Care Planning –

The Cornerstone of Care Transformation for People Living with Serious or Complex Chronic Conditions

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Care Coordination Workgroup

Maryland Health Services Cost Review Commission

COMPREHENSIVE UNDERSTANDING

PERSON-CENTERED CARE PLAN

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Steps in optimal care planning

1. Targeting who needs care planning – starting in Medicare – mainly frail, physically disabled, mentally disabled, ESRD, and end-of-life
2. Care Planning
   A. Current patient/family situation
   B. Likely future situation(s) with various strategies – and settle on relevant timeframe
   C. Patient/family priorities – hopes, fears, values – GOALS
   D. Negotiated, patient-driven care plan
   E. Available to those who need it, promptly
3. Evaluation and Feedback – system learning
4. Care plan use in system management – supply and quality issues for community

Details on Care planning elements

A. Current patient/family situation
   1. Medical and disabilities
   2. Housing/food/transportation
   3. Caregiving and personal care
   4. Relationships, financing, and abuse/neglect

Details on care plan elements

D. Negotiated, patient-driven care plan – including
   1. Goals
   2. Services and responsible party for each – and overall responsible party
   3. Likely challenges and responses
   4. Time for scheduled review
   5. Available 24/7 to address urgent issues
   6. Available appropriately to relevant service providers
   7. Care team members, including patient and caregivers

Thus – the care plan is showing up

- Already a core commitment of (and requirement for) PACE (Program of all-inclusive care of the elderly), home care, and hospice
- Central to the new Chronic Care Coordination service (using new CCM code = ~$42/mo/person to physician delivering a set of chronic care coordination services)
- Thin version (for only a couple of days) in transitions and referrals in Meaningful Use 3 (proposed)

The Chronic Care Management Code
List of Elements "typically included" in a Care Plan

- Problem list; expected outcome and prognosis; measureable treatment goals
- Symptom management and planned interventions (including preventive care)
- Community/social services
- Plan for care coordination with other providers
- Medication management
- Responsible individual for each intervention
- Requirements for periodic review/revision

Evaluation – for systems

- Sum up performance for individuals, examine outliers
- Feedback upstream – self-correcting process
- Use care plans to manage the service supply and quality
  - Aggregate optimal and actual care plans for a population
  - Geo-map home care services – meals, personal care, MDs, etc.
  - Examine gap between optimal and actual
  - Compare with past and with similar communities

To Start: Some Statewide *Care Plan* Strategies

1. Develop/acquire a standardized and user-friendly care plan tool and processes
2. Develop interoperability of EMRs
3. Share care plans within the care team
4. Give patients and families their care plans (electronically or on paper)
5. Create standards and infrastructure for Medicare's Chronic Care Management services
6. Develop and implement metrics to evaluate and improve care planning
7. Create regional shared savings and gain sharing programs between and among hospitals, payers, and various providers
8. Develop regional/local initiatives to monitor and manage regional/local system supply and performance
9. Develop methods to aggregate care plans in a geographic area and develop system management metrics from the care plans

Additional Information For Reference

Ancillary materials – just FYI

- Slide 12-22 – extras on care planning
- Slide 23-26 About the Chronic Care Management Code
- Slide 27-35 – the ONC model for care plans
- Slide 36-40 – mock-up of system management using care plans in a region

Why medical care changes for serious chronic conditions?

- Historical "fix it or forget it" model worked for responding to relatively sudden health issues
- Living with serious conditions always required a different model – but 100 years ago, this was mainly TB and SMI – and the model was institutionalization
- Now, most of us will live for years with serious, progressive, and ultimately disabling and fatal conditions
- A reactive model, limited to medical issues, does not deliver comfortable and meaningful living (nor would an institutionalization model!)

Also

- Reasonably healthy people facing a health crisis can generally be considered to be in a relevantly similar situation, and professional standards are (often)enough
- But each person living with serious chronic illnesses and disabilities has his or her own unique situation and priorities to consider in shaping a plan – good care customizes to the client's goals, resources, challenges, and priorities.
- And to do that, good care becomes pro-active, pre-planned, comprehensive, and longitudinal – and intensely personal – pursuing THIS patient/family goals, given an honest understanding of their situation.

Understanding Goals & Wishes

- At this time in your life, what makes you happy?
- What is most important in your life?
- What experiences have you had with serious illness?
- Can you imagine a health situation that would be so hard on you that you'd rather not survive?
- How do you balance enjoying the life you have with undertaking the burdens of medical care?
- Have you changed your mind about what is important to you over time?


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But “everyone” does care plans!

- Not really – hospitalists list meds and treatments; social service agencies “see” nutrition and housing and personal care; therapists attend to their agenda – for most patients, no one is pulling it all together
- Electronic medical records don’t generally have a spot to attach a care plan and essentially none have structured care plans – but ONC-HIT is working on this – elements are through HL-7 balloting and in demo mode in Mass.
- No example yet of a high-functioning, replicable, care plan method at scale – VA and KP coming close but without community-based providers - should give access to the right providers, present the salient information efficiently, reflect the patient/family priorities, be evaluated and improved

Slide 16

1 I would simplify and shorten this background and history section
Alice Burton, 1/30/2015

What's needed for care planning

- Commitment by service providers, clinicians, and patients
- Prognostication (for disabilities, service needs, survival)
- Teamwork – ad hoc vs enduring, core team and ancillary
- Responsible party – 24/7
- Accessible, reliable, available services
- Workable and accessible documentation
- Patient/family mobilization for active engagement
- Evaluation and feedback

