EHR & Exchange Standards - Continuity of Care Record

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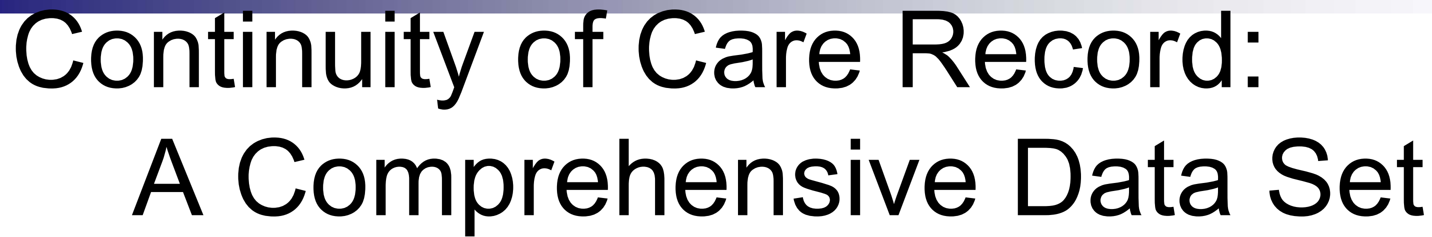


Continuity of Care Record: A Comprehensive Data Set

- Most relevant current and past administrative and clinical information about a patient’s health status and healthcare treatment
- Organized and transportable
- Prepared by a practitioner at the conclusion of a healthcare encounter
- Enables next practitioner to readily access such information

First Consensus re Data Needed for Care CCR Sponsors

- ASTM Int'l E31 Health Informatics Committee
- Massachusetts Medical Society
- HIMSS
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Medical Association
- Patient Safety Institute
- American Health Care Association
- National Association for the Support of LTC
- Mobile Healthcare Alliance (MoHCA)
- Medical Group Management Association
- American Academy of Osteopathic Family Physicians

Developers represent…

- ANSI-recognized standards development organization
- Over 400,000 clinicians
- Over 13,000 IT professionals
- Over 12,000 institutions in the long-term care community providing care to over 1.5 million elderly and disabled
- Major stakeholders in m-Health
- Patients, patient advocates, data sources, corporations, provider institutions….

Intent of CCR

- Enhance patient safety
- Reduce medical errors
- Reduce costs
- Enhance efficiency of health information exchange between providers
- Assure at least a minimum standard of health information transportability when a patient is seen in a new or different environment
- Facilitate access to patient information
- Support clinical practice and accelerate EMR adoption
- Improve population health

CCR Is Technology Independent

- XML coding allows
  - Import and export of all CCR data
  - Automated CCR transmission
  - Interchange between incompatible EHR systems
  - Preparation, transmission, and viewing of CCR in multiple ways
    - Browser
    - As an element in an HL7 message or CDA compliant document
    - In secure email
    - As PDF file, HTML file, or word processing document
    - On a CD, DVD, USB drive, smart card, etc.
- Paper allowed

Uses of the CCR

- For reimbursement
- For referrals or transfers, inpatient or outpatient
- For discharges without a referral or transfers
- For personal health records
- For enterprise specific information, e.g., home healthcare
- For clinical specialty information
- For disease management
- For other uses, e.g.,
  - Moving to a new community
  - Home health monitoring
  - Access while traveling
  - Disasters and other public health purposes

- Adopting CCR standardized data set for Medicaid billing would
  - Decrease costs, increase efficiency through
    - Consistency in data collection and exchange
  - Improve continuity, safety, quality of care
    - Emergency department visits, transfers, discharges, referrals
  - Improve analysis, reporting, and accountability
- Through participation in further development of CCR and related standards, Medicaid representatives can enhance its potential value
  - Improve communication and functionality

Components of the CCR

- Header
  - Unique identifier
  - Date/time of completion
  - Who/what from and to
  - Who about
  - Purpose
- Body
  - Administrative data
  - Clinical data
- Footer
  - Actors
  - References
  - Comments
  - Signature

Components of the CCR: Body

Administrative & Clinical Data

- Insurers/Payers
- Advance Directives
- Support
- Functional Status
- Problems
- Family History
- Social History
- Alerts
- Medications
- Medical Equipment
- Immunizations
- Vital Signs
- Results
- Procedures
- Encounters
- Plan of Care
- Healthcare Providers

Payers

- Fiduciary responsibility for patient
  - Third-party insurance, self-pay, other payer or guarantor
- All necessary data to
  - Contact
  - Bill to
  - Collect from
- Authorization data related to patient and/or provider

Advance Directives

- Are there any?
- If so, what are they?
- And where are they?
- Examples
  - DNR
  - Durable power of attorney for healthcare

Support

- Family
- Next of kin
- Legal guardian
- Durable power of attorney for healthcare
- Clergy
- Support organizations
- Does not include healthcare providers

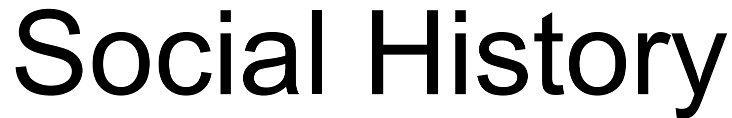
- Competency
- Ambulatory status
- Ability to care for self
- Activities of daily living
- Etc.

