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
# GNYHA DSRIP PPS & QE Care Plan

## Learning Collaboration

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

GREATER NEW YORK HOSPITAL ASSOCIATION
Care Plan “Translator”

Different Care Management Software/PPSs

Care Plan Content Workgroup standards for core data elements

Content and format vary

QEs/SHIN-NY Interface

Consolidated view of all care plans in a single format
Checking in: Are We Speaking the Same Language?

<table>
<thead>
<tr>
<th>Care Plan in this Context</th>
<th>Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Supports LONGITUNDINAL coordination of care across multiple sites</td>
<td>□ Summary of Care Document</td>
</tr>
<tr>
<td>□ Consensus-driven dynamic plan that represents a patient’s and care team members’ prioritized concerns, goals, and planned interventions.</td>
<td>□ Transitions of Care Plan</td>
</tr>
<tr>
<td>□ Represents synthesis and reconciliation of multiple plans of care; serves as a blueprint to guide the individual’s care</td>
<td>□ Transfer of Care Document</td>
</tr>
<tr>
<td></td>
<td>□ Advanced Care Planning (POLST)</td>
</tr>
<tr>
<td></td>
<td>□ Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>□ Plan of Care (Home Health Agency)</td>
</tr>
<tr>
<td></td>
<td>□ Comprehensive Care Plan (LTC Facilities)</td>
</tr>
</tbody>
</table>

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

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

Partner 1

Partner 2

Partner 3

GREATER NEW YORK HOSPITAL ASSOCIATION
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

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

<table>
<thead>
<tr>
<th>Phase</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and PPS Engagement</td>
<td>Jan - Feb 2016</td>
</tr>
<tr>
<td>Content and Standards Development</td>
<td>Feb - May 2016</td>
</tr>
<tr>
<td>Phase 1 Pilot Planning</td>
<td>May – June 2016</td>
</tr>
<tr>
<td>Phase 1 Pilot Implementation</td>
<td>July – Nov 2016</td>
</tr>
<tr>
<td>• PPS identify at least 2 partner sites with QE connection committed to participating in pilot</td>
<td></td>
</tr>
<tr>
<td>• PPS/partners commit to exchanging at least 20 care plans</td>
<td></td>
</tr>
<tr>
<td>• Pilot participants commit to joining hour-long bi-weekly check-in calls during pilot period and reporting out on experience to group.</td>
<td></td>
</tr>
<tr>
<td>Phase 2 Pilot Planning</td>
<td>July – Dec 2016</td>
</tr>
<tr>
<td>• Develop technical specification guidelines and business requirements to support C-CDA exchange</td>
<td></td>
</tr>
<tr>
<td>Phase 2 Pilot Implementation</td>
<td>Jan 2017 +</td>
</tr>
</tbody>
</table>
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
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?
9% of Staten Island PPS Medicaid Enrollees are defined as Super Utilizers

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

Avg. ED Visits/SU: 8.89

Average spending per Super Utilizer recipient is 3.1X greater

Cost per Medicaid Recipient $75K

Cost per SU Medicaid Recipient

... 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

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

**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).
CBC Creates Care Plan

Physician Communicates changes back to CBC

Physician Reviews Care Plan and Makes appropriate Modifications

CBC sends to delegate at partner site

Delegate disperses to appropriate care team

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

Patti Cuartas, PA, MBA, PMP
Senior Director, IT DSRIP Program

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

September 21, 2016
Contents

▶ Care Coordination Workgroup Summary
▶ GNYHA Pilot Background
▶ Mount Sinai Pilot Approach
▶ Stakeholder Benefit
▶ Partner Categories
▶ Assessment Outputs
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 Your Partners (KYP)**
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 PPSs determine how best to address capabilities for implementation, business and technical requirements, and adoption.
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.

