Longitudinal Coordination of Care

If you would like to follow the progress of work done by LCC, you are more than welcome to participate in the following HL7 Workgroups, to which all LCC work has been transitioned:

- **Structured Documents WG**
  - Responsible for C-CDA Standard Revisions
  - Meets every Thursday from 10 to 12pm ET
  - HL7 Structured Documents Wiki Reference the "Upcoming Calls" section for web meeting and dial-in information

- **Patient Care WG**
  - Responsible for Care Plan, Care Coordination and Health Concern Topic
  - **Care Plan Project** meets every other Weds from 4 to 5:30pm ET
  - **Health Concern Topic** meets every other Thursday from 4 to 5pm ET
  - HL7 Patient Care Wiki Reference the "Upcoming Calls" section for web meeting and dial-in information

Download the Closing Ceremony presentation: LCC Closing Ceremony Presentation Materials

View the Closing Ceremony recording: View on Vimeo

Implementation Resources

IG Artifact	Description	Date Uploaded
LCC Candidate Standards 2012-04-12	LCC Candidate Standards List	4/12/2012
LCC Candidate Standards 2012-07-10	LCC Candidate Standards List	7/10/2012
IMPACT Project High Level Implementation Guide	SEE Transitions of Care IG	January 2013
LCC Use Case 2.0 Functional Requirements	Care Plan Exchange Use Case functional requirements	May 2013
Introductory Materials	C-CDA R2 Introductory Materials	August 2013
Templates and Supporting Documents	Pre-balloted C-CDA R2 Implementation Guide	Aug 2013
Assessment Summary Document and Questionnaire Assessment Implementation Guide	Balloted by LTPAC	December 2012

Initiative Artifacts

Artifact	Description	Completion Date
Consolidated CDA Implementation Guide	C-CDA R1 Implementation Guide	1/11/2012
C-CDA R2 Implementation Guide	C-CDA R2 Templates for Clinical Notes DSTU R2 Implementation Guide	September 2013
Care Plan White Paper	Meaningful Use Requirements for Transitions of Care and Medically Complex and/or Functionally Impaired Persons White Paper	08/21/2012
Care Plan Glossary	List of terminology and definitions used in Care Plan documentation	December 2012

Background

Improving transitions of patients across acute and post-acute care settings has been a key driver of recent healthcare reform initiatives and regulations. Ineffective care transitions are widely recognized as major contributors to poor quality and waste. Gaps in treatment and poor communication among provider groups and between providers and patients have been shown to diminish patient health and increase costs. The Meaningful Use (MU) Electronic Health Record (EHR) Incentive Program addresses this gap by introducing two new measures to improve care coordination during Transitions of Care (ToC): 1) medication reconciliation during ToC and 2) Summary of Care record for ToC/referrals.

The ONC ToC Initiative emerged to identify and develop the standards that would enable the electronic exchange of core clinical information among providers, patients and other authorized entities so that Stage 1 and Stage 2 MU ToC requirements could be met. The ToC Initiative standards target specific provider groups or disciplines—eligible providers (EPs) and eligible hospitals (EHs)—and the software developers and vendors who would design or upgrade EHR systems to enable the exchange. Absent from these scenarios are the exchange requirements for interdisciplinary interventions and care planning across the continuum of care, regardless of setting or service provider. This limitation highlights a critical gap in both the provider and patient populations targeted by the MU Program. For example, each year an average of fifteen million medically complex and/or functionally impaired individuals receive care services not only from eligible provider groups, but also from nursing facilities (NFs), home health agencies (HHAs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and a wide array of social services and supports. The quantity of service delivery encounters required by these individuals, as well as the failure to deliver and coordinate needed services, are significant sources of frustration and errors, and thereby drivers of healthcare expenditures.

The S&I Longitudinal Coordination of Care (LCC) Initiative builds on the ToC Initiative standards and aims to address identified gaps in transitions of care and care planning.

Challenge Statement

Efficient health information exchange to support coordination of care across multiple clinicians and sites of service—regardless whether these sites receive MU incentive payments—requires more than medication reconciliation and care summary exchange. The availability and adoption of standards to support and inform care delivery without regard to setting are essential to alleviating fragmented, unsafe, duplicative and costly care for those patient populations that need it most.

Individuals of all ages are living longer with chronic illness and disability. As the number and complexity of their health conditions increase over time and episodes of acute illness are superimposed, the number of care providers contributing to the care of these individuals increases as well. It becomes significantly more difficult to align and coordinate care among diverse provider groups across multiple sites.

Without a process to reconcile potentially conflicting plans created by multiple providers, it is impossible to avoid unnecessary and potentially harmful interventions. Without such a process, it is also difficult to shift the perspective of providers from the management of currently active issues to consideration of future goals and expectations. Similarly, the challenge of establishing a consensus driven process across multiple disciplines and settings is confounded by a fragmented system of policies, technologies and services to support the process and thereby enable longitudinal coordination of care.