Facilitating Effective Transitions Between Long Term Care Facilities and Hospital Emergency Departments

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Conflict of Interest Disclosure

Bill Russell, MD
Rob Horst, MBA

• Dr. Russell is a paid consultant to Seasons Hospice and Palliative Care as well as the Office of the National Coordinator to support the Challenge Grant Awardees
• Rob Horst is a paid consultant to MedStar Health
Learning Objectives

1. Describe the technology, especially HIE which facilitate long-term care (LTC) and acute care transitions
2. Discuss challenges that prevent LTC facilities from adopting EHR technology
3. Evaluate data and measure performance of a new LTC HIE initiative
4. Compare outreach and project sharing dissemination methods
5. Develop a roadmap to increase EHR and HIE adoption by LTC facilities
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CRISP BACKGROUND
CRISP HIE Background

- Chesapeake Regional Information System for our Patients
- Maryland’s State-Designated HIE
- $20MM in State and Federal funding
- “Opt-out” model

Strategy:
- All 46 acute care hospitals sending ADT data as of Dec. 2012
- All sending clinical data by Dec. 2012
- Engage ambulatory and LTC providers
- Clinical data “backbone”
CRISP Challenge Grant

• $1.6MM awarded
• Theme: Improving long-term and post-acute care transitions
• Focus:
  – Continuity of Care Document (CCD) exchange between LTC and acute care hospitals to improve transitions
  – Engage LTC and promote HIE query use
  – HIE access to advance directives, MOLST forms
ONC Grantees for LTC Transitions

• Maryland
  – Nursing home / acute hospital transitions
  – LTC HIE query
  – State-wide MOLST directory

• Massachusetts
  – Propagate technology-enabled, standardized transition of care processes through education and IT adoption
  – UTF (universal transfer form) required by MA, forms the basis of the CCD+

• Colorado
  – Partnering with providers of care management and coordination to improve the initiation of care
  – Targeting populations in need of additional services

• Oklahoma
  – Hosting a EHR-Lite, facility and patient portals
  – Connect providers and patients during transitions and changes in condition
CRISP HIE Coverage
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WHY TRANSITIONS NEED INNOVATION
EHR Adoption Challenges For LTC

- No financial incentives for LTC
- Document architecture and payload standards not yet defined
- Pockets of adoption are related to regulatory or reimbursement requirements
  - Minimum Data Set (MDS) and Activities of Daily Living (ADL)
- Physician and nursing workflow are not well aligned
- Pharmacy data is not available
- High reliance on paper and fax based systems
Putting Things Into Context

• Persons who receive nursing home (NH) and home health agency (HHA) services experience frequent:
  – Transitions in care (NHs to and from hospitals)
  – Shared care (care delivery by remotely located, organizationally unaffiliated physicians, pharmacies, family members)
Transitions Are Dangerous

• 23% of hospitalized patients over the age of 65 are discharged to another institution
• 19% of patients discharged from a hospital to a skilled nursing facility are re-admitted to the hospital within 30 days
• Each time a patient’s medical record gets re-created, the chance for errors and harm to the patient increase

Transitions are Expensive

• Poor information transfer leads to recidivism to high-intensity care settings

• Redundant ordering of tests, diagnostic imaging and procedures

• Unwanted care, or even life support, in the absence of advance directives or MOLST forms

Transitions Of Care Studies

• Qualitative studies on transitions of care have shown:
  – Patients and their caregivers are unprepared for their role in the next care setting
  – Patients do not understand essential steps in the management of their condition
  – Patients are unable to contact appropriate healthcare practitioners for guidance

LTC Silo Spectrum of Care

- Home Care
- Independent
- PACE
- SNF
- ALF
- Adult Care
- LTAC
- IRF
- Acute Care
- Hospice

Relative Cost:
- High
- Low

Acuity Level:
- Low
- High

Courtesy of John F. Derr, R.Ph  Trustee, CCHIT
Impact of Payment Reform

COHESIVE AGENTS
- Physician
- ACO/ACC
- Medications
- Therapy
- Technology (HIT)

Relative Cost
- High
- Low

Acuity Level
- High

Home Care
- Independent
- SNF
- Adult Care
- PACE
- LTAC
- IRF

Acute Care

Courtesy of John F. Derr, R.Ph  Trustee, CCHIT
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TECHNOLOGIES TO FACILITATE TRANSITIONS
The Spectrum of LTC Adoption