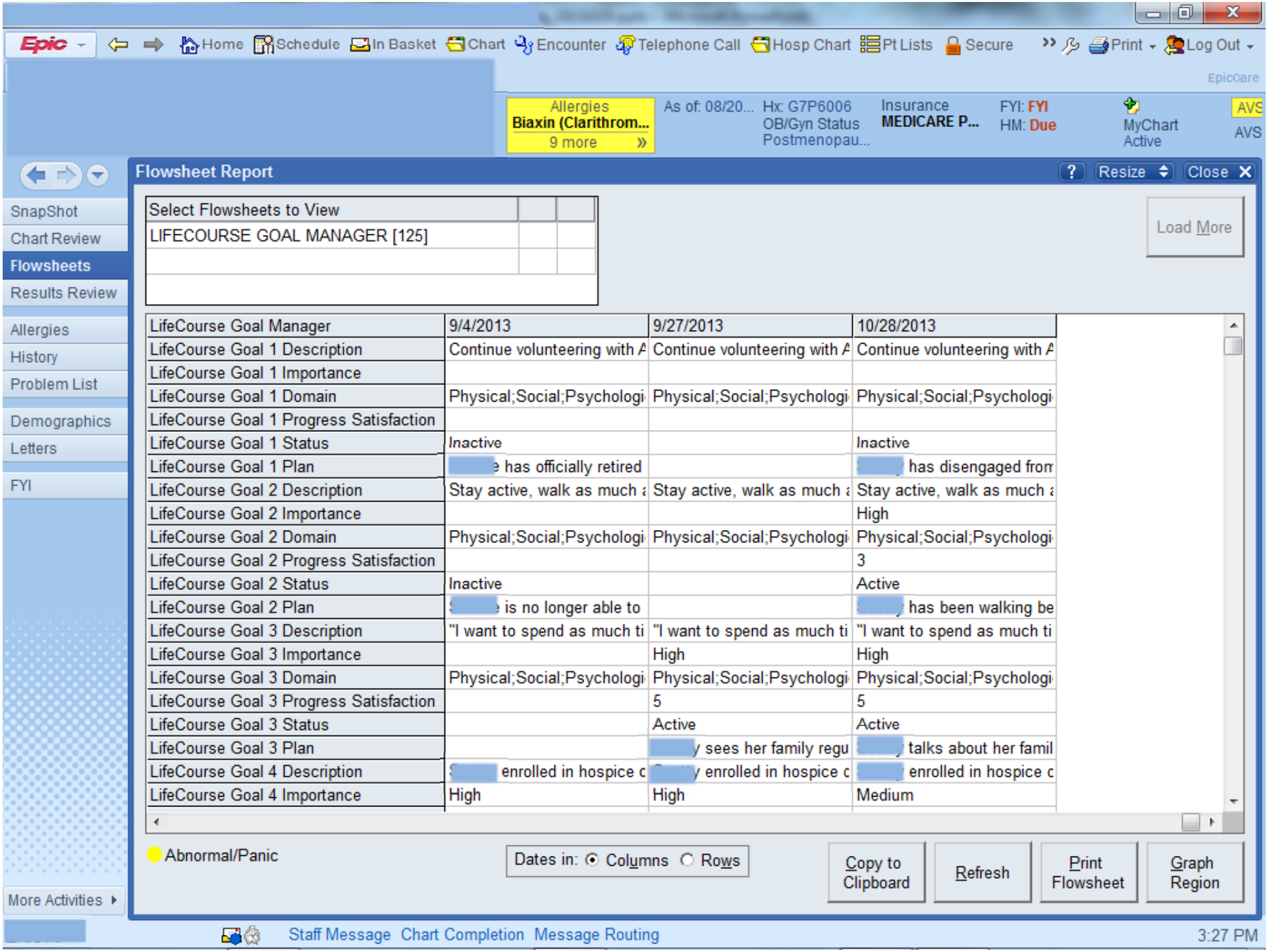
So – why don't we have care plans

- Care planning is unfamiliar and not easy.
- Method is not clear and documentation seems weighty.
- FFS stakeholders may profit from the dysfunctions.
- Existence or performance not usually measured.
- The conversion from mostly "rescue" medicine to mostly "living better with challenges" medicine is just beginning.
- Patients and families don't know to seek or value good care planning. Often reticent to deal with the future overtly.
- Advocates have not converged on demanding good care plans.

LifeCourse Goal Manager	4/21/2013
LifeCourse Goal 1	"I want to stay ir
LifeCourse Goal 1 Importance	High
LifeCourse Goal 1 Domain	Physical;Psychological;(
LifeCourse Goal 1 Progress Satisfaction	3
LifeCourse Goal 1 Status	Active
LifeCourse Goal 1 Plan	Explore relevant issues
LifeCourse Goal 2	"I want to get off been taking since I had
LifeCourse Goal 2 Importance	Medium
LifeCourse Goal 2 Domain	Physical;Psychological
LifeCourse Goal 2 Progress Satisfaction	2
LifeCourse Goal 2 Status	Active
LifeCourse Goal 2 Plan	LifeCourse Team to gui

LifeCourse Goal Manager	4/30/2013
LifeCourse Goal 1	"I want to stay in my house as long as possible."
LifeCourse Goal 1 Importance	High
LifeCourse Goal 1 Domain	Physical;Psychological;Cultural;Financial
LifeCourse Goal 1 Progress Satisfaction	3
LifeCourse Goal 1 Status	Active
LifeCourse Goal 1 Plan	Explore relevent issues around safety and care needs.
LifeCourse Goal 2	"I want to get off the pain medications that I have been taking since I had neck and shoulder pain
LifeCourse Goal 2 Importance	Medium
LifeCourse Goal 2 Domain	Physical;Psychological
LifeCourse Goal 2 Progress Satisfaction	2
LifeCourse Goal 2 Status	Active
LifeCourse Goal 2 Plan	LC Care Team to determine follow up.
LifeCourse Goal 3	[redacted] daughter would like help monitoring her mother's health, in an effort to avoid another stroke.
LifeCourse Goal 3 Importance	High
LifeCourse Goal 3 Domain	Physical;Social;Psychological;Family Caregiver
LifeCourse Goal 3 Progress Satisfaction	1
LifeCourse Goal 3 Status	Active
LifeCourse Goal 3 Plan	LC Care Team to explore supportive resources.
LifeCourse Goal 4	[redacted] daughter would like help planning for her mother's future care needs.
LifeCourse Goal 4 Importance	High
LifeCourse Goal 4 Domain	Physical;Social;Psychological;Financial;Family Caregiver
LifeCourse Goal 4 Progress Satisfaction	1
LifeCourse Goal 4 Status	Active
LifeCourse Goal 4 Plan	LC Care Team to advise.

