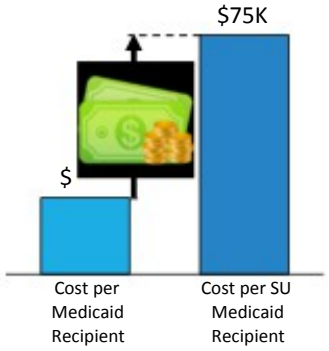
Identify Patients

- Which patients have visited multiple partners?

THE IMPACT OF SUPER UTILIZERS ON STATEN ISLAND PPS

9% of Staten Island PPS Medicaid Enrollees are defined as Super Utilizers

Average spending per Super Utilizer recipient is 3.1X greater



That population drives 45% of ED Visits by Medicaid enrollees…

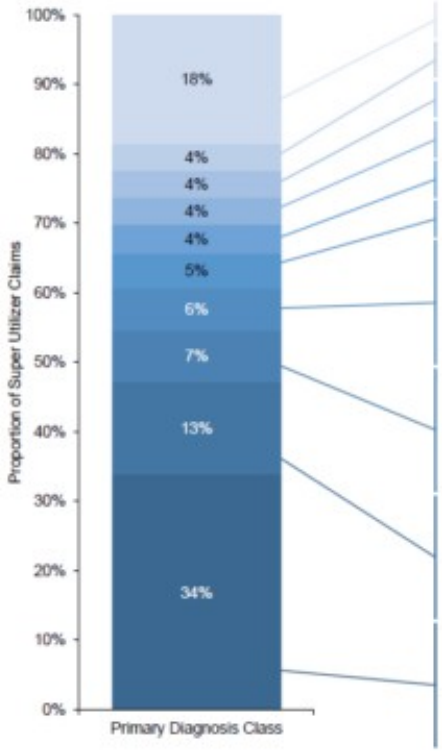
Avg. ED Visits/SU: 8.89

… and 63% of inpatient admissions

Avg. IP Admissions/SU: 1.89

Among claims by Super Utilizers at RUMC attributed to Staten Island PPS, primary diagnoses related to mental disorders, respiratory illnesses and injuries are prevalent

Primary Diagnosis Class and Top 3 Primary Diagnoses of Super Utilizer Claims at Richmond University Medical Center



Primary Diagnosis Class/Primary Diagnosis	Volume of Claims	Number of Super Utilizers
Other	**5,555**	**-**
Supple Class/Desc Of Patient Status & Other Hlth	**1,151**	**607**
Endocrine, Nutritional, Metabolic	**1,170**	**337**
Digestive System Diseases	**1,200**	**504**
Reason For Special Admissions And Exams	**1,247**	**214**
Genitourinary System Diseases	**1,492**	**465**
Nature Of Injury, Adverse Effects And Poisoning	**1,846**	**883**
1. Head injury, unspecified	7%	
2. Sprain of lumbar	4%	
3. Sprain of ankle, unspecified site	3%	
Diseases Of The Respiratory System	**2,201**	**733**
1. Asthma, unspecified type, with (acute) e	26%	
2. Acute upper respiratory infections of un	17%	
3. Acute pharyngitis	10%	
Signs, Symptoms, and Ill-Defined Conditions	**4,044**	**1,089**
1. Chest pain, unspecified	10%	
2. Abdominal pain, unspecified site	10%	
3. Headache	8%	
Mental Disorders	**10,171**	**929**
1. Schizoaffective disorder, unspecified	28%	
2. Paranoid type schizophrenia, unspecified	10%	
3. Depressive disorder, not elsewhere class	8%	

Richmond University Medical Center

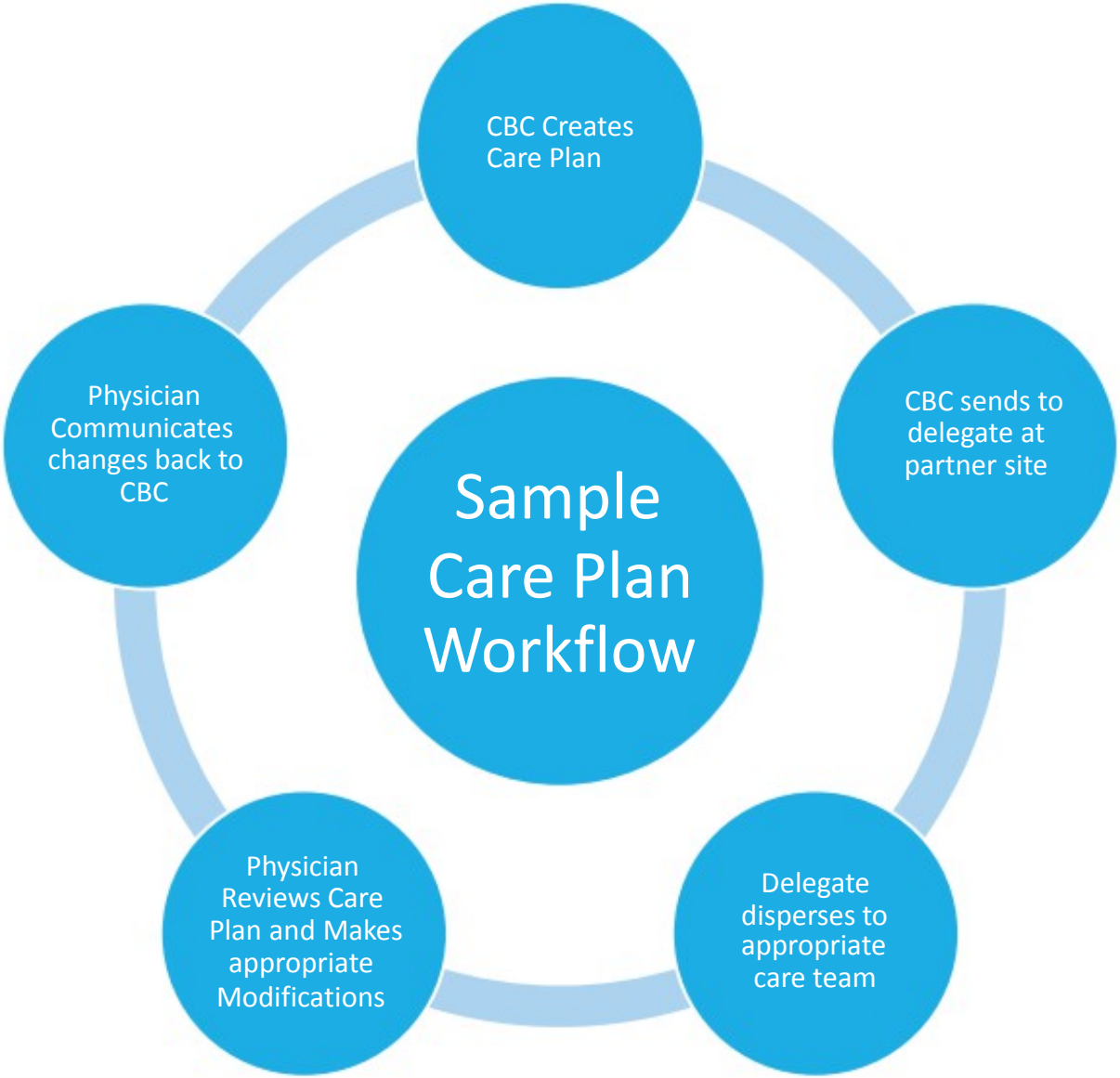
Unique Super Utilizers: 2,090

Super Utilizer Claims: 30,078

Note: Represents data over a two-year period (CY13-14)

Note: The top 3 Primary Diagnoses that account for the greatest volume of claims within a class have been included for the top 3 Primary Diagnoses with the greatest volume of claims (excl. Signs, Symptoms, and Ill-Defined Conditions)

NEW YORK STATE OF OPPORTUNITY. Department of Health


Sample Care Plan Workflow
CBC Creates Care Plan
CBC sends to delegate at partner site
Delegate disperses to appropriate care team
Physician Reviews Care Plan and Makes appropriate Modifications
Physician Communicates changes back to CBC

GNYHA Collaboration: Piloting Care Plan Exchange The Mount Sinai PPS Approach

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Senior Director, IT DSRIP Program

Dennis Lumbao, MBA
Project Manager, DSRIP PMO,
Care Coordination

September 21, 2016

Mount Sinai

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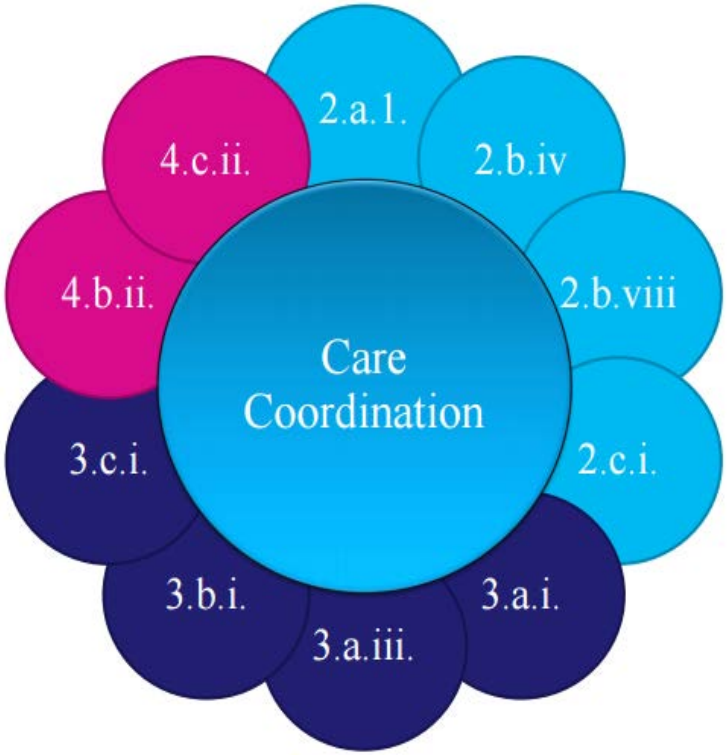
CARE COORDINATION WORKGROUP SUMMARY



- Considerations
- Challenges
- Partner Feedback
- Best Practices (Engagement)
  - Leverage existing resources
  - Partner interests
  - Partner needs
  - Conduct a strengths, weakness, opportunities, threat (SWOT) analysis
  - Confirm understanding on current state a.k.a.