<table>
<thead>
<tr>
<th>Phase 1: Planning</th>
<th>Phase II: Execution</th>
<th>Phase III: Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1-2</td>
<td>Week 3-4</td>
<td>Week 5-6</td>
</tr>
<tr>
<td>Prepare assessment</td>
<td>Complete pre-work</td>
<td>Execute phone interviews/potential site visits</td>
</tr>
</tbody>
</table>
# Stakeholder Benefits

## Understand PPS-wide gaps in care plan sharing process

<table>
<thead>
<tr>
<th>G NYHA</th>
<th>HIE</th>
<th>Vendors</th>
<th>PPS Leader</th>
<th>PPS Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

## Understand how partners interact with the HIE

<table>
<thead>
<tr>
<th>G NYHA</th>
<th>HIE</th>
<th>Vendors</th>
<th>PPS Leader</th>
<th>PPS Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

## Understand vendor role in care plan workflow

<table>
<thead>
<tr>
<th>G NYHA</th>
<th>HIE</th>
<th>Vendors</th>
<th>PPS Leader</th>
<th>PPS Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>

## Identify care plan sharing workflow pain points and critical success factors

<table>
<thead>
<tr>
<th>G NYHA</th>
<th>HIE</th>
<th>Vendors</th>
<th>PPS Leader</th>
<th>PPS Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td></td>
<td>✗</td>
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</tbody>
</table>

## Identify best practices for each partner category

<table>
<thead>
<tr>
<th>G NYHA</th>
<th>HIE</th>
<th>Vendors</th>
<th>PPS Leader</th>
<th>PPS Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✗</td>
<td>✗</td>
<td></td>
<td>✗</td>
</tr>
</tbody>
</table>
# Partner Categories

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

<table>
<thead>
<tr>
<th>Category 1 - Static care plan (Paper or Other - PDF/EMR)</th>
<th>Category 4 - Crimson Care Plan Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Premier</td>
<td>9 Bailey House</td>
</tr>
<tr>
<td>2 Amsterdam Nursing Home</td>
<td>10 ACMH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2 - HIE connectivity but does not share care plan information through HIE</th>
<th>Category 5 - Epic Care Plan Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Visiting Nurse Service of New York</td>
<td>11 Mount Sinai Health System</td>
</tr>
<tr>
<td>4 Mount Sinai Health System- St Lukes</td>
<td>12 Institute for Family Health</td>
</tr>
<tr>
<td>5 Housing Works</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 3 - HIE connectivity and share care plan information through HIE (Structured data and PDF)</th>
<th>Category 6 - EMR care plan (non-Crimson/Epic), and not connected to HIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 VIP Community Services</td>
<td>13 Cardinal Health Partners</td>
</tr>
<tr>
<td>7 Betances Health Center</td>
<td>14 Queens Coordinated Care Partners/ Mental Health Providers of Western Queens, Inc.</td>
</tr>
<tr>
<td>8 Bedford Medical Family Health Center</td>
<td></td>
</tr>
</tbody>
</table>

* The IT team leveraged existing assessment information and conducted additional outreach to create this list.
Information elaborated through phone calls and site visits...

**Assessment Questions**

**A. Care Plan Development and Management**
1. What type(s) of organization are you?
2. What are the major discrepancies between care plan type(s) in your organization?
3. What is your definition of a care plan?
4. Who initiates the development of a care plan(s) within your organization?
5. Who is responsible for the management of care plan(s) in your organization?
6. When are care plans initiated in your organization? When are they completed?
7. How is the development of care plan(s) initiated? What are the key workflows and hand-offs to initiate the process?
8. Where does your organization document care plan(s)?
9. Can you share a blank template of your care plan(s)?
10. 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**
1. Who is the target population?
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 (e.g., hospital, primary care, E.U.)
4. Include care at discharge, ED visit, other.

**C. Care Plan Sharing (Information exchange)**
1. Do you share care plan(s) with other providers?
2. With what type(s) of provider(s) do you share care plans(s)?
3. How do you share care plan(s) with other providers? Does the sharing process vary for any providers that you collaborate with?

...will reveal current state processes and insights.