Goals Current State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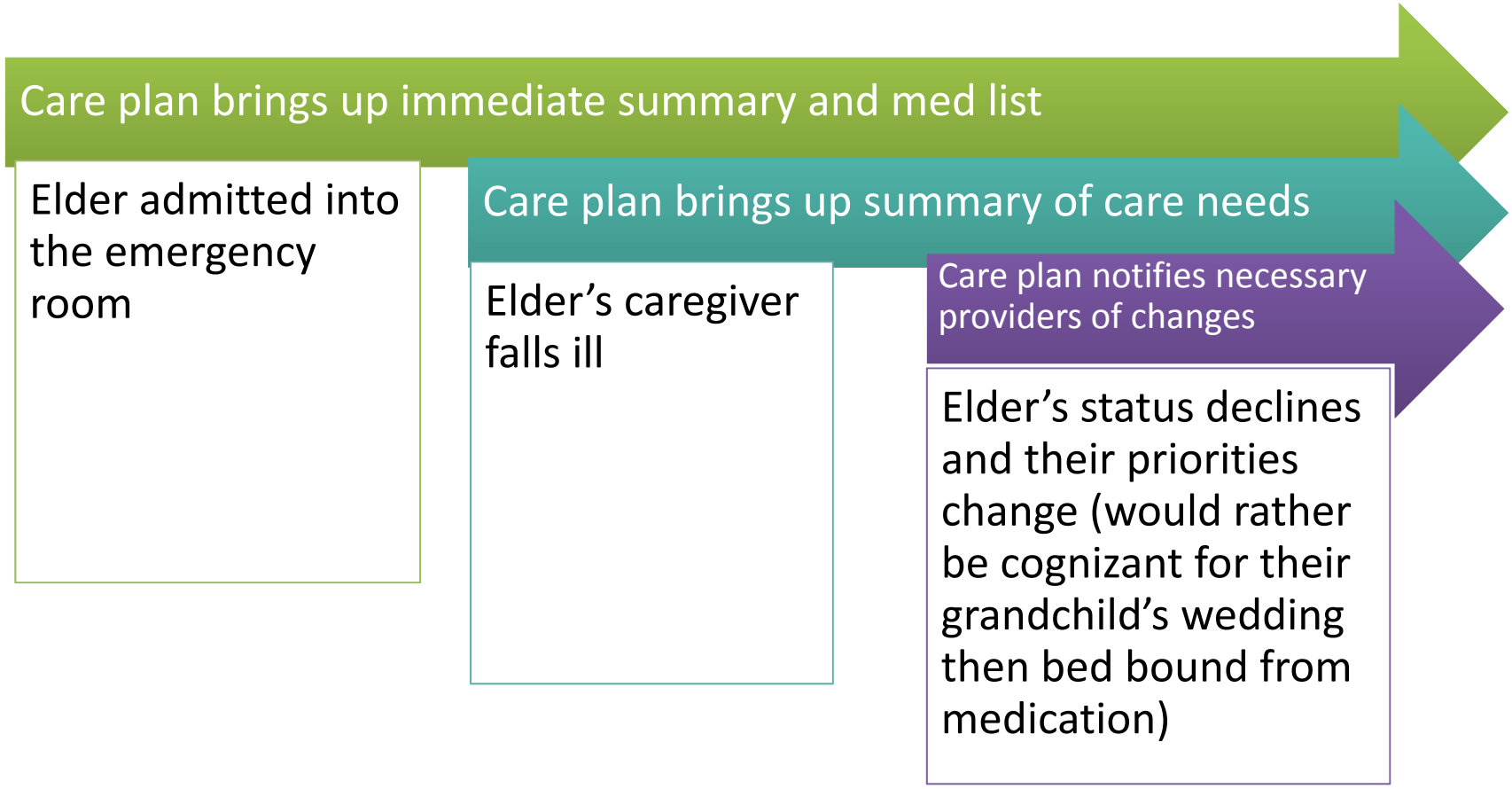
Results Review
Allergies
History
Problem List
Demographics
Letters
FYI
More Activities
Select Flowsheets to View
LIFECOURSE GOAL MANAGER [125]
Load More
LifeCourse Goal Manager | 9/4/2013 | 9/27/2013 | 10/28/2013
LifeCourse Goal 1 Description | Continue volunteering with A | Continue volunteering with A | Continue volunteering with A
LifeCourse Goal 1 Importance | | |
LifeCourse Goal 1 Domain | Physical;Social;Psychologi | Physical;Social;Psychologi | Physical;Social;Psychologi
LifeCourse Goal 1 Progress Satisfaction | | |
LifeCourse Goal 1 Status | Inactive | | Inactive
LifeCourse Goal 1 Plan | e has officially retired | | has disengaged from
LifeCourse Goal 2 Description | Stay active, walk as much a | Stay active, walk as much a | Stay active, walk as much a
LifeCourse Goal 2 Importance | | | High
LifeCourse Goal 2 Domain | Physical;Social;Psychologi | Physical;Social;Psychologi | Physical;Social;Psychologi
LifeCourse Goal 2 Progress Satisfaction | | | 3
LifeCourse Goal 2 Status | Inactive | | Active
LifeCourse Goal 2 Plan | e is no longer able to | | has been walking be
LifeCourse Goal 3 Description | "I want to spend as much ti | "I want to spend as much ti | "I want to spend as much ti
LifeCourse Goal 3 Importance | | High | High
LifeCourse Goal 3 Domain | Physical;Social;Psychologi | Physical;Social;Psychologi | Physical;Social;Psychologi
LifeCourse Goal 3 Progress Satisfaction | | 5 | 5
LifeCourse Goal 3 Status | | Active | Active
LifeCourse Goal 3 Plan | | y sees her family regu | talks about her famil
LifeCourse Goal 4 Description | enrolled in hospice c | y enrolled in hospice c | enrolled in hospice c
LifeCourse Goal 4 Importance | High | High | Medium
Abnormal/Panic
Dates in: Columns Rows
Copy to Clipboard
Refresh
Print Flowsheet
Graph Region
Staff Message
Chart Completion
Message Routing
3:27 PM

Technology


Care plan brings up immediate summary and med list
Elder admitted into the emergency room
Care plan brings up summary of care needs
Elder's caregiver falls ill
Care plan notifies necessary providers of changes
Elder's status declines and their priorities change (would rather be cognizant for their grandchild's wedding then bed bound from medication)

Possible evaluation for individuals

- Utilization metrics – total cost, Medicare cost, readmissions/1000/quarter
- Patient/family reported metrics – confidence, best life possible under the circumstances, services aligned with goals
- Serious adverse events – pressure ulcers, unwanted major treatments, unwanted hospitalization or SNF, falls with injury, iatrogenic infection
- Points of positive experience – meaningful living, comfort, caregiver having adequate support, pleased with service array and care planning process

Potential of Medicare's Chronic Care Management Code

- Pays $40-42/month
- For Medicare patients with 2 or more chronic conditions expected to last through death or at least 12 months, and that have significant risk of death, exacerbation, or functional decline
- With a comprehensive care plan established, implemented revised, or monitored
- Who consent and pay 20% co-pay
- SO – a practice with the average number of 3279 patients
- Has 22% Medicare, of which 2/3 qualify
- SO a potential of $238,000 per year of new income