- Relevant current and past clinical problems, conditions, diagnoses, symptoms, findings, and complaints

Family History

- Blood or genetic relatives in terms of possible or relevant health risk factors for patient

Social History

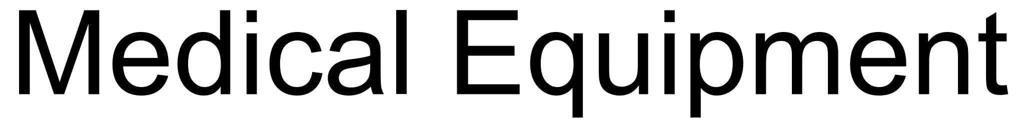


- Occupational
- Personal (e.g., lifestyle)
- Social
- Environmental
- Administrative data such as marital status, race, ethnicity, religious affiliation

Alerts

- Allergies
- Adverse reactions
- Alerts
- Critically important variations from the norm
- Prompts or warnings related to patient safety

- Patient's current medications and pertinent medication history
  - Both prescription and OTC
- Harmonized with NCPDP medication data



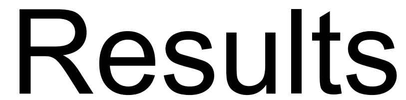
- Implanted and external medical devices and equipment relevant to current health status

Immunizations

- Current immunization status
- Pertinent immunization history

Vital Signs

- Current and historically relevant vital signs
- At minimum pertinent vital signs such as most recent, maximum or minimum or both, baseline, relevant trends
- Allows specialties to record data specific to their needs



- Laboratory, diagnostic, and therapeutic results

Procedures

- Interventional, surgical, diagnostic, and therapeutic procedures
- Preferred controlled vocabularies
  - SNOMED-CT and current CPT code set for procedures
  - LOINC for results

Encounters

- Hospitalizations
- Office visits
- Home health visits
- Long-term care stays
- Other pertinent encounters

Plan of Care

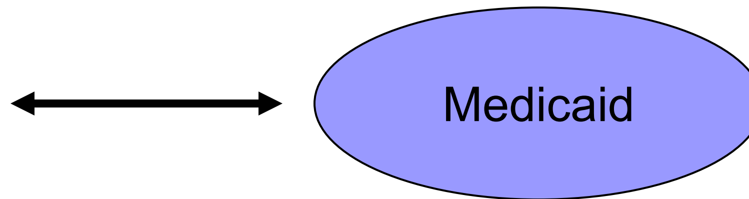
- All active, incomplete, or pending orders, appointments, referrals, procedures, services, etc.
- Clinical reminders prompting disease prevention, disease management, patient safety, and healthcare quality improvements, including widely accepted performance measures

Healthcare Providers

- Healthcare providers
  - Names
  - Specialties
  - Contact information
- Linked to diagnoses, medications, procedures, results, encounters, plan of care, etc.

Current and Future Work

- CCR Acceleration Task Group
- Develop next version of CCR
- Address specific needs
  - ObGyn
  - Long-term care
  - Dental
  - HIV (clinical trials)
  - Other specialties
  - Narratives
  - Advance Directives
  - PHRs



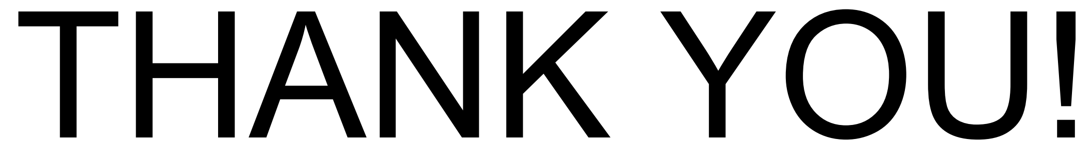
- Continue harmonization with other SDOs, including HL7, NCPDP, X12, etc.
- Cultivate international interest: Europe, Asia, Mideast
- Address security further
- Develop voluntary healthcare identifier standard

Potential Medicaid Roles

- Implement CCR on state-by-state basis
  - Improve quality of care
  - Reduce costs
  - Increase efficiency
  - Enhance consistency
- Evaluate how CCR can be used for deriving and verifying claims data

How to Obtain E2369

- Text, spreadsheet, and implementation guide:
  - Free to ASTM E31 members or
  - $67 to nonmembers
- XML schema: Sold separately for $62
- To join, go to www.astm.org
  - Click "membership", then click "Join ASTM International" - $75/year
  - Specify you want to join Committee E31 and the E31.28 Electronic Health Record Subcommittee
  - Select the virtual format Volume 14.01
- To purchase, go to www.astm.org
  - Enter E2369 in search box
  - Follow prompts



For further information…

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