

Care Coordination and Health IT

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Vision of Care Coordination and Health IT

- A set of unified principles that should be considered in the implementation of health IT to ensure its effectiveness in supporting care coordination.
- Four key components including:
 - Information Sharing
 - Team Based Care
 - Care Plans
 - Organization of Information and Services

What Is Not Included

- Not the intention to assume that every organization or individual involved with care coordination activities possess a robust health IT system
- Rather it is written as a visionary and aspirational document to provide key principles and components to incorporate into health IT supported care coordination as the process of care coordination is better understood and the technology to support it evolves

What Is Care Coordination

- Care coordination is a process that relies on the collaboration of several actors across the continuum of care. These include, but are not limited to; patients and their caregivers, hospitals, clinics and others entities responsible for the provision of care.



Models of Care Coordination

- Care coordination models first emerged to help the elderly manage home and community-based long-term care services.
- A medical model of care coordination focuses on the need to coordinate multiple treatments for individuals with complex chronic conditions.
- The integrated model of care coordination has recently emerged to integrate medical and supportive services, and was targeted for the Medicaid and Medicare programs as well as those who were dually eligible for services.

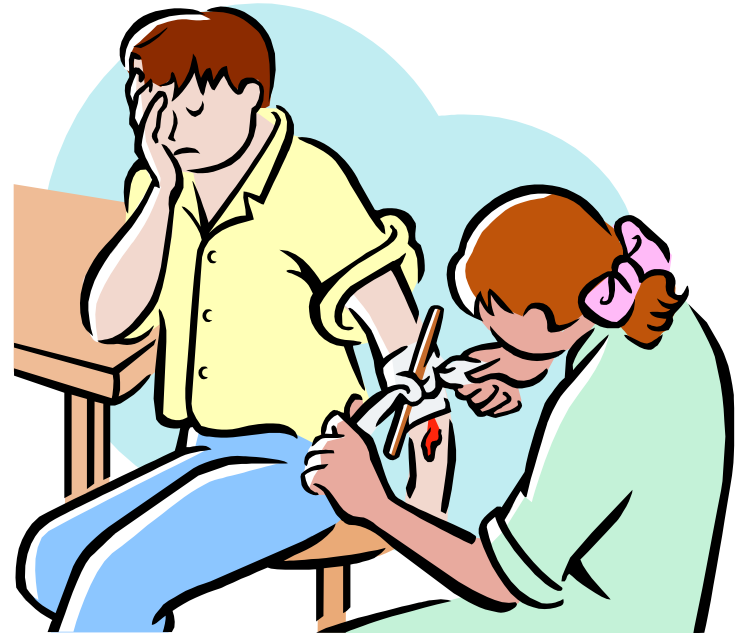
The Use of Health IT



- The use of health IT can support the coordination of patient care across each of these models
 - Monitoring and Disease Management
 - Analyze Data to Identify Adverse Symptoms for a Patient
 - Interventions

Importance of Care Coordination

- The ACA charged the Department of Health and Human Services (HHS) with developing a National Quality Strategy (NQS) to align and focus public and private efforts to improve the effectiveness, safety, and affordability of health care in our nation



ACA Programs

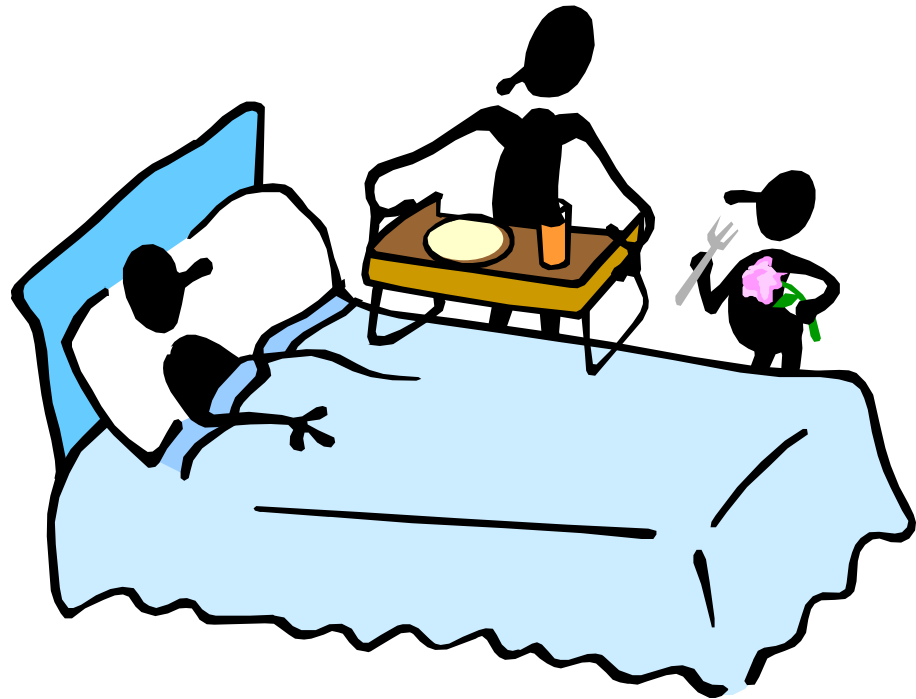
- The ACA also provided for several programs and initiatives to advance care coordination.
 - The Medicare Community-Based Care Transitions Program
 - Incentives to reduce Medicare hospital readmissions
 - Medicare Independence at Home demonstration
 - Medical Home models in Medicare and Medicaid
 - Federally Qualified Health Center Advanced Primary Care Practice (FQHC APCP) demonstration project
 - Medicare Shared Savings program.