The Physician Practice must have 5 capabilities

1. Consent of the patient (and only one practice can bill)
2. Use a certified EHR for
   - Structured recording of demographics, problems, medications, and allergies
   - Creation of a summary care record and plan (which is separately billable), which can be transmitted electronically (and not by fax) and is accessible 24/7 to all service providers
   - Documenting consent
   - Giving the care plan to the patient, and
   - Communicating with home and community-based providers about psychosocial needs and function (care coordination)

The Physician Practice must have 5 capabilities

3. Patient must be able to reach a member of the care team 24/7 and that person must have access to the care plan. Also, the patient must be able to see a particular member of the care team for routine appointments, and must have available enhanced opportunities for communication (including telephone or internet)
4. Follow-up after ER or hospitalization (cannot bill TCM and CCM in the same month), coordinate referrals and share information electronically with other providers
5. Coordinate care with home and community-based service providers, documented in the certified electronic record

And then the practice must provide

- 20 minutes (or more) of services in each calendar month doing non-face-to-face care management services
- By clinical staff, directed by a physician or other qualified health care professional

Longitudinal Care Planning

A Vision of the Longitudinal Coordination of Care Workgroup

This set of 10 slides shows the model of care planning used in developing HIT standards

Slide 27

12 recommend dropping this

Alice Burton, 1/30/2015

13

LCC Workgroup Leads/Co-authors

•Larry Garber, MD	LTPAC Care Transitions
•Terry O'Malley, MD	LTPAC Care Transitions
•Bill Russell, MD	Longitudinal Care Plan
•Laura Heermann Langford,PhD,RN	Longitudinal Care Plan
•Russ Leftwich, MD	Longitudinal Care Plan
•Jennie Harvell	Pt. Assessment Summary
•Sue Mitchell, RHIA	Pt. Assessment Summary