**Current State Process Flow**

**Category Insights**

- Stage 1: Static care plan
  - EMR care plan
  - No HIE connectivity

- Stage 2: HIE connectivity
  - Does not share care plan info through HIE

- Stage 3: HIE connectivity
  - Share care plan info through HIE

- Stage 4: HIE connectivity
  - Share care plan info through HIE
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

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase I - Planning</strong></td>
<td></td>
</tr>
<tr>
<td>1  Pilot Partner List and Categories</td>
<td>List of targeted partners for current state assessment based on stratification criteria</td>
</tr>
<tr>
<td>2  Overall Pilot Plan and approach</td>
<td>Plan for partner outreach including interview questions, care plan process reference, and timeline</td>
</tr>
<tr>
<td><strong>Phase II - Execution</strong></td>
<td></td>
</tr>
<tr>
<td>3  Interview Pre-Work Worksheet</td>
<td>Questions related to care plan development and sharing that partners will complete prior to a phone interview, in order to guide the discussion</td>
</tr>
<tr>
<td>4  Phone Interviews/ Site Visit Deep Dive Questionnaire</td>
<td>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</td>
</tr>
<tr>
<td><strong>Phase III - Analysis</strong></td>
<td></td>
</tr>
<tr>
<td>6  Current State Care Plan Sharing Process Map</td>
<td>Current care plan sharing process map for each category</td>
</tr>
<tr>
<td>7  Pilot Analysis and Insights</td>
<td>A document summarizing process gaps as well as adoption/implementation critical success factors for each category</td>
</tr>
<tr>
<td>Category</td>
<td>Format</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Static (Paper/EMR View Only)</td>
</tr>
<tr>
<td>2</td>
<td>EMR other than Crimson / Epic</td>
</tr>
<tr>
<td>3</td>
<td>EMR other than Crimson / Epic</td>
</tr>
<tr>
<td>4</td>
<td>Crimson</td>
</tr>
<tr>
<td>5</td>
<td>Epic Healthy Planet</td>
</tr>
<tr>
<td>6</td>
<td>EMR other than Crimson / Epic</td>
</tr>
</tbody>
</table>
THANK YOU
Care Plan Exchange Pilot

NewYork–Presbyterian Performing Provider System

Patricia Hernandez, LCSW
Manager, Team-Based Care
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
Care Plan Exchange
Phase 2 Pilot

September 21, 2016
<table>
<thead>
<tr>
<th>Topic</th>
<th>Slide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Phase 2 Pilot</td>
<td>3</td>
</tr>
<tr>
<td>C-CDA Template of Comprehensive Care Plan</td>
<td>4</td>
</tr>
<tr>
<td>Information Flow between Care Manager and Provider</td>
<td>5</td>
</tr>
<tr>
<td>Draft Display of Care Plan in Portal</td>
<td>16</td>
</tr>
</tbody>
</table>
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

Concerns
Associated Assessments (LINK)

Goals
Associated Person-Entered Goals (LINK e.g. future patient portal)

Goal 1.1
Priority
Status
Completed Interventions (LINK)

Goal 1.2
Priority
Status
Completed Interventions (LINK)

Interventions
Associated Person Preferences (LINK)

To-Do 1.1.1
Assigned to
Start Date
Target
Completed Date
Barriers/Strengths/Preferences
Action Taken

To-Do 1.1.2
Assigned to
Start Date
Target
Completed Date
Barriers/Strengths/Preferences
Action Taken

To-Do 1.2.1
Assigned to
Start Date
Target
Completed Date
Barriers/Strengths/Preferences
Action Taken

To-Do 1.2.2
Assigned to
Start Date
Target
Completed Date
Barriers/Strengths/Preferences
Action Taken

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

= Does not exist yet
Information Flow between Care Manager and Provider
Phase 2: Pilot Real-World Implementation of C-CDA R2.1 Care Plan

CONTAINER WITH PATIENT’S CARE PLANS:
* John Doe (Software 1)
* John Doe (Software 2)
* John Doe (Software 3)

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

5. Provider queries QE and views Care Plan(s) in QE Portal.
   - Currently building Portal view of Care Plan.
   - In future, will design how to present multiple Care Plans at once.
   - Many EHRs offer single sign-on into Healthix portal.