Know **Y**our **P**artners

(KYP)

GNYHA PILOT BACKGROUND

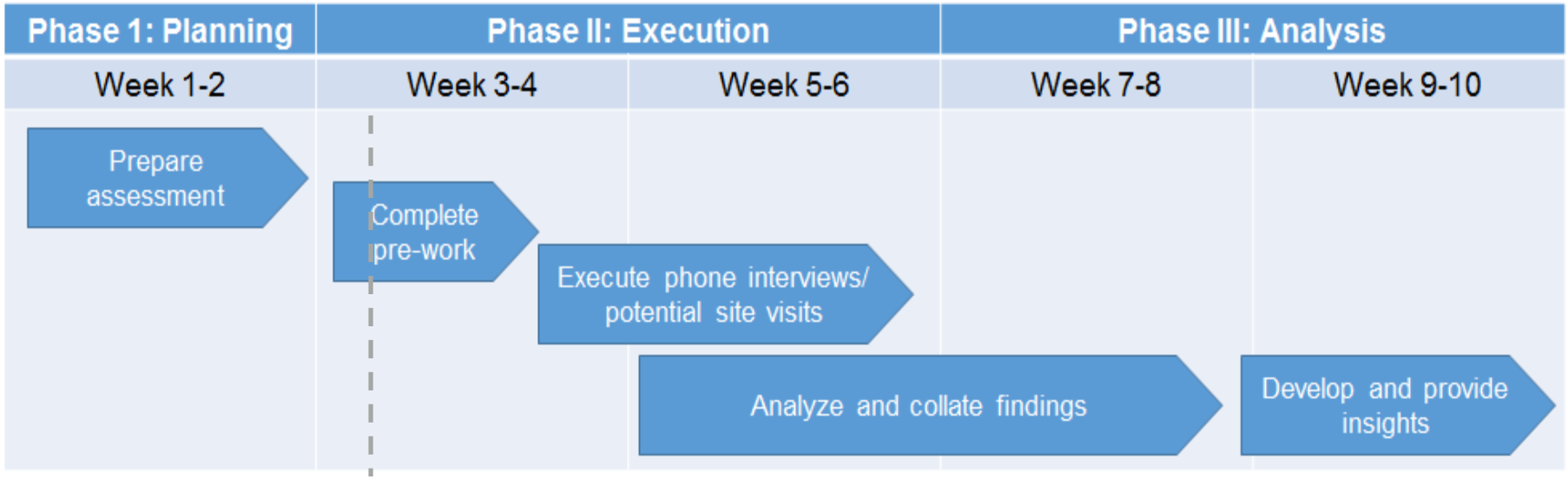
- The Greater New York Hospital Association is looking to align care plan structure and enhance care plan sharing processes across PPSs in order to meet DSRIP objectives

- The information technology group is responsible for conducting a care plan pilot assessment to help PPS determine how best to address capabilities for implementation, business and technical requirements, and adoption

Source: GNYHA DSRIP Care Plan QE Collaboration 6.22.16

MOUNT SINAI PPS PILOT APPROACH

- The IT analyst team will conduct a current state assessment for 14 partners across categories with unique care plan sharing characteristics (e.g., Paper care plan and HIE sharing)
- The team will conduct phone calls and site visits, as needed, to gather information related to care plan development, management and sharing
- They hosted a partner introduction webinar and phone calls on 9/14, and will complete the pilot analysis in November, 2016



STAKEHOLDER BENEFITS

	GNYHA	HIE	Vendors	PPS Leader	PPS Partner
✓ Understand PPS-wide gaps in care plan sharing process	X	X		X	
✓ Understand how partners interact with the HIE	X	X		X	
✓ Understand vendor role in care plan workflow	X		X	X	X
✓ Identify care plan sharing workflow pain points and critical success factors	X		X	X	X
✓ Identify best practices for each partner category	X		X	X	X

PARTNER CATEGORIES

Partners are assessed in groups based on care plan sharing characteristics*

Category 1– Static care plan (Paper or Other - PDF/EMR)	
1	Premier
2	Amsterdam Nursing Home
Category 2 - HIE connectivity but does not share care plan information through HIE	
3	Visiting Nurse Service of New York
4	Mount Sinai Health System- St Lukes
5	Housing Works
Category 3 - HIE connectivity and share care plan information through HIE (Structured data and PDF)	
6	VIP Community Services
7	Betances Health Center
8	Bedford Medical Family Health Center

Category 4 – Crimson Care Plan Users	
9	Bailey House
10	ACMH
Category 5 – Epic Care Plan Users	
11	Mount Sinai Health System
12	Institute for Family Health
Category 6 - EMR care plan (non-Crimson/Epic), and not connected to HIE	
13	Cardinal Health Partners
14	Queens Coordinated Care Partners/ Mental Health Providers of Western Queens, Inc.

** The IT team leveraged existing assessment information and conducted additional outreach to create this list*

ASSESSMENT OUTPUTS

Information elaborated through phone calls and site visits…

…will reveal current state processes and insights.

Assessment Questions

A. Care Plan Development and Management

1. What type(s) of organization are you?
4. What are the major discrepancies between care plan type(s) in your organization?
5. What is your definition of a care plan?
6. Who initiates the development of a care plan(s) within your organization?
7. Who is responsible for the management of care plan(s) in your organization?
8. When are care plans initiated in your organization? When are they completed?
9. How is the development of care plan(s) initiated? What are the key workflows and hand-offs to initiate the process?
10. Where does your organization document care plan(s)?
11. Can you share a blank template of your care plan(s)?
12. For each care plan that your organization uses, what content is included?
    a. Goals and Interventions?
    b. Gaps in Care?
    c. Clinical and Non-Clinical Needs?

B. Target Patient Population for Assignment

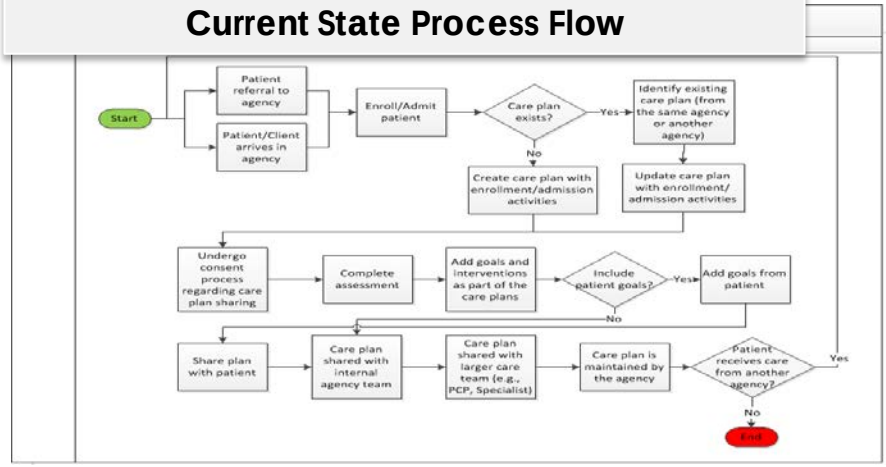
2. Which of the following patient eligibility criteria inform your care plan assignment? Indicate all that apply: clinical status/patient risk status, ED utilization, demographic characteristics, program enrollment (i.e. Health Home), other
3. Point of service (eg hospital, primary care, ED)
4. Inciting event (eg discharge, ED visit, other)

C. Care Plan Sharing (Information exchange)

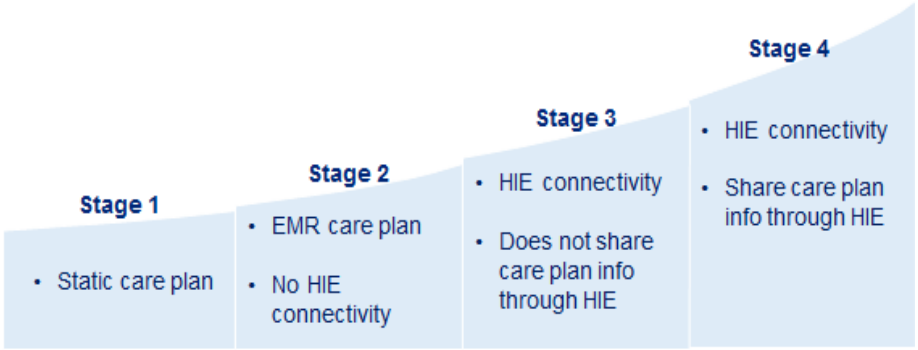
2. Do you share care plan(s) with other providers?
3. With what type(s) of providers do you share care plan(s)?
4. How do you share care plan(s) with other providers? Does this sharing process vary for any providers that you collaborate with?

2 | Page

Current State Process Flow



Category Insights



Appendix

STAKEHOLDER BENEFITS

GNYHA

- Understand PPS-wide gaps in care plan sharing processes
- Identify best practices to scale state-wide improvement

HIE

- Understand the level of partner interaction
- Identify gaps to HIE connectivity and sharing for various categories

Vendors

- Understand vendor role in workflow: EMR, care management, Patient engagement and others
- Incorporate best practices based on assessment findings to increase adoption

PPS Leader

- Gain insight into pilot group care plan sharing processes and improvements for categories
- Identify next steps to scale care plan sharing improvement efforts across partners

PPS Participant

- Understand the current state care plan sharing workflow and pain points
- Understand critical success factors to improved sharing specific to the partner category

OUTPUT DETAIL

Name		Description
Phase I – Planning		
1	**Pilot Partner List and Categories**	List of targeted partners for current state assessment based on stratification criteria
2	**Overall Pilot Plan and approach**	Plan for partner outreach including interview questions, care plan process reference, and timeline
Phase II – Execution		
3	**Interview Pre-Work Worksheet**	Questions related to care plan development and sharing that partners will complete prior to a phone interview, in order to guide the discussion
4	**Phone Interviews/ Site Visit Deep Dive Questionnaire**	Deep dive questions to gather information about the care plan sharing process. These questions highlight implementation components including the target population, care plan development and oversight, and information exchange
Phase III – Analysis		
6	**Current State Care Plan Sharing Process Map**	Current care plan sharing process map for each category
7	**Pilot Analysis and Insights**	A document summarizing process gaps as well as adoption/ implementation critical success factors for each category

CATEGORY DETAIL

Category	Format	Connected to HIE?	Who are you?
1	Static (Paper/EMR View Only)	✓ / ✗	You view the patient care plan in an EMR or on paper. You print a static version of the care plan from an application, or manage the care plan on paper. You share and gather care plan information among providers through email/fax/mail/telephone.
2	EMR other than Crimson / Epic	✓	You view and update a care plan in your EMR. You are connected to the HIE and can view patient information in the HIE from other organizations, however you do not send the care plan or care plan information to the HIE. You usually share care plan information through your EMR or through email/fax/mail/telephone.
3	EMR other than Crimson / Epic	✓	You view and update a care plan in your EMR which is connected to the HIE. You can view patient information in the HIE from other organizations and you also send the care plan/care plan information from your EMR or care management application to the HIE.
4	**Crimson**	✗	You view and update a care plan in Crimson Care Management. You are able to view patient care plan information for other organizations that also use Crimson. If you need to share the care plan or view care plans from other organizations, you do so either through email/fax/mail/telephone, EMR or the HIE.
5	Epic Healthy Planet	✓	You view and update a care plan in Epic Healthy Planet. If you need to share the care plan or view care plans from other organizations, you do so either through email/fax/mail/telephone , EMR or the HIE.
6	EMR other than Crimson / Epic	✗	You view and manage a care plan in your EMR. You are not connected to the HIE, and therefore are unable to view patient information through the HIE. If you need to share the care plan or view care plan information from other organizations, you do so through an EMR system or through email/fax/mail/telephone.

