Implementing Health Information Exchange in the Long-term and Post Acute Care Community

Perspectives for LTPAC Providers and their Affiliated Organizations

Webinar
December 12, 2012

To ask a question during the webinar --
1) Post a question at any time in the Chat Box
2) Live Q&A will be held at the end of the webinar
Session Overview

Gain a brief overview of industry and government influences shaping the direction and requirements for HIE and highlight current demonstration projects and tools to implement exchange in the LTPAC setting.

This session --

- Discusses the Meaningful Use program and other drivers of transformation
- Provide information on current demonstration projects and programs for HIE in LTPAC
- Provides practical tools and resources for implementing HIE in LTPAC
- Discuss priority standards activities to support HIE
Speakers

- Jennie Harvell, ASPE
  - Jennie.Harvell@hhs.gov
- Maria Harr, CMS
  - Maria.Harr@cms.hhs.gov
- Elizabeth Palena Hall, ONC
  - Elizabeth.PalenaHall@hhs.gov
- Brian Yeaman, Oklahoma Challenge Grant
  - BYeaman@yeamanandassociates.com
- Jim Younkin, Keystone HEI/Beacon Community
  - jryounkin@geisinger.edu
- Larry Garber, Massachusetts A Challenge Grant
  - Lawrence.Garber@reliantmedicalgroup.org
- Evelyn Gallego, ONC Standards & Interoperability Framework
  - evelyn.gallego@siframework.org
OVERVIEW OF DRIVERS FOR HEALTH INFORMATION EXCHANGE
The Changing Healthcare System

Moving from procedure and episodic based payment to payment based on health outcomes

The Affordable Care Act

- Accountable Care Organizations
- Other Shared Savings Models
- Patient Centered Medical Homes
- Health Homes
- Wellness Approach to Care vs. Episodic Disease Approach
The Changing Healthcare System

- HITECH
- Incentives for the Use of Electronic Health Records
  - Physicians
  - Hospitals
- Care Coordination
- Home Monitoring
ONC’s Approach

• Interoperability is a *journey*, not a destination

• Leverage *government as a platform* for innovation to create conditions of interoperability

• Health information exchange is *not one-size-fits-all*

• Multiple approaches will exist *side-by-side*

• Build in *incremental steps* – “don’t let the perfect be the enemy of the good”
ONC’s Role - Reduce Cost and Increase Trust and Value To Mobilize Exchange

**COST**
- **Standards:** Identify and urge adoption of scalable, highly adoptable standards that solve core interoperability issues for full portfolio of exchange options
- **Market:** Encourage business practices and policies that allow information to follow patients to support patient care
- **HIE Program:** Jump start needed services and policies

**VALUE**
- Payment reforms
- Meaningful Use
- Interoperability and wide-scale adoption

**TRUST**
- Identify and urge adoption of policies needed for trusted information exchange

**ONC’s ROLE**
Exchange Priorities in 2012 - Driving Forward on Multiple Fronts

• More rigorous exchange requirements in Stage 2 to support better care coordination

• Standards building blocks are in place, with clear priorities to address missing pieces in 2012

• NwHIN Governance increases trust and reduces the need for one-to-one negotiations among exchange organizations

• State HIE Program jump starts needed services and policies
Proposed Stage Two Meaningful Use Exchange Requirements (summary)

- Provide summary of care document for more than 65% of transitions of care and referrals with **10% sent electronically** (across vendor and provider boundaries)
- Patients can **view, download or transmit** their own health information
- **Successful ongoing submission** of information to public health agencies (immunizations, syndromic surveillance, ELR)
The first challenge was to make sure that information produced by every EHR was understandable by another clinician and could be incorporated into his EHR.

Next we needed a common approach to transport, allowing information to move from one point to another.