Note: Some providers may consume the CDA Care Plan into their EHR and return Assessments and Outcomes in a CDA from their EHR.
Phase 2: Pilot Real-World Implementation of C-CDA R2.1 Care Plan

6. Provider enters new data from patient visit.
   - Actions, outcomes, suggestions for Care Manager.

Note: Some providers may consume the CDA Care Plan into their EHR and return Assessments and Outcomes in a CDA from their EHR.
**Phase 2: Pilot Real-World Implementation of C-CDA R2.1 Care Plan**

**7. QE transmits new data to Care Manager.**

- **QE**
  - Patient Matching Algorithm
  - Add Care Plan to Existing Data

- **Clinical Viewer**
  - CONTAINER WITH PATIENT’S CARE PLANS:
    - John Doe (Software 1)
    - John Doe (Software 2)
    - John Doe (Software 3)

- **Update Form**

- **View Care Plan**
- **Actions, Outcomes, Suggestions in Update Form**

Note: Some providers may consume the CDA Care Plan into their EHR and return Assessments and Outcomes in a CDA from their EHR.
8. Care Manager decides whether to update 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.
Draft Display of Care Plan in Portal
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.
Care Plan Window: Summary
Demographics Tab
## Care Goals

<table>
<thead>
<tr>
<th>UPDATE</th>
<th>CONCERN</th>
<th>GOAL</th>
<th>TO DO</th>
<th>CREATOR</th>
<th>ASSIGNED TO</th>
<th>DATE/TIME</th>
<th>PRIORITY</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL</td>
<td>Diabetes not controlled</td>
<td>Develop action plan</td>
<td></td>
<td>Hanson, Mitch</td>
<td>1/1/16 - 12:00pm</td>
<td>In Progress</td>
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<tr>
<td></td>
<td>Diabetic not controlled</td>
<td>Reduce Weight</td>
<td></td>
<td>Anand, Dev</td>
<td>1/1/16 - 1:30pm</td>
<td>In Progress</td>
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## Interventions

<table>
<thead>
<tr>
<th>UPDATE</th>
<th>GOAL</th>
<th>TO DO</th>
<th>ASSIGNED TO</th>
<th>START DATE</th>
<th>TARGET</th>
<th>BARRIERS/SPECIAL NEEDS/PREFERENCES</th>
<th>ACTION TAKEN</th>
<th>TIME/DATE</th>
<th>COMPLETED (IF APPLICABLE)</th>
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<tbody>
<tr>
<td></td>
<td>Develop action plan with patient</td>
<td>Review medication list</td>
<td>Dee, Jane</td>
<td>1/5/2016</td>
<td>1/1/16</td>
<td>Missed appointments</td>
<td>Reminder Call</td>
<td>1/5/2016</td>
<td></td>
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<tr>
<td></td>
<td>BEHAVIORAL HEALTH</td>
<td>Engages in binge eating</td>
<td>Anand, Dev</td>
<td>1/1/16</td>
<td>1:30pm</td>
<td>Medium</td>
<td>In Progress</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COMMUNITY &amp; OTHER SUPPORTS</td>
<td>Engages in binge eating</td>
<td>Anand, Dev</td>
<td>1/1/16</td>
<td>1:30pm</td>
<td>Medium</td>
<td>In Progress</td>
<td></td>
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</tbody>
</table>
Programs and Care Teams

Cohane, Robert M
Male • 70 Years (1945-01-01) • 123 Some Ave, BROOKLYN, NY 11224 • 7185551212

Care Team Members
Care Plan Owner: Hanson, Mitch, Care Manager, XYZ Clinic, 212.555.1234, mhanson@xyzc.org
PCP: Anand, Dev
Other: Smith, John