THANK YOU

Care Plan Exchange Pilot

NewYork-Presbyterian Performing Provider System

Patricia Hernandez, LCSW
Manager, Team-Based Care

NewYork-Presbyterian
Performing Provider System

Care Plan Pilot Components

- **Target Population**
  - Patients enrolled in NYP's Health Home Program with a positive HIV diagnosis
  - Shared patients of NYP's Comprehensive Health Program (CHP) and ASCNYC (HH downstream partner)

- **Care Plan Development**
  - Initiated by ASCNYC's Health Home Care Coordinator within 30-45 days post enrollment into the Health Home
  - Care Plan is documented in Allscripts Care Director

Care Plan Pilot Components

- **Health Information Exchange**
  - Allscripts Care Director sends Care Plans (in PDF) to Healthix
  - Providers and other care team members at CHP will view patient's care plan in the Healthix portal
  - Healthix consent will be captured at the time of registration at the CHP site

- **Care Plan Oversight**
  - All changes to the care plan will be made by ASCNYC's Health Home Care Coordinator
  - CHP Care Team and Health Home Coordinator will meet every month to review patient's care plan and make updates as needed

Provider Engagement

- **Internal Efforts**
  - Healthix Steering Committee and Workgroups
  - Healthix 101 Webinars and FAQs on PPS website

- **External Efforts**
  - Healthix Kickoff Meetings (lead by DSRIP IS Team– includes Collaborator, DSRIP Project Leads, and Healthix)
  - Healthix 101 Webinars and FAQs on PPS website
  - IT/Data Governance Committee

Healthix

Care Plan Exchange
Phase 2 Pilot

September 21, 2016

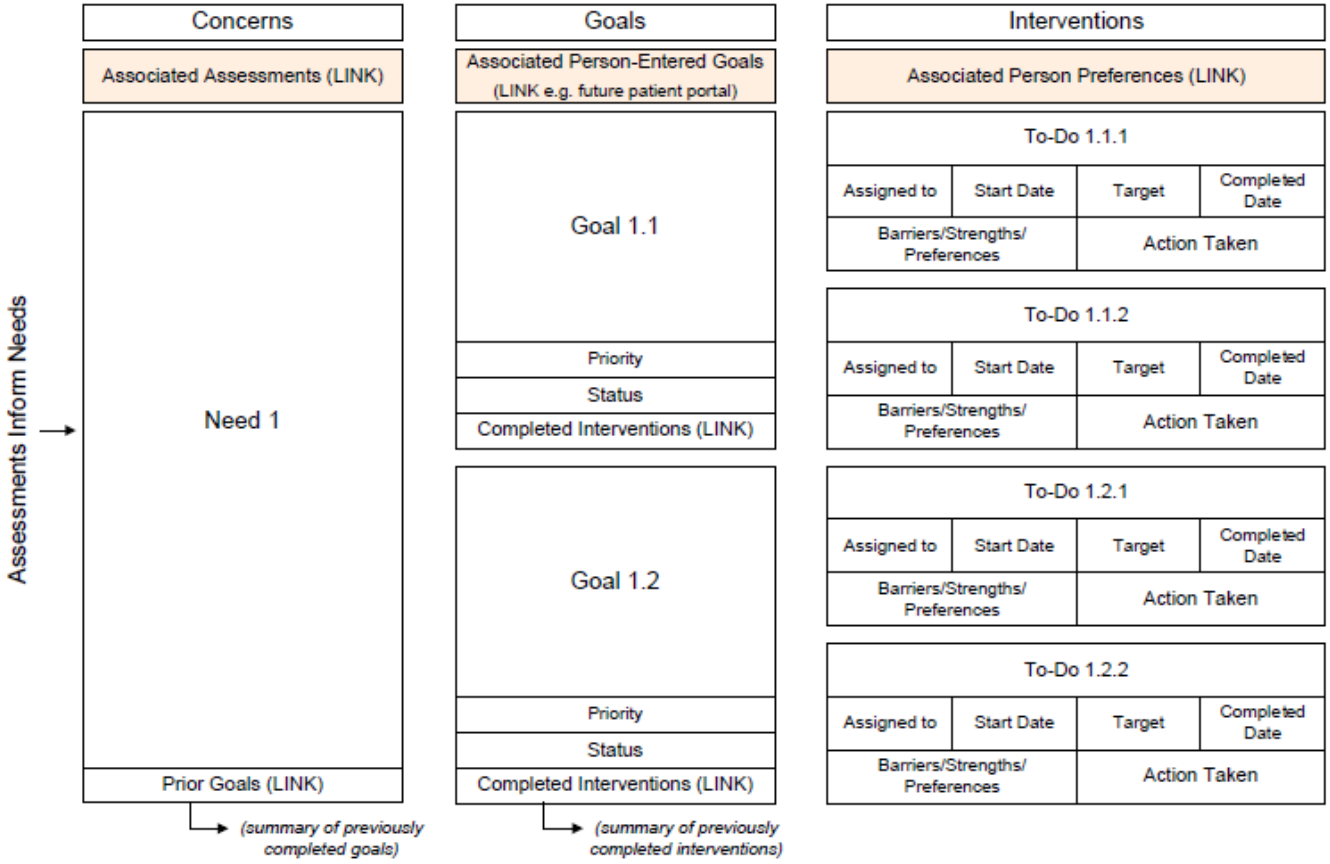
Agenda

Scope of Phase 2 Pilot

- Focus is on communication with provider in the community.
- Care Plan uses standard content and structure from Phase 1.
- Exchange Care Plans between Care Manager, QE, and Provider using current national technical standard
  - Uses CDA r2.1 document including:
    - Health Concerns field
    - Treatment Plan section (for Goals and To-Dos)
    - Add Assessments and Outcomes to Treatment Plan section
- Phase 2 participants include two Care Management groups that:
  - Use different care management software
  - Serve the same PPS as well as other PPSs.
- Software development will continue through Q4 2016.

C-CDA Template of Comprehensive Care Plan

GNYHA Care Plan and QE Learning Collaborative
C-CDA Template: Containerized Design for Comprehensive Care Plan
Version 1.2 May 25, 2016



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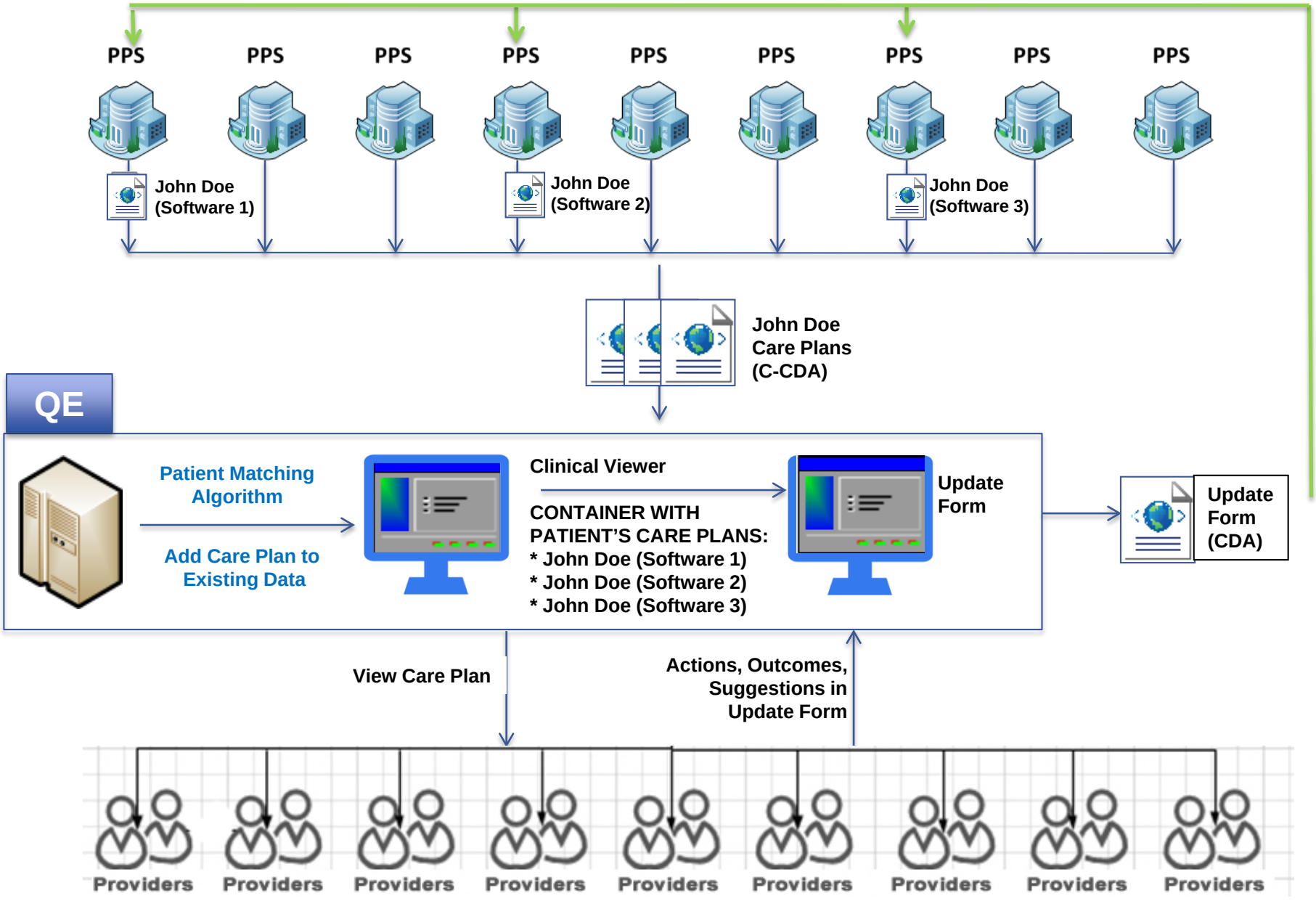
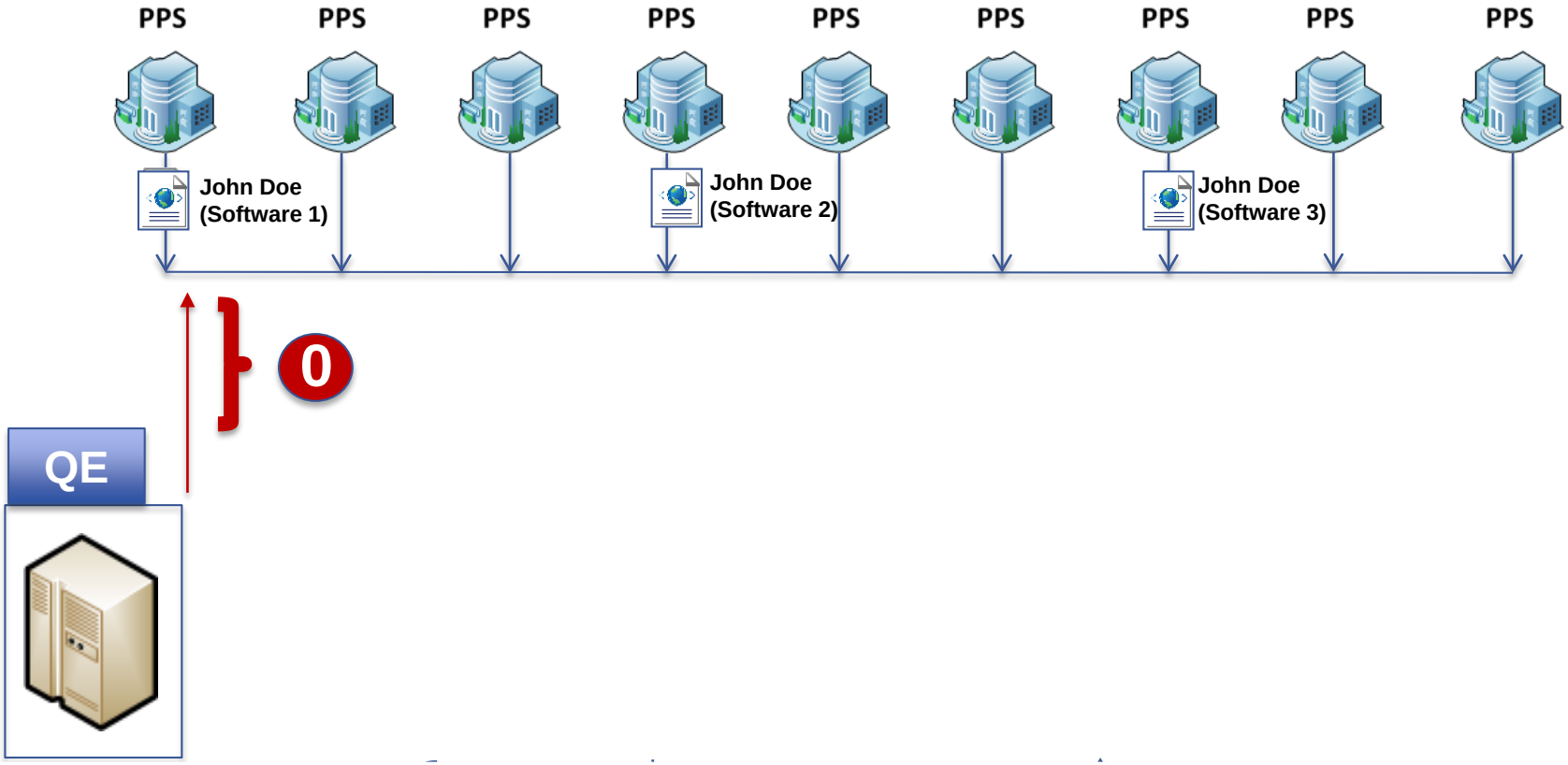
Healthix