And it was clear that we needed more highly specified standards to support care transitions and lab results delivery.
Certification for Other Settings

- Nothing prohibits anyone from getting a technology certified to as many criteria as they wish even if the technology is not designed for or marketed to eligible providers
- Certification ensures that the technology is capable of sharing a C-CDA with other certified technologies and that it can both create and consume information in C-CDA

“We encourage EHR technology developers to certify EHR Modules to the transitions of care certification criteria (§ 170.314(b)(1) and (2)) as well as any other certification criteria that may make it more effective and efficient for EPs, EHs, and CAHs to electronically exchange health information with health care providers in other health care settings.”
Maria Harr, MBA, RHIA
Government Task Leader, CMS

QIO 10\textsuperscript{TH} SOW
HEALTH IT FOR POST ACUTE CARE (HITPAC)
Agenda

- Project Overview
- Benefits
- Future Opportunities
- Resources
CMS Vision and Goals

- Promote effective coordination of care
- Assure care is person and family-centered
- Promote the best possible prevention and treatment of the leading causes of mortality, starting with cardiovascular disease
- Help communities support better health
- Make care more affordable for individuals, families, employers, and governments by reducing the costs of care through continual improvement
Project Overview

• Quality Improvement Organizations (QIOs) provide technical assistance to post acute care providers to effectively use patient assessment tools to standardize information across multiple healthcare settings using health information technology.

• These improvement efforts aim to improve:
  – patient coordination
  – prioritize transitions of care
  – reduce medication errors
  – create key partnerships
  – disseminate best practices
  – apply effective quality improvement techniques using Health Information Technology
SIP Overview

• Objectives:
  – Advance the work of QIOs as “Innovators”
  – Test new concepts, implement HIT Standards and solve documentation gaps using HIT
  – Assist LTPAC providers to adopt HIT (ineligible for MU incentives)
  – Create partnerships with State HIE, RECs and other stakeholders

• Period of Performance: September, 2012-September, 2013
• QIO Selection Rationale: 3 QIOs
• Target Areas: Minnesota, Pennsylvania, Colorado (not recruited by QIO ICPC AIM)
<table>
<thead>
<tr>
<th>State</th>
<th>Major Activities</th>
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</thead>
<tbody>
<tr>
<td>Minnesota (Stratis Health)</td>
<td>• Toolkit to improve HIT in NHs (3 main components: Adopt, Utilize, Exchange)</td>
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</table>
| Pennsylvania (Quality Insights) | • QIO & REC grant received  
                        | • Collaboration with Keystone Beacon Community focusing on CCD exchange, communication tools, etc. |
| Colorado (Colorado Foundation for Medical Care) | • Health Information Exchange Initiatives  
                        | • Strong Collaboration with CORHIO  
                        | • Care Transitions Toolkit |
HITPAC SIP Overview:

- Special Innovation Project
- Centers for Medicare & Medicaid Services
- Further advance EHR use and adoption at the State level
- Work towards a true health information exchange around transitions of care

- Communities Recruited
- Work toward standardized structured common language
- Reduce medication errors
- Standardized Patient Assessment content

- Care Transitions toolkit
- Educational Webinars
- Technical assistance
Benefits:

*Long Term Post Acute Care (LTPAC) Facilities will receive help with:*

- Technical assistance; Identify barriers and best practices
- Use of patient assessment content (e.g., MDS) to support transitions of care and shared care.
- Health IT standards that support interoperable exchange
- Education and technical assistance on medication management using HIT and HIE activities
- Assist with workflow and organizational culture HIT adoption
- Education on use of data elements
Acute Care Facilities- Hospitals will receive:

- Assistance with Health IT standards that support interoperable exchange of patient assessment content
- HIPTAC will provide education and assistance on the topic of Stage 2 Meaningful Use Core Measure 12
- Assistance with incorporating HIE into daily operational workflow
- Technical assistance, facilitation with data elements, training on workflow redesign
<table>
<thead>
<tr>
<th>QIOs will</th>
<th>Participating organization will</th>
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<tbody>
<tr>
<td>Provide a qualified team of staff to lead and support the project</td>
<td>Create a multidisciplinary team committed to the aims of the project and to working with the QIO</td>
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</tbody>
</table>
| Designate a primary contact, who will have expertise and ready access to best practices, resources, and tools | Designate one person who, in a leadership capacity, can drive and support the organization’s efforts  
Obtain endorsement from its Board, CEO, and Quality Director |
<p>| Meet on-site at the organization with the project team as appropriate    | Participate in on-site visits                                       |</p>
<table>
<thead>
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<th>QIOs will</th>
<th>Participating Organization will</th>
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<tr>
<td>Develop and facilitate opportunities for project teams to come together in collaborative educational workshops for learning, sharing, and networking</td>
<td>Participate in educational sessions, collaborative sessions, and teleconference calls</td>
</tr>
<tr>
<td>Provide reporting assistance to project teams, provide assistance with synthesizing data results</td>
<td>Assist QIOs to aggregate de-identified baseline and re-measurement data around re-hospitalizations and med errors, and other data we mutually identify</td>
</tr>
<tr>
<td>Provide support to project teams to use data results to make organizational changes</td>
<td>Establish target goals and work on improving systems of care</td>
</tr>
<tr>
<td>Maintain a strong commitment to leverage opportunities to advance and align the project with partners and stakeholders</td>
<td>Be willing to share best practices and lessons learned</td>
</tr>
<tr>
<td>Provide a template for the project team’s organization to release news of organizations participation in a new project to local media</td>
<td>Provide local media with information of participation in this project and be identified publicly with the project</td>
</tr>
<tr>
<td>Promote accomplishments and lessons learned of project team organizations</td>
<td>Share experiences and outcomes with others</td>
</tr>
<tr>
<td>Maintain confidentiality around organizational data gathered through the project</td>
<td></td>
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</tbody>
</table>
Future Opportunities

- Work with stakeholders at national, state and local levels to identify opportunities to include LTPAC in health IT and innovation initiatives.
- Expand the work under this LTPAC SIP to other states and consider for future QIO work.
- Leverage health information exchange (HIE) through the State HIE programs.
Become involved!

- Participate in learning collaborative & share best practices
- Developing liaisons with parallel interventions projects to align efforts
- Participate in QIO learning and Action Network (10th SOW -ICPC & IIPC)
- Partner with professional organizations, State Health IT grantees, REC's and Beacons.
Resources

• **Signed Participation Agreements by December 21st, 2012**

• **Minnesota QIO: www.stratishealth.org**, Candy Hanson, Program Manager

• **Colorado QIO: www.cfmc.org**
  Karen Frederick Gallegos, Director of Quality Improvement Services & Analytic Services

• **Pennsylvania QIO: www.pareachwest.org**
  Philip Magistro, Director of Health Informatics
Exchange Tools to Support LTPAC HIE

1) Direct
Elizabeth Palena Hall
ONC

OVERVIEW OF DIRECT
OKLAHOMA CHALLENGE
GRANT- USE CASES OF DIRECT
Brian Yeaman, MD
Principle Investigator
Challenge Grant Goals

Grant Narrative

• Avoidance of unnecessary transfers
• Coordination and avoidance of intervention due to the lack of documentation
• “Implementation of processes that optimize efficient and well-orchestrated patient transfers.”