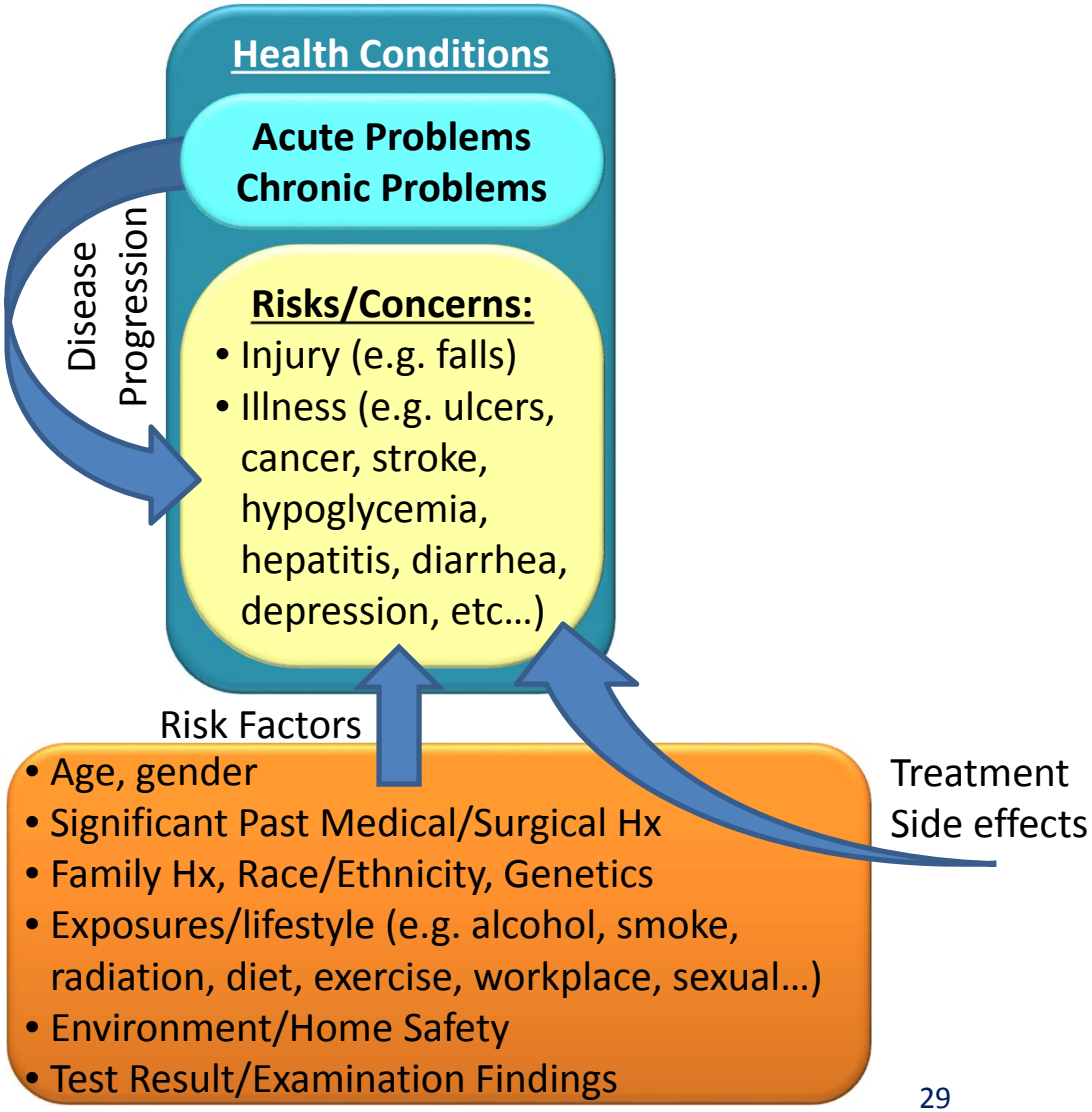
Slide 28

13 Recommend dropping this

Alice Burton, 1/30/2015

14 atients have current conditions, risks for conditions, and concerns

Risks come from many sources



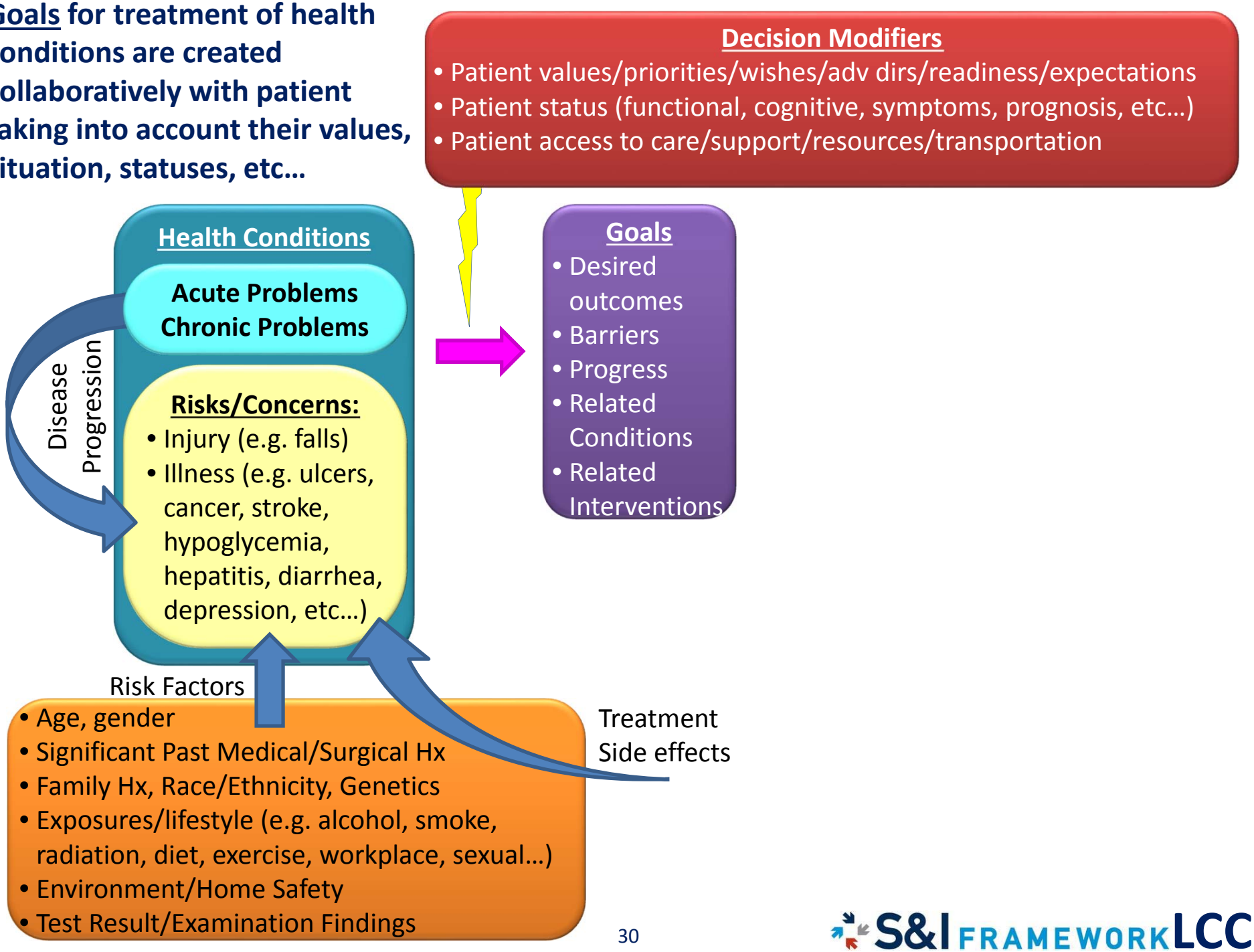
Slide 29

14 I think thsi graphic is good. But there is a lot of comlexity here. Is there a much higher level version of this? Maybe just headers in top left corner of each.

I worry that we will lose them in the complexity of this chart.

Alice Burton, 1/30/2015

Goals for treatment of health conditions are created collaboratively with patient taking into account their values, situation, statuses, etc…



Decision making is enhanced with evidence based medicine, clinical practice guidelines, and other medical knowledge

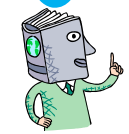
Decision Modifiers
- Patient values/priorities/wishes/adv dirs/readiness/expectations
- Patient status (functional, cognitive, symptoms, prognosis, etc…)
- Patient access to care/support/resources/transportation

Health Conditions

Acute Problems
Chronic Problems

Disease Progression

Risks/Concerns:
- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc…)