Information Flow between Care Manager and Provider

Phase 2: Pilot Real-World Implementation of C-CDA R2.1 Care Plan

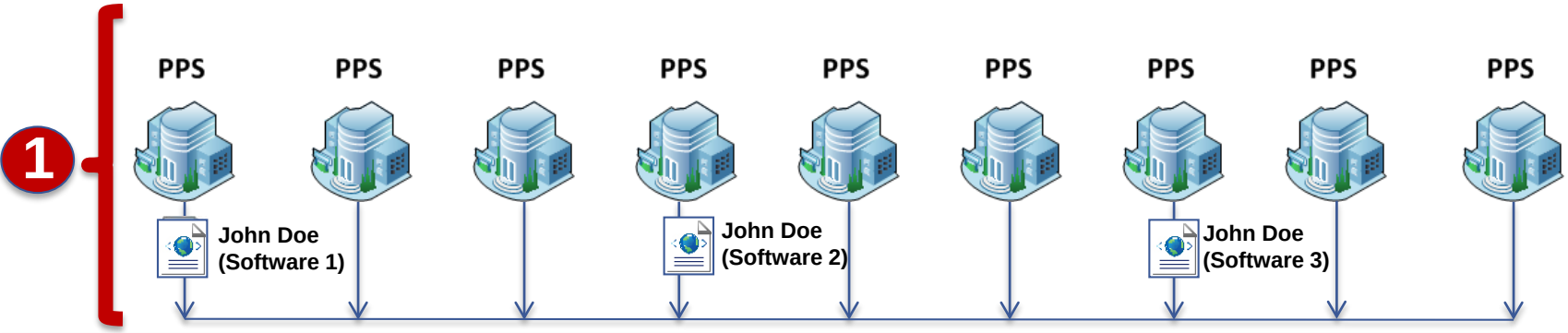


Note: Some providers may consume the CDA Care Plan into their EHR and return Assessments and Outcomes in a CDA from their EHR.



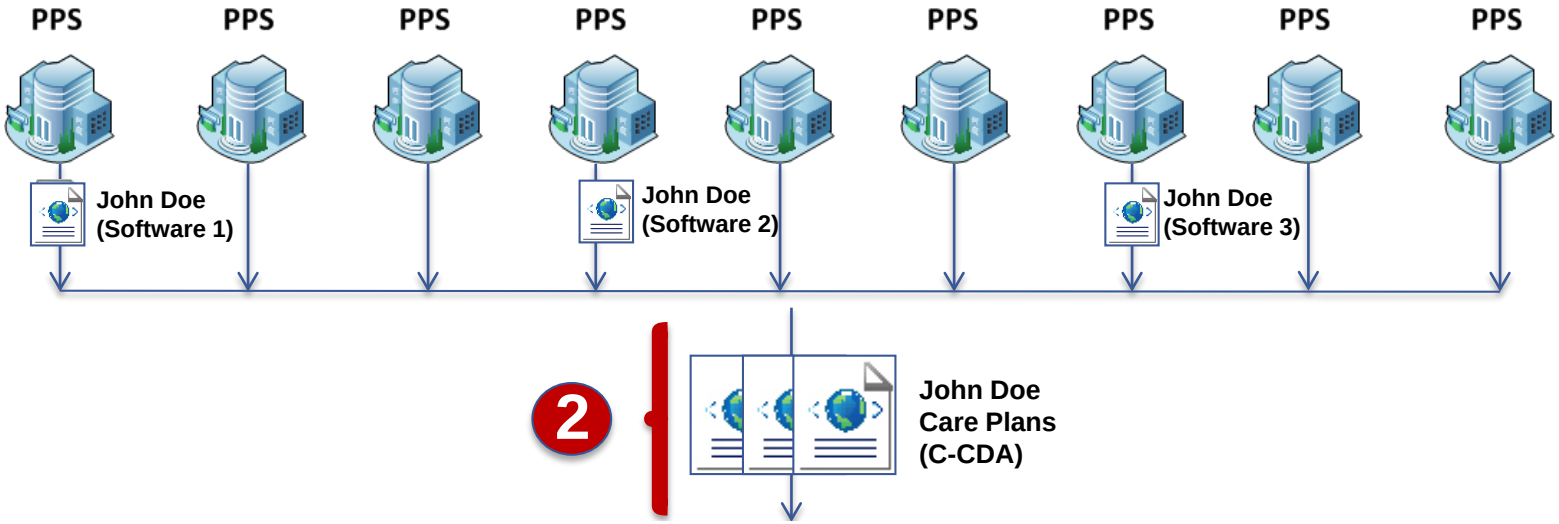
0. Care Management software retrieves the patient's data from Healthix

- To create initial load of patient information
- Healthix automatically sends data from subsequent patient encounters