UPDATE FORM CARE PLAN (PDF)

<table>
<thead>
<tr>
<th>PROGRAMS</th>
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<tbody>
<tr>
<td>PROGRAM ENROLLMENT</td>
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<tr>
<td>HEALTH HOME</td>
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<tr>
<td>COMMUNITY BASED PROGRAM</td>
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CARE TEAM DETAILS

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>FACILITY</th>
<th>PHONE</th>
<th>EMAIL</th>
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</thead>
<tbody>
<tr>
<td>Hanson, Mitch</td>
<td>Care Manager</td>
<td>XYZ Clinic</td>
<td>212.555.1234</td>
<td><a href="mailto:mhanson@xyzc.org">mhanson@xyzc.org</a></td>
</tr>
<tr>
<td>Anand, Dev</td>
<td>PCP</td>
<td>Best Medical Center</td>
<td>212-888-5555</td>
<td><a href="mailto:danand@BMC.org">danand@BMC.org</a></td>
</tr>
<tr>
<td>Smith, John</td>
<td>Psychologist</td>
<td>ABC Facility</td>
<td>212 444 1234</td>
<td><a href="mailto:jsmith@abc.com">jsmith@abc.com</a></td>
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</tbody>
</table>

Brooklyn Community Services
285 Schermerhorn Street, Brooklyn NY 11217
718.310.5600
## Service & Referrals

**Cohane, Robert M**  
Male  •  70 Years (1945-01-01)  •  123 Some Ave, BROOKLYN, NY 11224  •  7188855121

### Care Team Members
- **Care Plan Owner:** Hanson, Mitch, Care Manager, XYZ Clinic, 212 555 1234, mhanson@xyzc.org
- **PCP:** Anand, Dev
- **Other:** Smith, John

### Service & Referrals

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PROVIDER NAME</th>
<th>SPECIALITY</th>
<th>ORGANIZATION</th>
<th>REQUIRED SERVICES</th>
<th>PRESCRIPTION /UNIT</th>
<th>FREQUENCY</th>
<th>START DATE</th>
<th>END DATE</th>
<th>PRIORITY</th>
<th>MODIFIED DATE</th>
<th>MODIFIED BY</th>
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<tbody>
<tr>
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<td>Doe, Jane</td>
<td>Nutrition</td>
<td>Mt. Sinai</td>
<td>Assessment</td>
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<td>Behavioral Health</td>
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<td>Psychotherapy</td>
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<td>2/1/2016</td>
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<td>Medium</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Update Form

Cohane, Robert M
Male • 70 Years (1945-01-01) • 123 Some Ave, BROOKLYN, NY 11224 • 7185551212

Care Team Members
Care Plan Owner: Hanson, Mitch. Care Manager, XYZ Clinic, 212.555.1234, mhanson@xyzc.org
PCP: Anand, Dev
Other: Smith, John

<table>
<thead>
<tr>
<th>CARE GOALS</th>
<th>CONCERN</th>
<th>GOAL</th>
<th>TO DO</th>
<th>CREATOR</th>
<th>ASSIGNED TO</th>
<th>DATE/TIME</th>
<th>PRIORITY</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetic not controlled</td>
<td>Reduce Weight</td>
<td></td>
<td>Anand, Dev</td>
<td>1/1/16 - 1:30pm</td>
<td>In Progress</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>GOAL</th>
<th>TO DO</th>
<th>ASSIGNED TO</th>
<th>START DATE</th>
<th>TARGET</th>
<th>BARRIERS/STRENGTHS/PREFERENCES</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop action plan with patient</td>
<td>Review medication list</td>
<td>Jan, Doe</td>
<td>1/1/2016</td>
<td>10/1/2016</td>
<td>Missed appointments</td>
<td>Reminder Cat</td>
</tr>
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</table>

- OK
- CANCEL

UPDATE FORM
Q&A