Well-documented issues

• Medication errors
• Errors in transitions of care (i.e.; communication
• Familiarity with the patient
• Lab/Pharmacy environment
Contributing Factors

The call for technology

• Rising patient age population and increased technology
• “According to one estimate, end-of-life care accounts for about 10-12% of all healthcare spending. Annual expenditures for hospice and home care-two healthcare segments that are closely involved in the provision of end-of-life care- are about $3.5 billion and $29 billion, respectively.”
• The communication of the patients underlying illness and condition are the most important in determining outcomes.
SMRTNET Contains 3.2 million patient records and will be contributed by nursing homes on monthly and discharge basis.
Vendor use cases

Challenge Grant Care in Transitions
Vendor Use Case
LTC EHR- CareTracker

Resident Documentation

- ADLs
- Mood and Behaviors
- Bladder and Bowel
- Meals and Snacks
- Height/Weights
- Restorative
- Skin
- Vitals
- Recreation Therapy
- Interact

© 2012 LTC EHR- CareTracker

6/1/2012 7:41:35 AM

Show Work List

More Information

Back

Logout
SBAR

Need to know message
SBAR Report  05/02/2012 10:47 AM

Facility:  

Smith, John T (1105)

SBAR

Before calling MD/NP/PA:
- Evaluate the resident, complete the SBAR form (use N/A for not applicable)
- Check VS: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- Review chart: most recent progress notes and nurse’s notes from previous shift, any recent labs
- Review an INTERACT II Care Path or Acute Change in Status File Card if indicated
- Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

Situation

The symptom/sign/change I’m calling about is: Wheezing or chest tightness at rest, inability to stand without severe dizziness or light headedness
This started: Yesterday
This has gotten worse since it started
Things that make the condition worse are: Lying flat
Things that make the condition better are: Sitting upright
Other things that have occurred with this change are: Needing more breathing in

Background

Primary diagnosis and/or reason resident is at the nursing home: Parkinson’s
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other): Increased SOB, Lethargy, Increased Leedon

Vital Signs:
- BP: 136/84  HR: 122  RR: 22  Temp: 102.2
- Pulse Oximetry: 86% on RA: 92 on 02 at 2 L/min via NC
- Change in function or mobility: N/A
- Medication changes or new order in the last 2 weeks: N/A
- Mental status changes (e.g. confusion/agitation/languidity): Lethargy - Increased O/T, SOB
- GI/GU Changes: N/A
- Pain level/location: Generalized
- Change in intake/hydration: N/A
- Change in skin or wound status: N/A
- Labs: No Change - Recent
- Advance directives: Full Code
- Allergies: Sulfur
- Any other data:

Assessment

RN Response:
What do you think is going on with the resident? I think that the problem may be: N/O CHF

LPM Response:
The resident appears (e.g. SOB, in pain, more confused): NA

Request

I suggest or request:
- Provider visit (MD/NP/PA)
- Monitor vital signs and observe
- Lab work, x-rays, EKG, other tests
- Change in Current Orders:

Staff Name:  Valerie Bloomer, RN
Reported to:  Name: T. Merrill, MD
Email:  Phone:  Resident Name: John T. Smith

Date: 05/02/2012  Time: 10:47 AM

Progress Note:

Signature:  Signature:  RN/LPN  Date: / / Time: _ AM/PM

Return call/new orders from MD/NP/PA:  Date: / / Time: _ AM/PM
### Heads Up

**CNR:** No

**Heads Up:** (Clinical Issues Requiring Attention, Special Circumstances or Potential Complications)
Resident with fever of 103

### Brief Summary

**Reason for Transfer:** Resident exhibits signs and symptoms of UTI with Possible Septicemia.

**Summary:** 87 year old male was found this morning with fever of 103 treated with Acetaminophen 500mg with little response, he also complains of generalized myalgia and painful urination. Resident looks confused.

**Principle Diagnosis at Discharge/Transfer: UTI**

### Nursing Evaluation:

<table>
<thead>
<tr>
<th>Mental Status at Discharge/Transfer</th>
<th>Functional Status at Discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert, oriented, follows instructions</td>
<td>□ Ambulates independently</td>
</tr>
<tr>
<td>Alert, disoriented, but can follow simple instructions</td>
<td>□ Ambulates with assistance</td>
</tr>
<tr>
<td>Alert, disoriented, but cannot follow simple instructions</td>
<td>□ Ambulates with assistive device</td>
</tr>
<tr>
<td>Not Alert</td>
<td>□ Not ambulatory</td>
</tr>
</tbody>
</table>