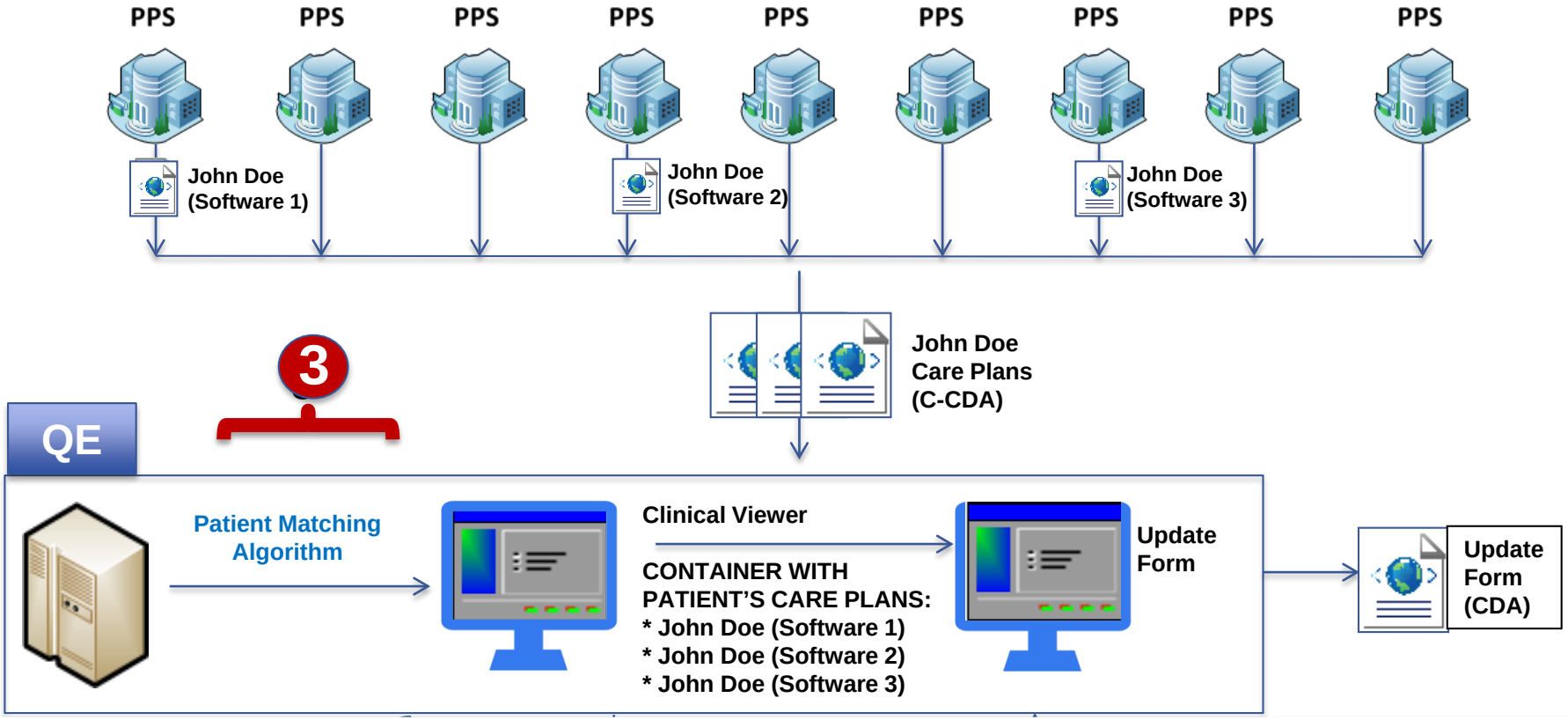


1. Care Manager creates Care Plan in care management software.

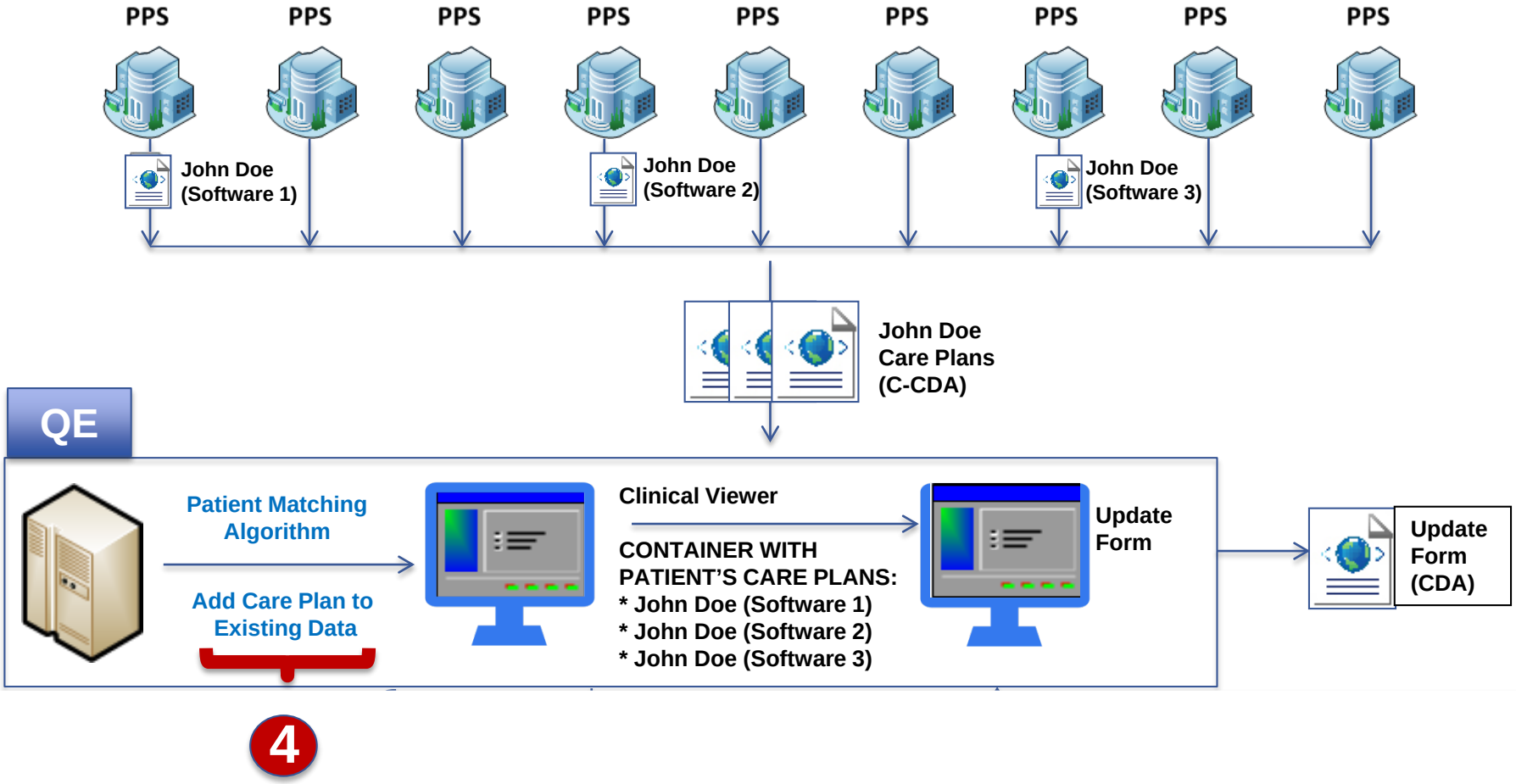
- If patient sees providers in multiple PPSs, he/she may have a Care Plan in each PPS.
- Initial implementation assumes one Care Plan per patient.
- Each PPS uses its owns care management software.



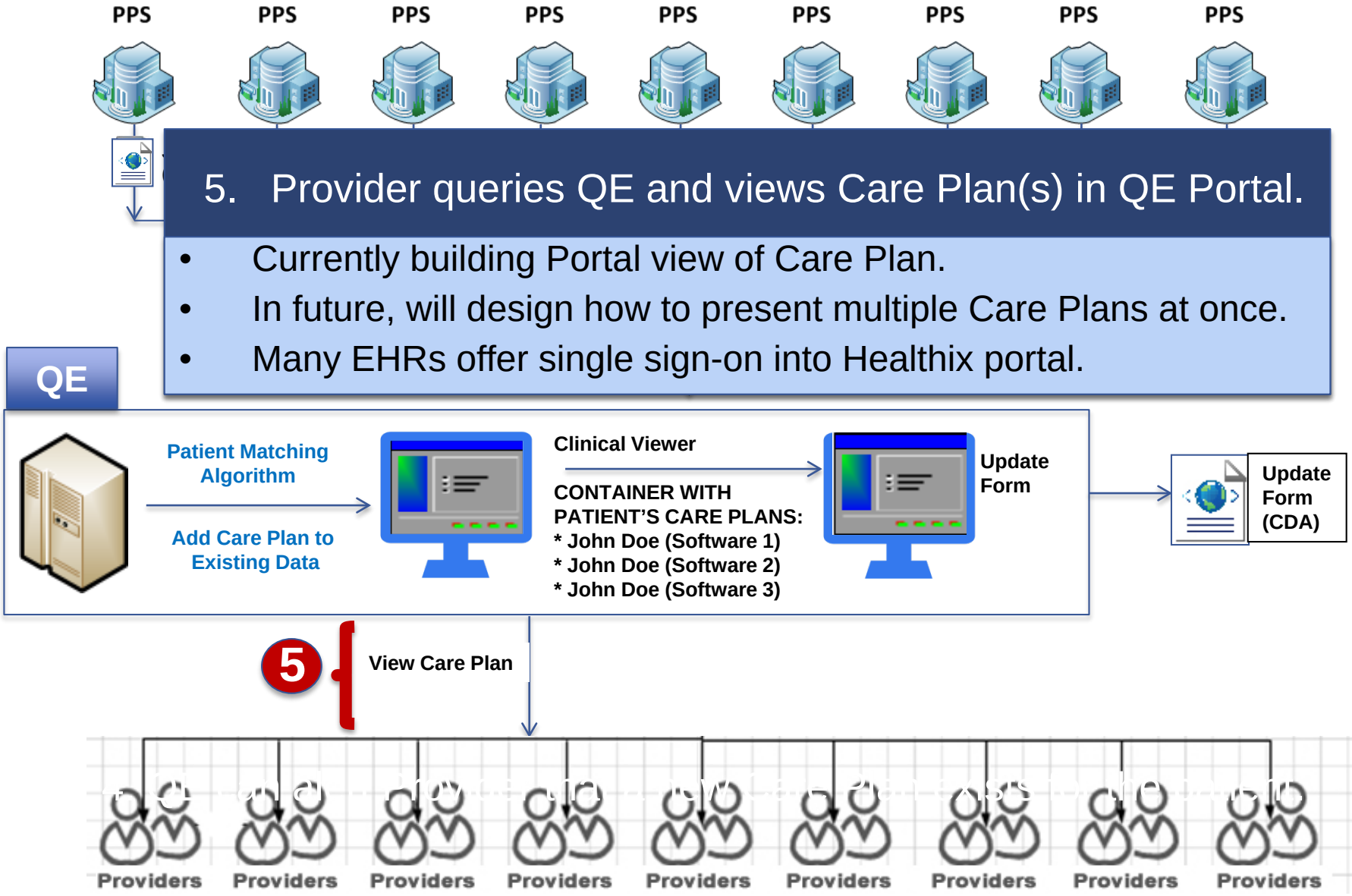
2. Care management software sends Care Plan to QE as a C-CDA Document.



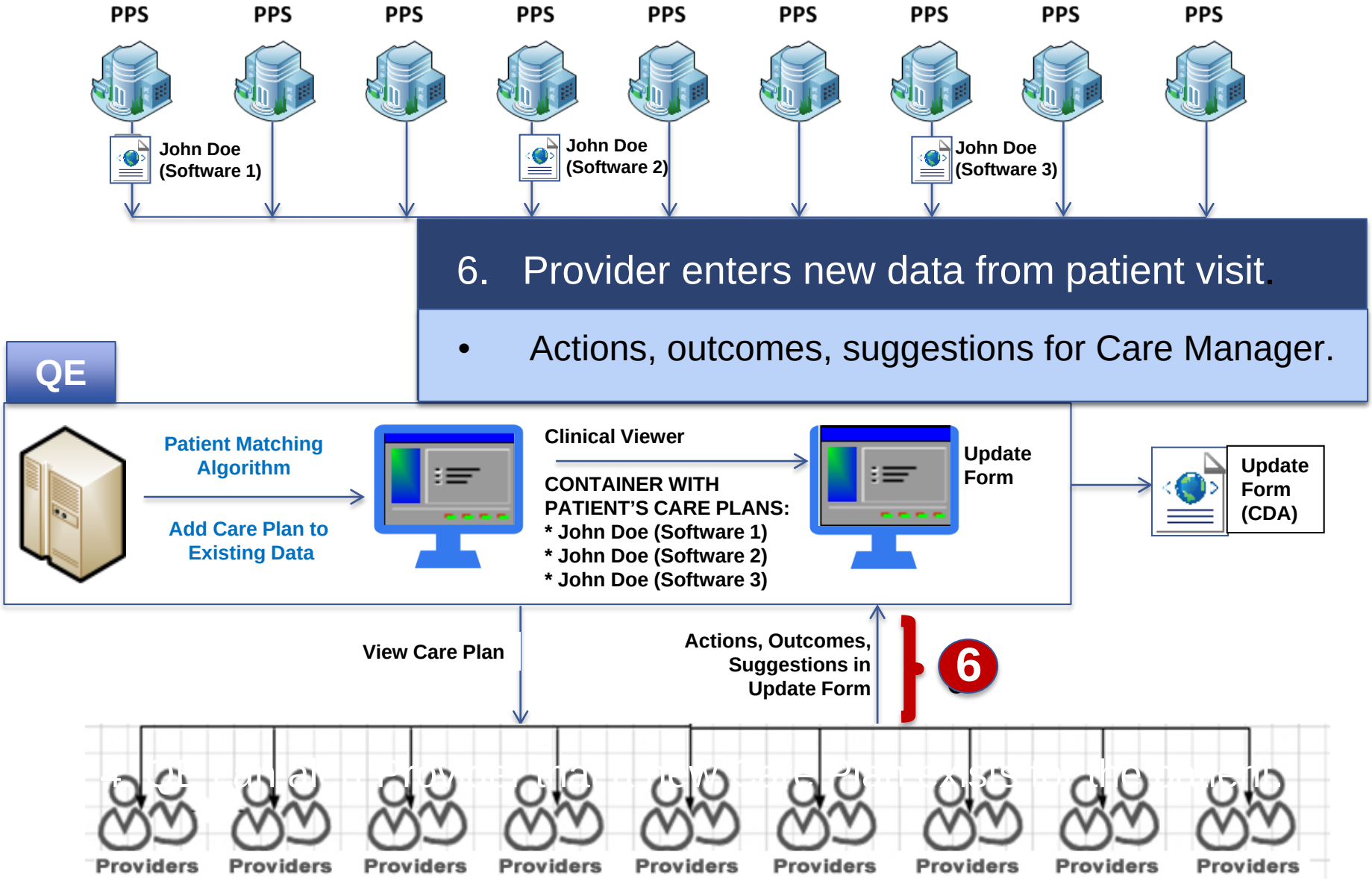
3. QE adds the Care Plan(s) to its existing data on the patient.