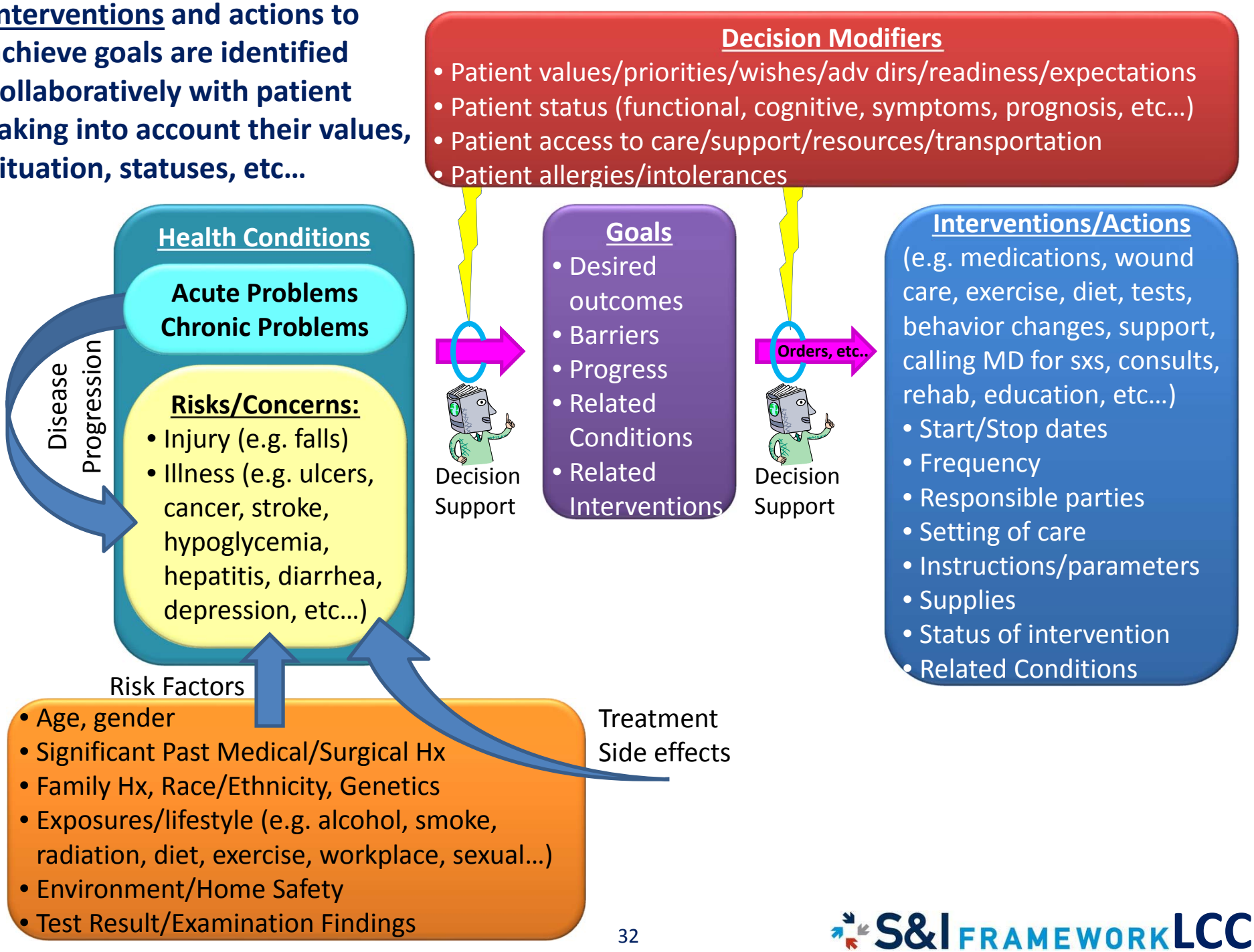
Decision Support

Goals
- Desired outcomes
- Barriers
- Progress
- Related Conditions
- Related Interventions

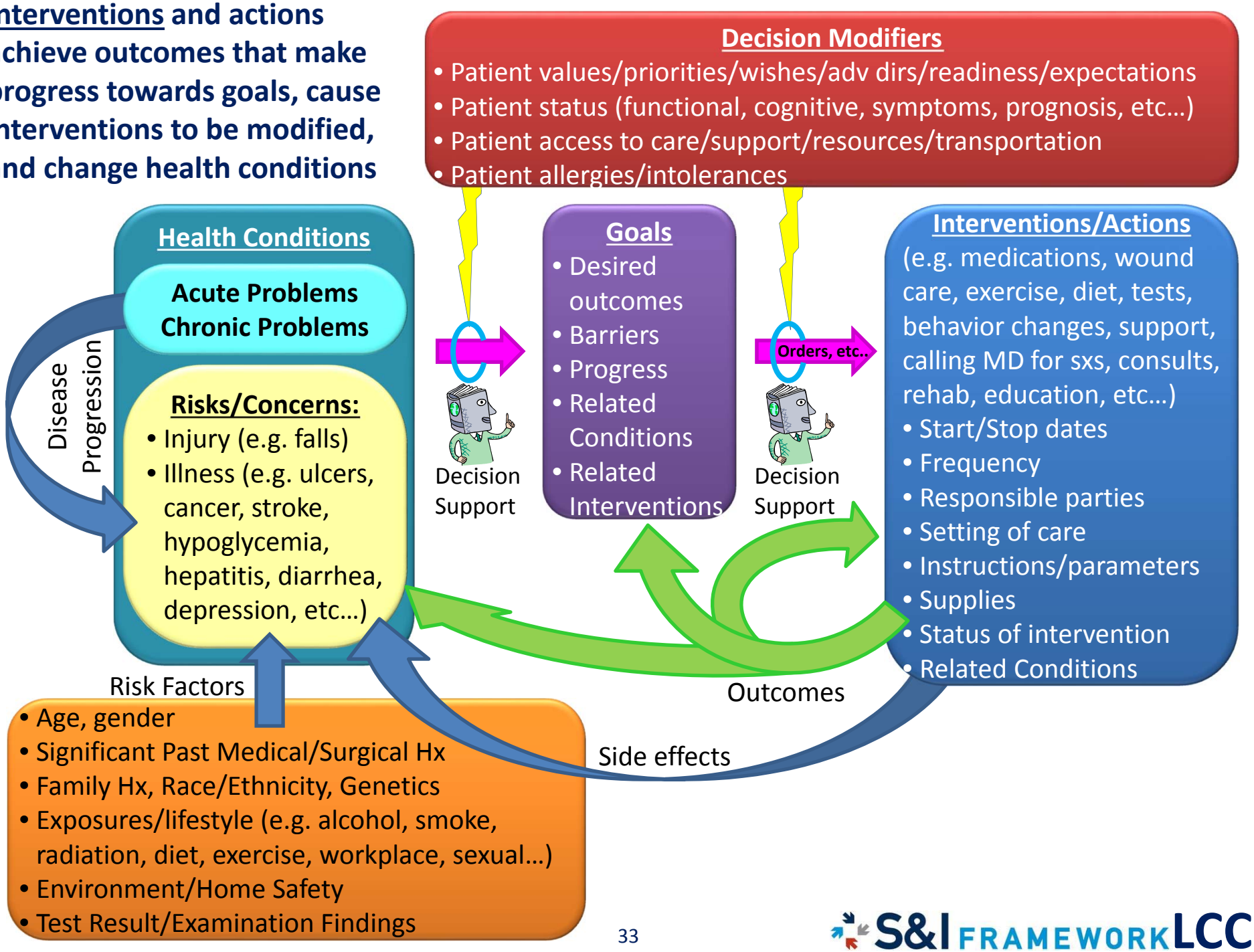
Risk Factors
- Age, gender
- Significant Past Medical/Surgical Hx
- Family Hx, Race/Ethnicity, Genetics
- Exposures/lifestyle (e.g. alcohol, smoke, radiation, diet, exercise, workplace, sexual…)
- Environment/Home Safety
- Test Result/Examination Findings