• Larger LTC facilities with resources have built or acquired comprehensive EHRs
  – Adoption of best of breed with extensive integrations (e.g. Erickson Living)
  – Some have adopted very unique device strategies to support their workforce

• Partial NH adoption is common
  – Standalone MDS, CPOE (provided by pharmacy vendor), ADL tracking
  – Care planning and coordination typically on paper or not tightly aligned with nursing assessment process
Infrastructure

- Assessments
- Orders
- E-Rx (retail)
- Labs
- Documents
- Images
- Flags (Falls)

Application

- Integration Servers
  - HL7 to Vision
  - CCD
- Work Flow Alignment
  - NCPDP 8
  - HL7
  - CCD
- Erickson Wound Documentation Application
  - Web
- Centricity
  - Web
- Resident Health Portal
  - HL7 /Application integration
  - Vital Signs
  - Clinical Notes
  - Rehab Assessments
  - Advance Directives
- HealthUnity
  - HIE

User

- IDC Team (Extended Care)
- Home Nursing
- Rehab Services
- Social Work (IL)
- Medical Providers
- Care Managers (EA)
- Residents and Families
- Security
- Hospitals and Specialists

Vision

Portal/Web (ER Summary, Vision Portal)
Drivers of Partial Adoption for Incentive Ineligibles

- Minimum Data Set (MDS)
- Activity of Daily Living (ADL)
- CPOE and eRx
- Clinical Nursing Documentation
- Pharmacy Vendors
- Payment
- Regulatory
- HIE

???
CRISP Transition Strategy

1. Hospital EHR sends discharge summary, lab/rad and other data

Acute Care Hospital

- EHR
  - HL7 Interface
  - Lab, Rad, Reports

2. Nursing Home EHR sends CCD

Nursing Home

- EHR
  - HL7 Interface
  - CCD

3. Both can use the HIE Portal to query HIE data during transitions

CRISP HIE Portal
CRISP Advance Directive Registry

Nursing Home:
Advance Directives, MOLST forms, other documents

Physician Practice:
Advance Care Planning, MOLST forms

Acute Care Hospital
Query Access

Query Access for
First Responders
Future CRISP DIRECT Strategy

1. Nurse creates DIRECT message in CRISP portal.
2. Nurse performs entity address lookup in HISP provider directory.
3. Nurse provides textual care summary or attaches CCD if available.
4. Entity notification of DIRECT message from Nursing Home.

Subject: Transfer for Mary Smith

Mary Smith fell and is being transferred to your care. Find attached clinical summary.
- Nursing Home

To: Hospital@CRISP.Direct.com
From: LTC@CRISP.Direct.com
DIRECT Connect

**Benefits**
- Secure Provider-to-providers or provider to entity messaging
- Low cost and small technology footprint

**Drawbacks**
- Provider-to-provider not useful for emergent transitions
- Dependent on HISPs which are slow to emerge
- Dependent on vendor support on both sides of equation (eligibles and non-eligibles)
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ROADMAP TO INCREASE EHR AND HIE ADOPTION
LTPAC HIT Roadmap

• Long Term and Post Acute Care Health IT Collaborative
  – Stakeholders recognize common interests and vision for health information technology
  – Formed to advance HIT issues through coordinated efforts
  – Road map published every two years to provide guidance to provider organizations, policy-makers, vendors, payers, and other stakeholders

• 2012 LTPAC Health IT Road Map will be the 4th Road Map published
The Health IT Strategic Plan

**LTPAC Roadmap**

- Aligns with the National Strategy
  - Workforce
  - Patient engagement
  - Quality
  - Care coordination
  - Financial performance

- Coming June, 2012

http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3581&PageId=23952
Need A Federal Focus

• Harmonize ONC’s Standards & Interoperability (S&I) efforts with LTPAC Collaborative
• Harmonize efforts to improve transitions across HHS departments
• HIE
  – Challenge grants need to produce valuable, repeatable and scalable use cases
  – Easy access to key clinical data for transitions
## Transition Initiatives