4. QE can alert Provider that a new Care Plan exists for the patient.



Note: Some providers may consume the CDA Care Plan into their EHR and return Assessments and Outcomes in a CDA from their EHR.



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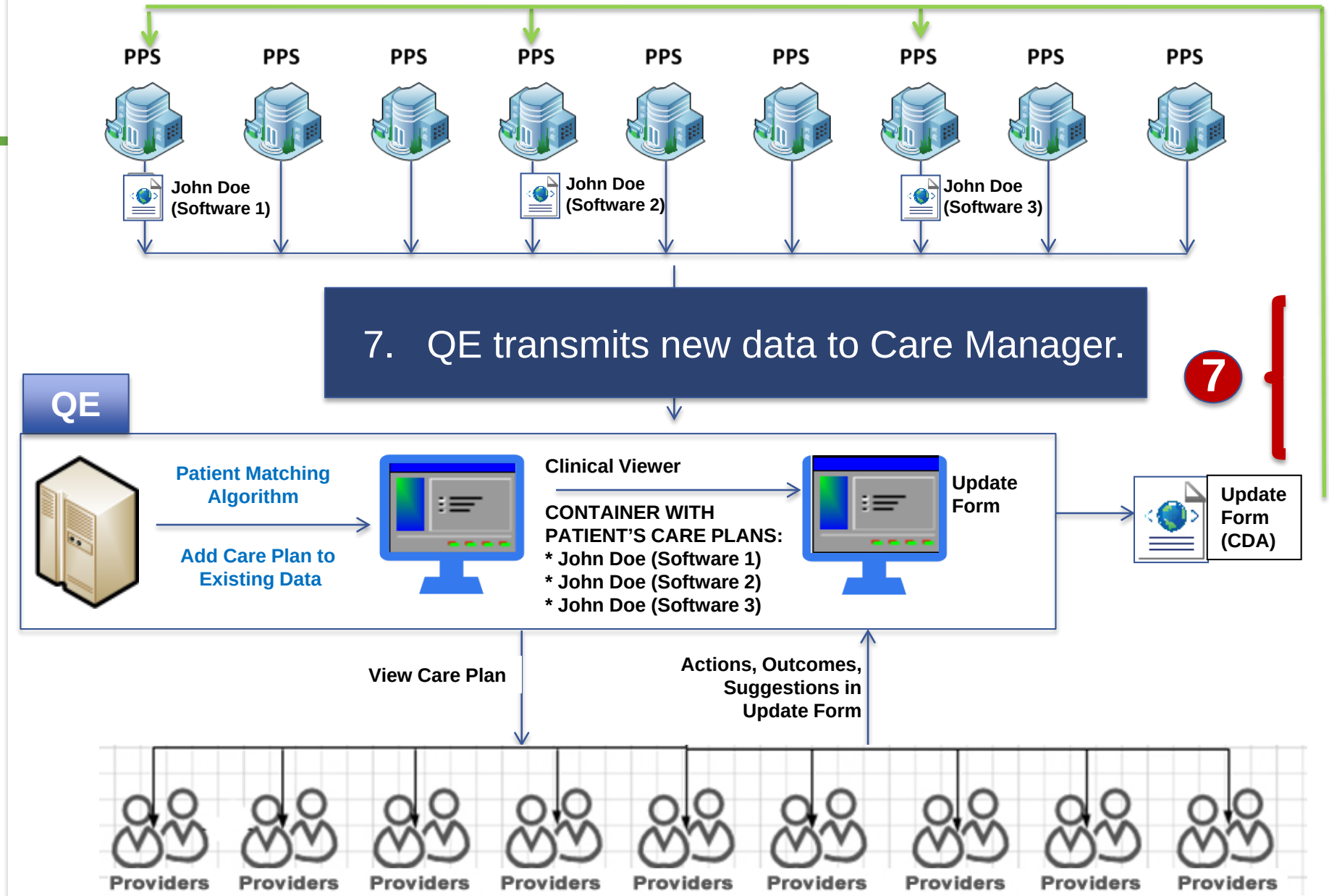
Phase 2: Pilot Real-World Implementation of C-CDA R2.1 Care Plan



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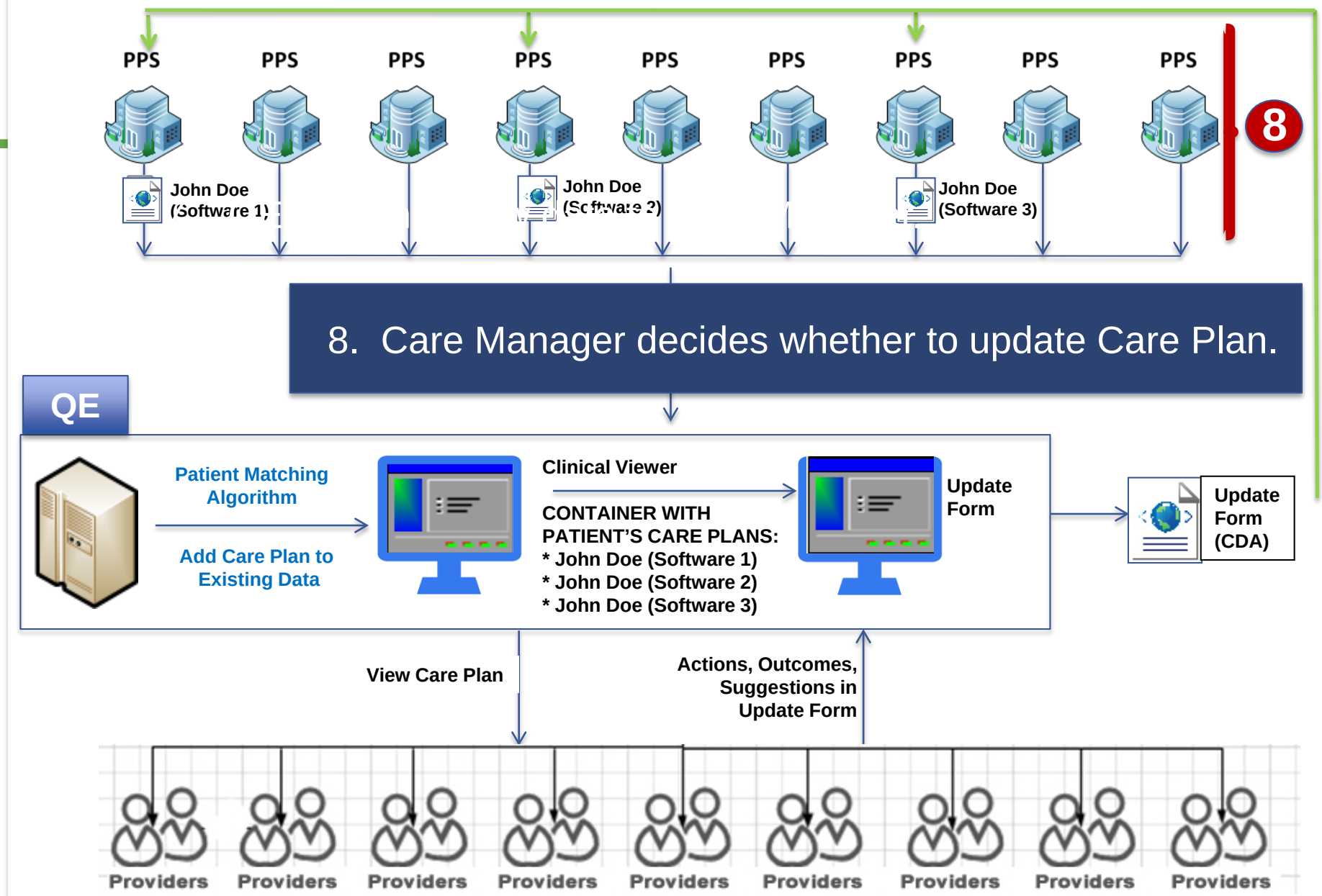


Note: Some providers may consume the CDA Care Plan into their EHR and return Assessments and Outcomes in a CDA from their EHR.

Draft Display of Care Plan in Portal

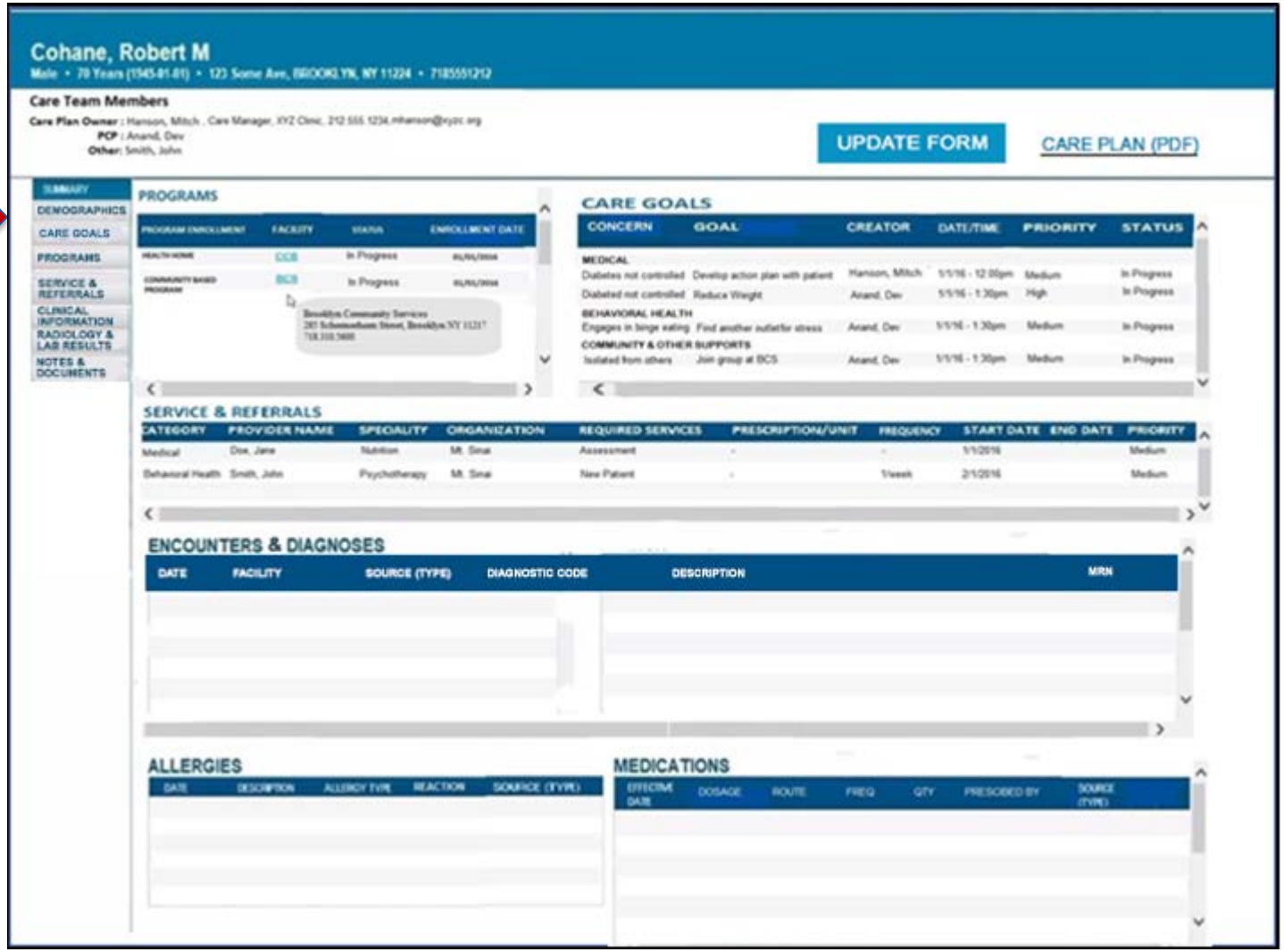
Draft Display of Care Plan in Portal

Click Care Plan. Search Patient.

