Maryland Challenge Project

Improving Care Transitions Using Health Information Exchange

March 2012
Facilitating Effective Transitions Between Long Term Care Facilities and Hospital Emergency Departments

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 admit/discharge/demographic data as of 12/2011
  - 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
- Propagating 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
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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
• Persons who receive nursing home and home health agency services experience frequent:
  – Transitions in care (nursing homes ↔ 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 readmitted 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

Relative Cost

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

Acuity Level

Low
High

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

Relative Cost

Acuity Level

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

Home Care
SNF
ALF
Hospice
Adult Care
Independent

Courtesy of John F. Derr, R.Ph Trustee, CCHIT
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TECHNOLOGIES TO FACILITATE TRANSITIONS
• 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 application and 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
1. Hospital EHR sends discharge summary, lab/rad and other data

2. Nursing Home EHR sends CCD

3. Both can use the HIE Portal to query HIE data during transitions
CRISP Advance Directives Service

Nursing Home:
Advance Directives, MOLST forms, other documents

Physician Practice:
Advance Care Planning, MOLST forms

CRISP HIE

HIE Query

Acute Care Hospital Query Access

Query Access for First Responders
DIRECT Secure Messaging

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)
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

To: Hospital@CRISP.Direct.com
From: LTC@CRISP.Direct.com
Subject: Transfer for Mary Smith

"Mary Smith fell and is being transferred to your care. Find attached clinical summary."
- Nursing Home
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ROADMAP TO INCREASE EHR AND HIE ADOPTION
• 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
Evaluating Transition Intervention

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

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

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)

Pre-Intervention Survey
- 90 Days

PointClickCare
BlueStep
GE Centricity

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

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