Treatment Side effects

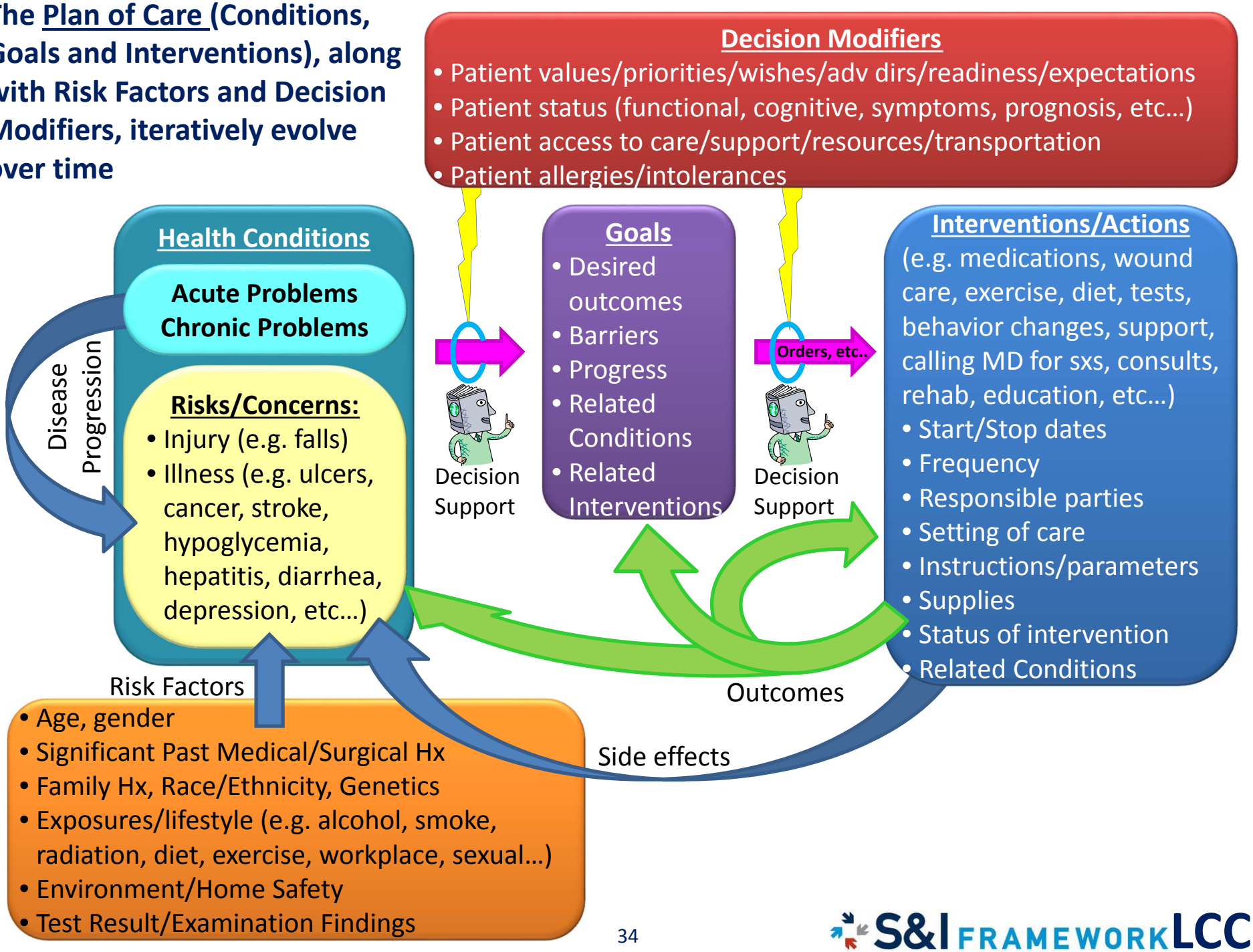
Interventions and actions to achieve goals are identified collaboratively with patient taking into account their values, situation, statuses, etc…

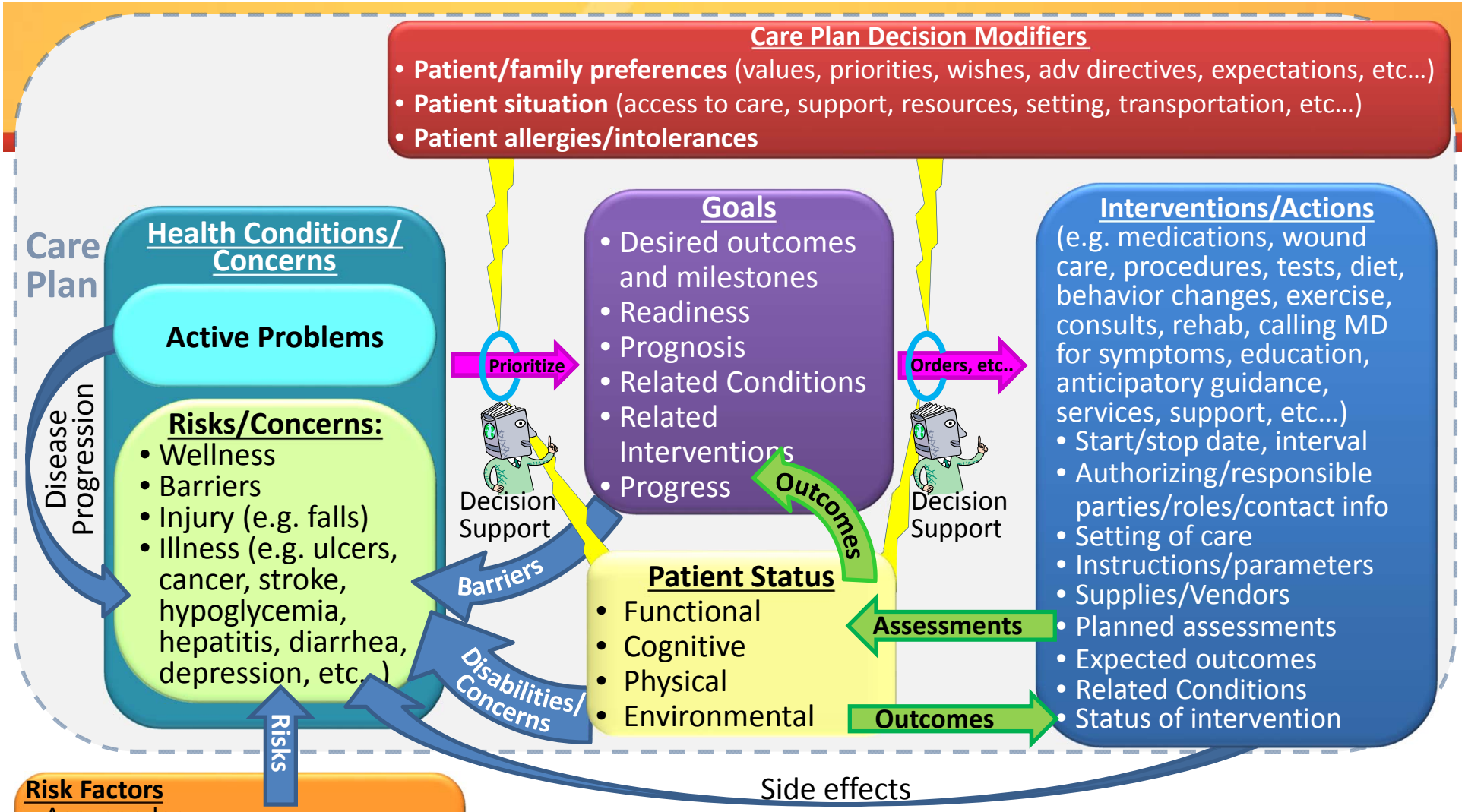


Interventions and actions achieve outcomes that make progress towards goals, cause interventions to be modified, and change health conditions