- Healthix will display Programs, Health Concerns, Goals, To-Dos, Services & Referrals, and Care Team from the Care Plan.
- User can also toggle into the Healthix Patient Record to see demographic and clinical data from all the sources in Healthix.

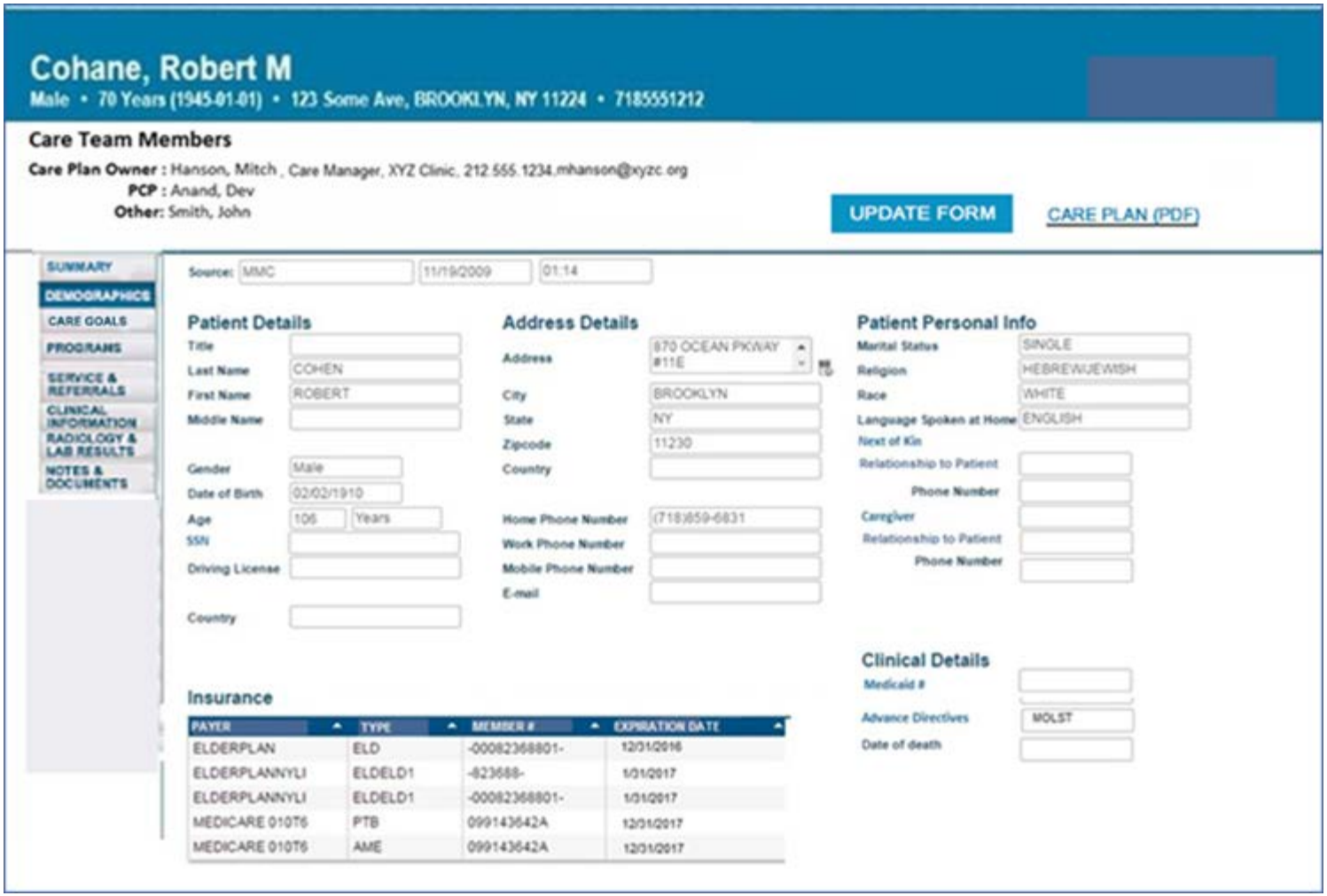
Healthix

Care Plan Window: Summary



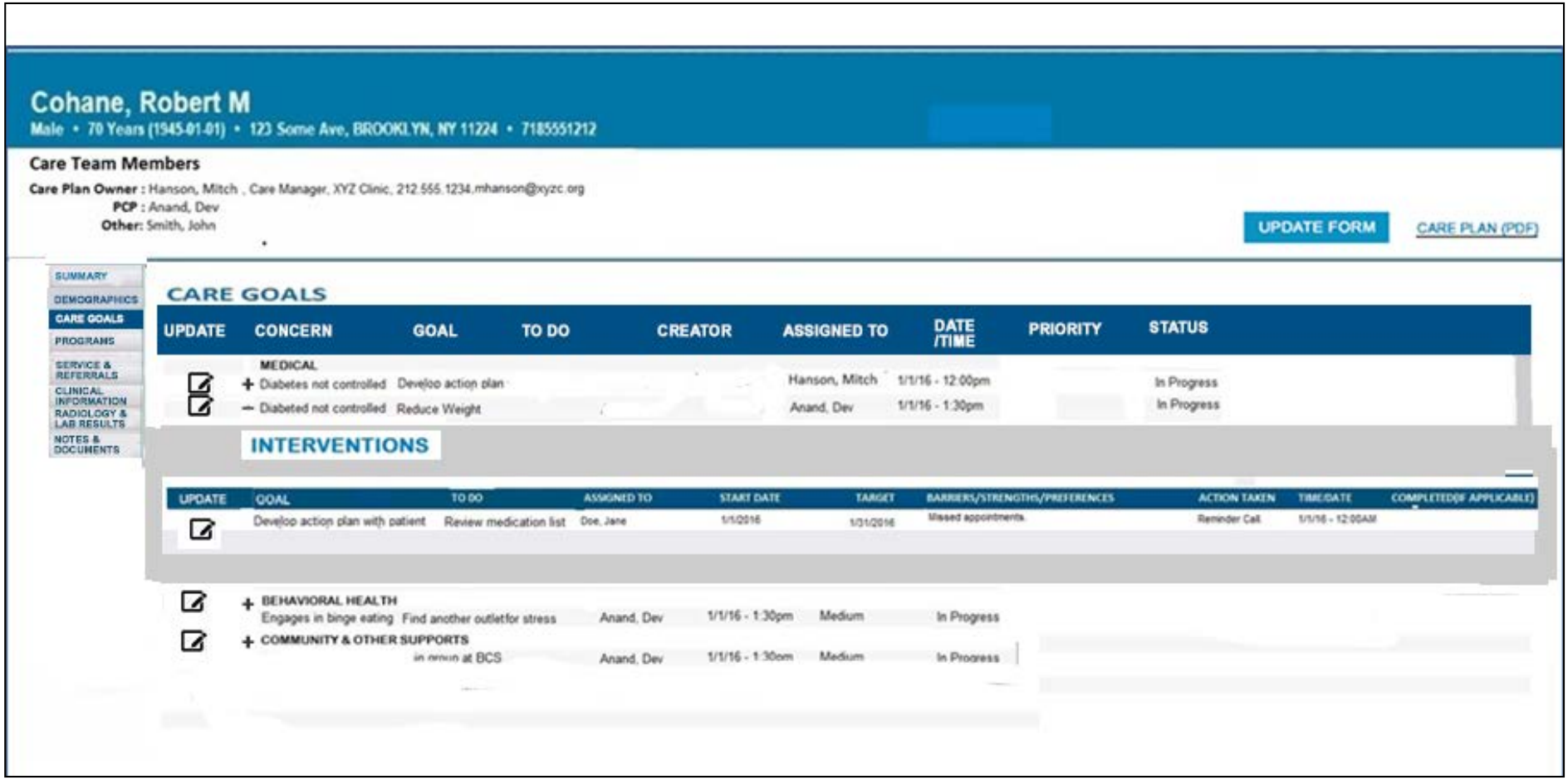
Healthix

Demographics Tab



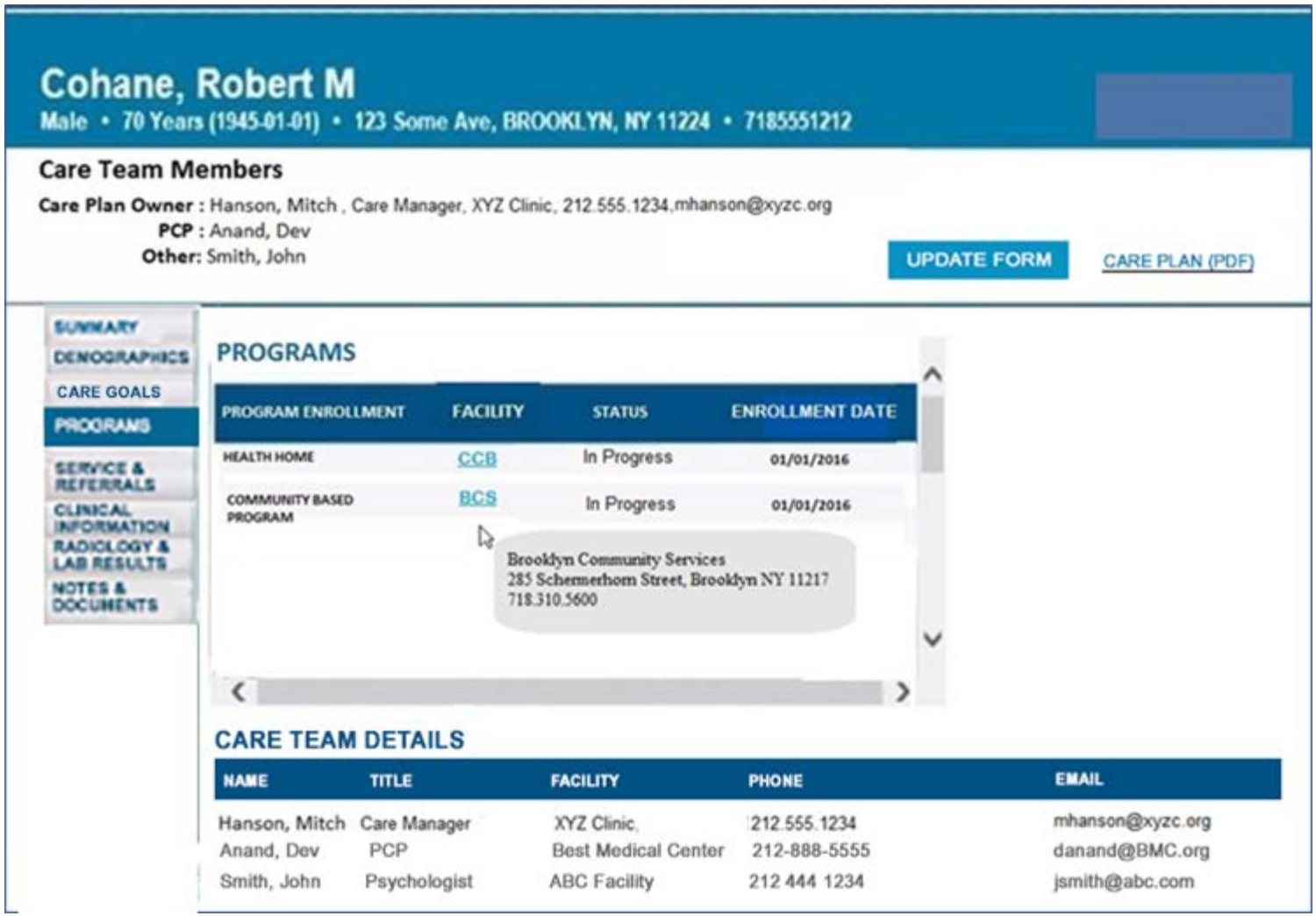