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<th><strong>CMS</strong></th>
<th><strong>ONC</strong></th>
<th><strong>Others</strong></th>
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<tr>
<td>• Medical Home/ACO’s</td>
<td>• HIE Grants</td>
<td>• Assistant Secretary Planning &amp; Evaluation (ASPE)</td>
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<td>• Partnership for Patients</td>
<td>• Certification Programs</td>
<td>– MDS and OASIS</td>
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<td>• Innovation Center</td>
<td>• Beacon Grants</td>
<td>– Physician Plan of Care</td>
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<td>– Challenge.gov</td>
<td>– Reengineering Process</td>
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<tr>
<td>• Community based care delivery</td>
<td>• Challenge Grants</td>
<td>• National Quality Forum(NQF)</td>
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<td>models</td>
<td>– Payload</td>
<td>– Measures development for quality transitions</td>
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<td>• Medicaid waiver programs</td>
<td>– Process alignment</td>
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<td>– Adoption</td>
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<td>• S&amp;I Framework</td>
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<td>– Document architecture</td>
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Evaluating Transition Intervention

Pre-Intervention Survey
- 90 Days
  - Collect baseline information regarding data availability at the time of patient intake

Intervention
- Make demographic data, lab, clinical documents available in real time
- Push data from CRISP to the LTCs in real time. (data may include: lab, radiology, meds, discharge summary data)

Performance Measures
- 30-day hospital readmission rates
- % of patients transferred with complete data sets
- Increase patient understanding of her/his care during transition process

Software Tools:
- PointClickCare
- BlueStep
- GE Centricity

Timeline:
- Aug 2011
- Oct 2011
- ADT data: Jan 2012
- Feb 2012
- Clinical Data: Mar – Jun 2012
- Feb 2014
LTPAC HIT Collaborative Members

- American Health Information Management Association
- LeadingAge (formerly AAHSA)
- LeadingAge Center for Aging Services Technology
- American Health Care Association and National Center for Assisted Living
- National Association for Home Care & Hospice and Home Care Technology Association of America
- National Association for the Support of Long Term Care
- American Society of Consulting Pharmacists
- American Association of Nurse Assessment Coordination
- Health Information Management System Society
- The Commonwealth Fund
- National Pace Association
Resources

- Leading Age ([www.LeadingAge.org](http://www.LeadingAge.org))
  - **National Contact**: Barbara Manard  ([bmanard@LeadingAge.org](mailto:bmanard@LeadingAge.org))
  - **State Affiliates listing**: [www.leadingage.org/StateSearch.aspx](http://www.leadingage.org/StateSearch.aspx)
- Long Term and Post Acute Care (LTPAC) HIT Collaborative ([www.ltpachealthit.org](http://www.ltpachealthit.org))
  - **National Contact**: Michelle Dougherty ([michelle.dougherty@ahima.org](mailto:michelle.dougherty@ahima.org))
  - **State Affiliates listing**: N/A
- National Alliance for Care Giving ([www.caregiving.org/](http://www.caregiving.org/))
  - **National Contact**: Gail Hunt ([gailhunt@caregiving.org](mailto:gailhunt@caregiving.org))
  - **State Affiliates listing**: [www.caregiving.org/coalitions/coalitions-by-state](http://www.caregiving.org/coalitions/coalitions-by-state)
- National Association for the Support of Long Term Care ([www.nasl.org](http://www.nasl.org))
  - **National Contact**: Cynthia Morton ([cynthia@nasl.org](mailto:cynthia@nasl.org))
  - **State Affiliates listing**: N/A
- National Association for Home Care and Hospice ([www.nahc.org](http://www.nahc.org))
  - **National Contact**: Rich Brennan ([rdb@nahc.org](mailto:rdb@nahc.org))
  - **State Affiliates listing**: [www.nahc.org/stateforum/directory.html](http://www.nahc.org/stateforum/directory.html)
- National Center for Assisted Living ([www.ahcanctal.org/ncal/Pages/default.aspx](http://www.ahcanctal.org/ncal/Pages/default.aspx))
  - **National Contact**: Shelley Sabo ([ssabo@ahca.org](mailto:ssabo@ahca.org))
  - **State Affiliates listing**: [www.ahcanctal.org/ncal/about/Pages/StateAffiliates.aspx](http://www.ahcanctal.org/ncal/about/Pages/StateAffiliates.aspx)
- National Association of State Units on Aging ([www.nasua.org](http://www.nasua.org))
  - **State Affiliates listing**: [www.nasuad.org/about_nasuad/state_agency_website_links.html](http://www.nasuad.org/about_nasuad/state_agency_website_links.html)
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