### Pain Assessment:

**Pain:** Yes

**Pain Score:** 8 out of 10

**Pain Scoring System Used:** Numeric Scale

**Location(s):** Urethra when urinating

**Pain Medication/s:** Acetaminophen 500mg

**Scripts sent:** Yes

**Other treatment modalities:** N/A

### Isolation/Precaution:

- [ ] N/A
- [ ] MRSA
- [ ] VRE
- [ ] C-DIFF
- [ ] Other

### Communication:

**Interpreter Required:** No

**Primary Language:**
- [ ] Understand
- [ ] Speak
- [ ] Read
- [ ] Write

**Secondary Language:**
- [ ] Understand
- [ ] Speak
- [ ] Read
- [ ] Write

**Aphasia:**
- [ ] Expressive
- [ ] Receptive
- [ ] N/A

**Sign Language:**
Health Information Exchange

“2.7 Million Lives across 28 Hospitals”

SMRTNET
SECURE MEDICAL RECORDS TRANSFER NETWORK

PATIENT-CENTERED HEALTHCARE

WELLNESS

NPHO

Direct Project

HIE

Norman Regional
HEALTH SYSTEM

Hospitals

Nursing Home

HL7

HL7

Preventive Services Reminder System
School of Family and Preventive Medicine
University of Oklahoma Health Sciences Center
DIRECT INBOX: OVERVIEW

- SBAR
- Universal Transfer Form
- Facility FaceSheet
DIRECT INBOX: OVERVIEW

- Ability to add patient context
  - Cerner solutions can use to attempt a patient match. The information is also included at the beginning of the message text so all recipients will see it

- Ability to request replies to go to a different Direct email address.
DIRECT INBOX: OVERVIEW

- Ability to export the message as a PDF
- Ability to quickly add sender and recipients to your contact list
EXCHANGING LTPAC INFORMATION THROUGH A REPOSITORY – THE KEYSTONE BEACON APPROACH
KeyHIE Transform™
Overview
Keystone Health information Exchange®

Members
- 36 Care Delivery Organizations
- 286 care sites

Patient information
- 4.4 million patients
- 650,000+ patient authorizations
- 9.5 million clinical documents / results
- 35,000 Continuity of Care documents (CCDs)

Use
- 1,178 networked PHR users
- 2,109 clinician users
- 274 LTPAC users
- Encounter-triggered alerts to clinicians
- Monthly analytics to hospitals & clinics
The opportunity:

- 15,000+ Nursing Homes
- 12,000+ Home health agencies
- Few of these with EHRs can produce a CCD
Innovate & Test – LTPAC to HIE

KeyHiE

Transform™ (The “Gobbler”)

HL7 Balloted. Nationally available Web service.

LTPAC  MDS or OASIS  Clinical Summary  HIE
Sample Shared Electronic Health Record

1. Problems
2. Procedures
3. Family History
4. Social History
5. Payers
6. Immunizations
7. Medications
8. Medical Equipment
9. Vital Signs
10. Functional Status
11. Results
12. Allergies
13. Encounters
14. Plan of Care
15. Purpose
16. Advance Directives
Dec 2012 Vendor contracted

Dec 2012 HL7 Approval

Jan 2012 Development & Testing

Feb 2013 Production pilots

Apr 2013 General availability
ADVANCING POINT TO POINT EXCHANGE: MA CHALLENGE GRANT IMPACT - CONNECTING NURSING FACILITIES AND HOME CARE TO THE HEALTHCARE SYSTEM OF THE FUTURE
Agenda

- IMPACT – engaging Long Term and Post-Acute Care (LTPAC) providers
- LAND & SEE – software to facilitate integrating LTPAC into electronic health information exchanges (HIE)
IMPACT Grant