Healthix

Care Goals



Healthix

Programs and Care Teams



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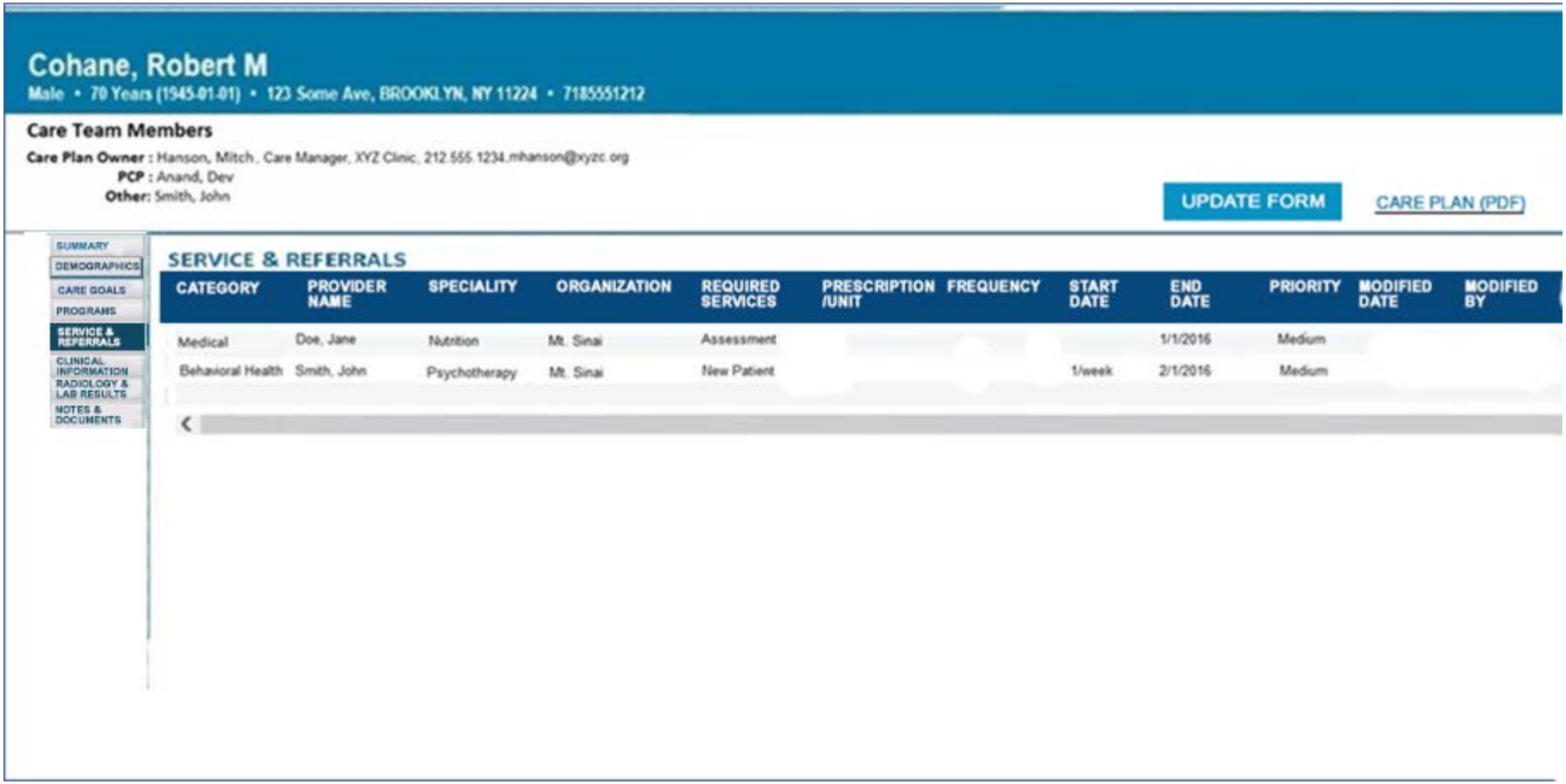
Service & Referrals



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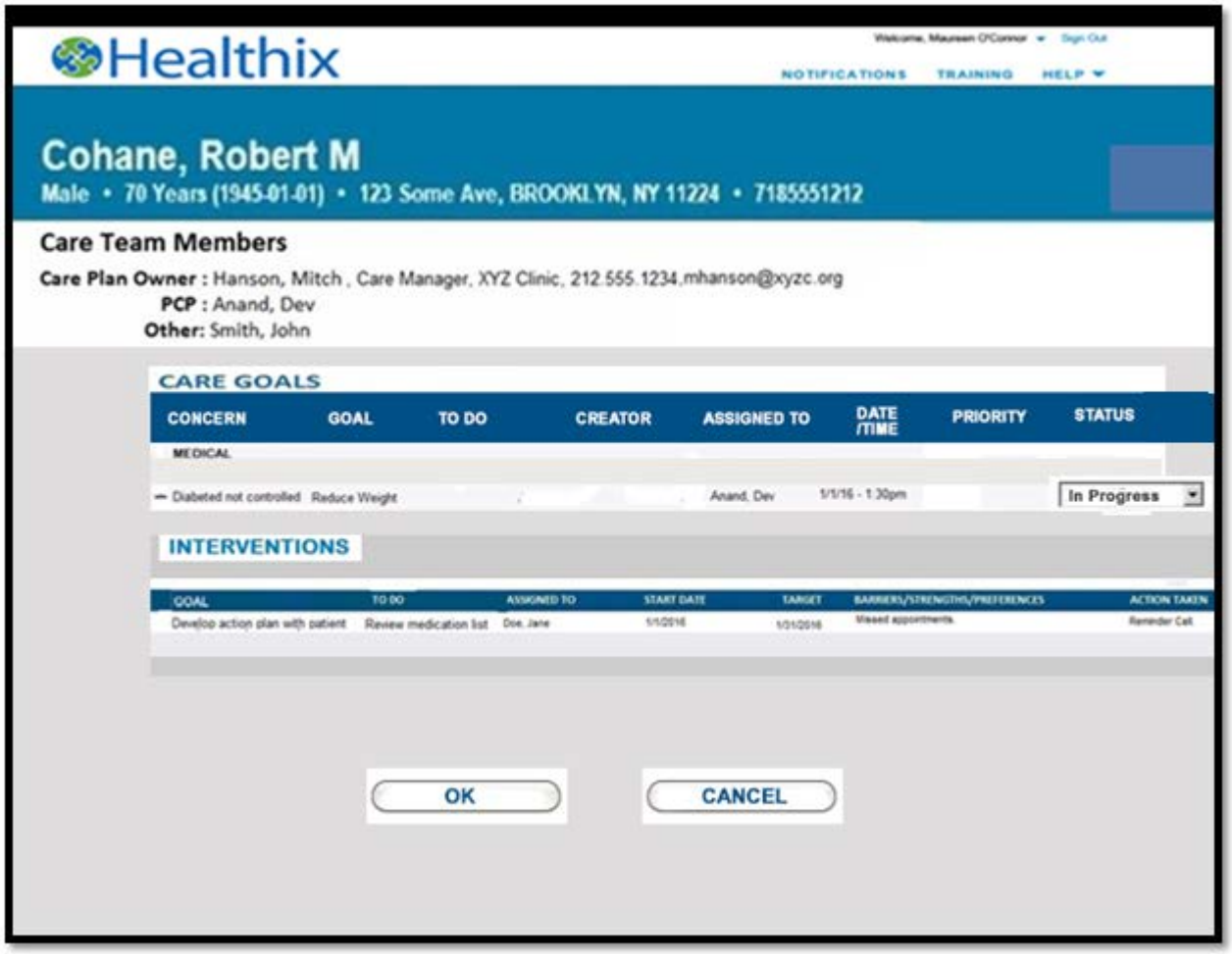
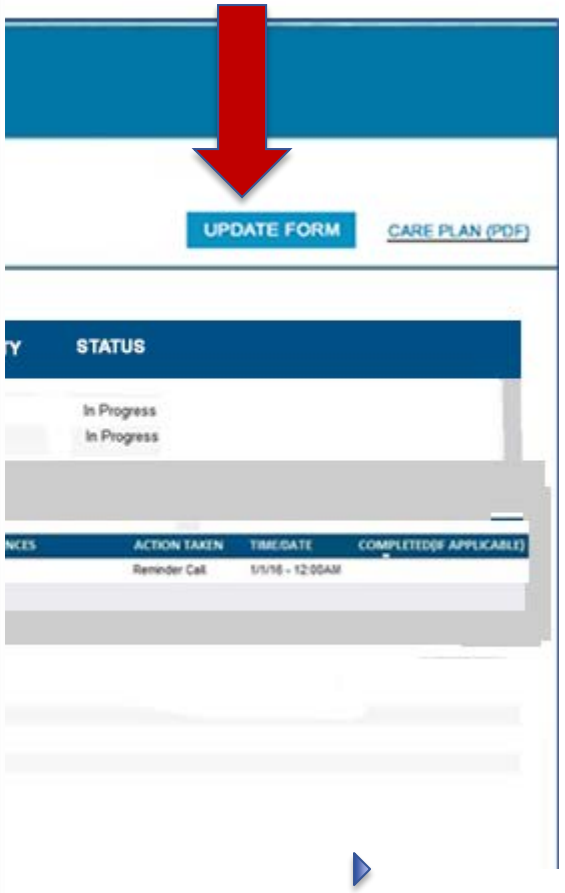
Update Form





Healthix

Q&A

NEW YORK STATE | Department of Health | Medicaid Redesign Team