The Plan of Care (Conditions, Goals and Interventions), along with Risk Factors and Decision Modifiers, iteratively evolve over time





The Care Plan (Concerns, Goals, Interventions , and Care Team), along with Risk Factors and Decision Modifiers, iteratively evolve over time

An Ideal Service Production System:

An introduction to the idea of local monitoring and management in 5 slides

- What inputs would you need to optimize service production for a community?
- What follows is an untested "alpha version" - many important elements not yet included, but it models a very appealing approach.
- ***With good care plans for persons with complex needs in a population, one could model the ideal service production system.***

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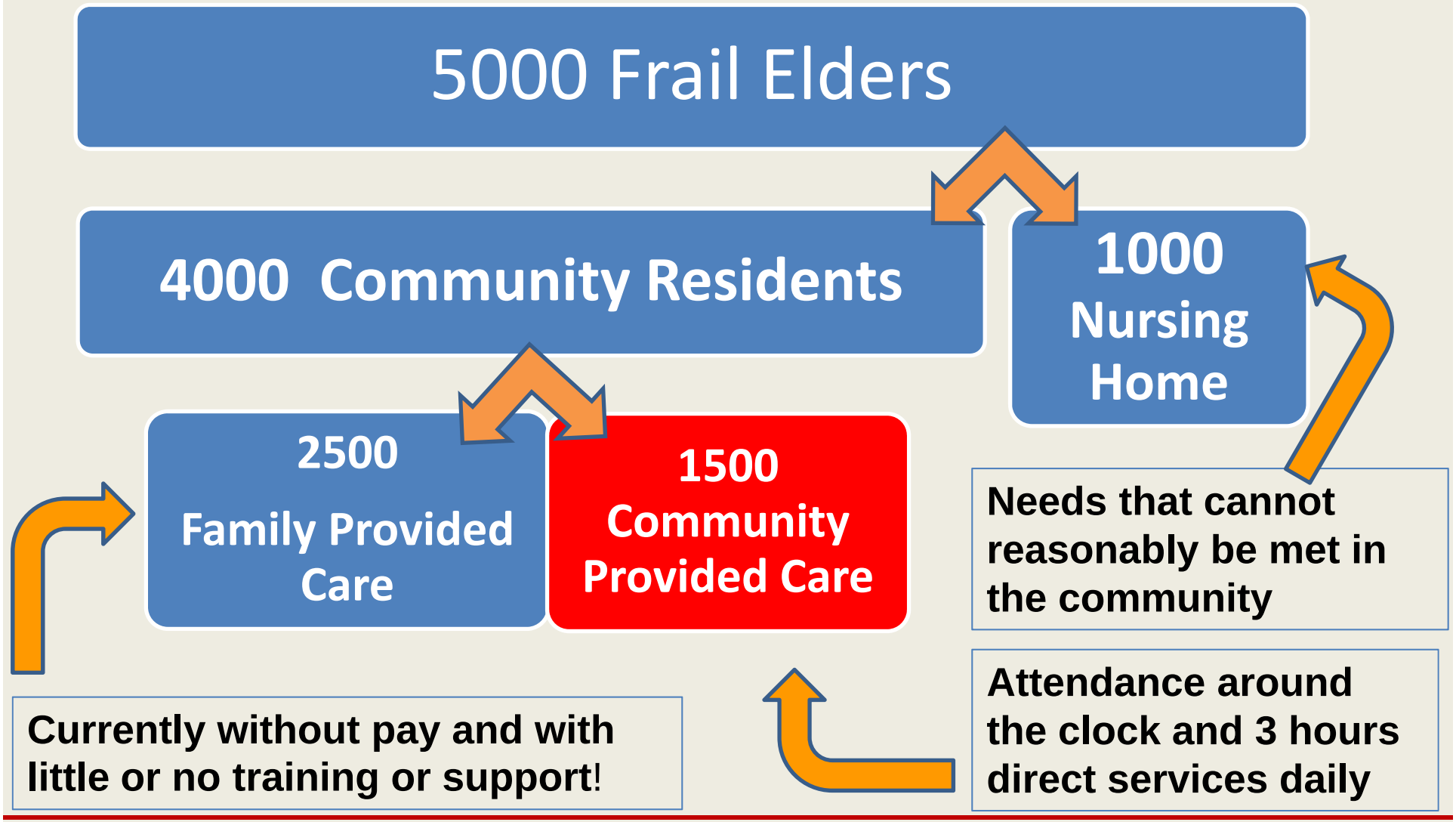
"Alpha" Optimal Production System – *How many frail elderly?*

- In a community of 600,000 residents, about 6000 die each year, about 5000 in old age, and about half have frailty as their last phase of life.
  - 2500 – single overwhelming disease
  - 2500 – frailty

- Substantial self-care disability will last an average of 2 years before death

- **Thus, at any one time, about 5000 frail adults ≥65 years of age will be in need of supportive services**

"Alpha" Optimal Production System
– *Where, what & how will needed care be provided?*



"Alpha" Optimal Production System
–Primary Care Provider home visits

- **Number of home visits**
  - 4000 people living with serious frailty in the community
  - Routine visit every 4 months
  - Urgent visit 3/year

4000 X 6 = 24,000 visits needed

10 X 240 = 2400 visits / PCP / year

- **Primary Care Provider**
  - Can see ~10 visits/day (with assistant/driver)
  - ~240 days per year
  - The community needs 10 full-time PCPs (and 10 full-time assistants/drivers)
  - Plus 24/7 coverage for urgent situations

"Alpha" Optimal Production System
– *Summary of needs?*

	1000 NH Elders	1500 Community Elders
Direct care workers	500	1500 (½-3 per person)
Nurses	100	500
Therapists	100	100
Primary Care Providers	5	10
PCP Assistants		10
Hospital Beds	50	250