Private Sector Efforts

- Numerous private sector efforts have focused on this critical issue
 - One in particular is the multi-stakeholder, consensus-based work of the National Quality Forum (NQF) endorsed a definition and framework for care coordination in May 2006
 - Also did a portfolio of care coordination preferred practices and performance measures in 2010
 - NQF also convened a Care Coordination Steering Committee which will develop a pathway toward implementation of emerging care coordination measures, including electronic capabilities and feasibility to support care coordination and quality measures

Health IT and Care Coordination

While care coordination remains a “people centric” function, it is difficult for people to coordinate care effectively in a complex environment without employing health information technology (health IT), such as electronic health records (EHRs) and health information exchanges (HIEs), making health IT an essential tool for achieving higher quality, better coordinated care.



NQF Framework

- The framework endorsed by NQF in 2006 identified five domains in the process of care coordination:
 - Healthcare home
 - Proactive plan of care and follow-up
 - Communication
 - Information systems
 - Transitions

Role of Health IT



- Health IT clearly has a tremendous role to play in each of these domains
 - Right information; right place; right time
 - Bi-directional communication
 - Longitudinal record of care

Key Principles Defining the Value of Health IT

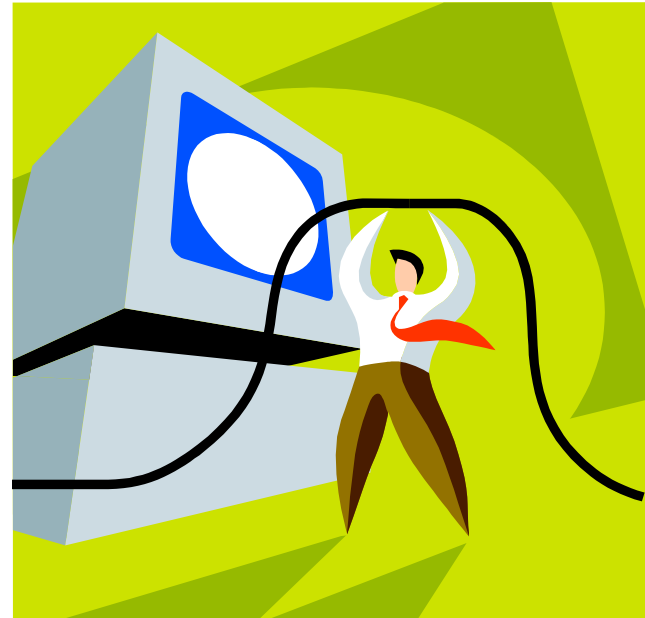
- The following set of principles should be incorporated into the implementation of health IT to ensure its effectiveness in supporting care coordination
 - Information should be accessible
 - Technology should facilitate trust
 - Information should be actionable, timely, and capable of being customized
 - Technology should support the patient and provider relationship.

Key Principles Defining the Value of Health IT (con't)

- A proactive plan of care is central to effective care coordination
- Successful care coordination requires numerous linkages throughout the healthcare system, as well as to non-health related community supports
- Technology should streamline and coordinate clinical workflows across the continuum of care.

Key Components

- In order to achieve the specific benefits health IT can bring to the care coordination process, industry should focus on creating and implementing tools that address a number of key components
- Key components indicates the functional capabilities that electronic health systems must have in order to support care coordination and should be developed and implemented in adherence to each of the key principles



Information Sharing

- In order to successfully support care coordination, information should be available, accessible and integrated in the care team's work flow
- Electronic healthcare record systems should include specific role-based permissions; track assignments and responsibilities among care team members and allow access for multiple, authorized individuals.
- All information about a patient's health status, should be available wherever possible and to those that need it based on their role
- Standardization of terminology is necessary both for interoperability and for clear, consistent communication across the spectrum of care.

Team-Based Care

- The health IT system should facilitate patient engagement, allow for successful collaborative efforts between care team members, and produce effective communication amongst the patients, family, care team and care givers.
- Health IT systems should utilized technologies to facilitate decision-making and planning for transitions of care.
- The systems should enable reminders, contact preferences and other functions that are capable of receiving information back from the patient in response to prescribed educational information
- The patient and/or caregiver should have continued bidirectional communication with the care team throughout the course of care
- Health IT should enable a primary coordinator of care, with other disciplines, contributing as appropriate, as well as the ability to change this primary coordinator of care as is needed by the patient.

Care Plans

- Health IT is essential to produce actionable, tailored, information in useable forms for the patient, family and healthcare provider –not just elements of data
- The health IT infrastructure should enable a comprehensive, interoperable and longitudinal view of pertinent clinical and patient contributed data from a variety of sources at the point of care
- The infrastructure should be developed for managing care plans that incorporate systems for registering, tracking, measuring, reporting and improving essential coordinated services.
- Information should be updated according to new information gathered, either through additional encounters, secure messaging or information entered via a patient health record or patient portal

Organization of Information and Services

- The health IT infrastructure should enable collaborative decision making support among different clinicians and patients
- Should incorporate systems for tracking, measuring, reporting, enhancing communication and improving essential coordinated services
- Should support meaningful clinician-patient communication and improve accessibility of the healthcare organization to the patient
- The infrastructure should work to facilitate team-based care, and supported by a multi-disciplinary team that includes, but is not limited to, other clinical staff, social workers, mental health workers, health educators, and care givers, as clinically appropriate
- The health IT infrastructure should include agreed upon processes and procedures for clinical notification between hospitals and outpatient clinicians.

Conclusion

- Health IT implementation will not happen overnight and many relevant parties are at varying stages of implementation. As technology continues to develop, it is important to remain mindful that the integration of health IT into care coordination is a continuously evolving process
- Even with the evolving functionality, particular attention must be given to the patient, who is at the center of all care coordination activities
- Care coordination is not simply a technical issue, but also one in which multiple providers and caregivers must come together to provide care and services for a patient