February 2011 – HHS/ONC awarded $1.7M HIE Challenge Grant to state of Massachusetts (MTC/MeHi):

Improving Massachusetts Post-Acute Care Transfers (IMPACT)
IMPACT Objectives & Strategies

• Facilitate developing a national standard of data elements for transitions across the continuum of care

• Develop software tools to acquire/view/edit/send these data elements (LAND & SEE)

• Integrate and validate tools into Worcester County using Learning Collaborative methodology

• Measure outcomes
Pilot Sites

• St Vincent Hospital and UMass Memorial Healthcare
• Reliant Medical Group (formerly known as Fallon Clinic) and Family Health Center of Worcester (FQHC)
• 2 Home Health agencies (VNA Care Network & Overlook VNA)
• 1 Long Term Acute Care Hospital (Kindred Parkview)
• 1 Inpatient Rehab Facility (Fairlawn)
• 8 Skilled Nursing and Extended Care Facilities
HIE Guiding Principles

A successful HIE needs to:
• Provide **value** (Benefits > Cost)
• Fit into real-world **workflows**
• Earn the **trust** of the stakeholders
HIE Guiding Principles

**Value**
- Understand importance of care transitions
- Walk in each other’s shoes
  - Sender needs to understand what data are needed by receivers and why
  - Receiver needs to appreciate the difficulty or constraints in collecting data

**Trust**
- Satisfy data needs of receivers
- Ensure that data collection and transfer leverages existing data and efficiently fits into workflows

**Useable**
- Ensure software matches organization’s level of technological progress
Dataset Stakeholders/Contributors

• State (Massachusetts)
  – IMPACT learning collaborative participants
  – MA Universal Transfer Form workgroup
  – Boston’s Hebrew Senior Life eTransfer Form
  – MA Coalition for the Prevention of Medical Errors
  – MA Wound Care Committee
  – Home Care Alliance of MA (HCA)

• National
  – NY’s eMOLST
  – Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
  – Substance Abuse, Mental Health Services Agency (SAMHSA)
  – Administration for Community Living (ACL)
  – Aging Disability Resource Centers (ADRC)
  – National Council for Community Behavioral Healthcare
  – National Association for Homecare and Hospice (NAHC)
  – Transfer of Care & CCD/CDA Consolidation Initiatives (ONC’s S&I Framework)
  – Longitudinal Coordination of Care Work Group (ONC S&I Framework)
  – ONC Beacon Communities and LTPAC Workgroups
  – Assistant Secretary for Planning and Evaluation (ASPE)/Geisinger MDS HIE
  – Centers for Medicare & Medicaid Services (CMS)(MDS/OASIS/IRF-PAI/CARE)
  – INTERACT (Interventions to Reduce Acute Care Transfers)
Datasets for Care Transitions

- 175 element CCD
- 325 element IMPACT for basic LTPAC needs
- 480+ elements for Longitudinal Coordination of Care
IMPACT Learning Collaborative: Testing the Care Transitions Datasets

16 organization, 40 participants, 6 meetings over 2 months, and several hundred patient transfers w/ paper...
Senders found the data

I was able to send all of the requested IMPACT data elements

- Yes: 93%
- No: 7%
Receivers got most of their needs

- Yes: 92%
- No: 8%
Getting Connected:
LAND & SEE
• Sites with EHR or electronic assessment tool use these applications to enter data elements
  — LAND ("Local" Adaptor for Network Distribution) acts as a data courier to gather, transform and securely transfer data if no support for Direct SMTP/SMIME or IHE XDR

• Non-EHR users complete all of the data fields and routing using a web browser to access their “Surrogate EHR Environment” (SEE)
  — Can receive, view, reconcile, edit, and send CDA-based documents
Using SEE for LTPAC Workflows

• Sources of information:
  – Transfer of Care dataset received upon admission
  – Assessment data (e.g., MDS, OASIS, etc.)
  – INTERACT II (SNF declining patient assessment tools: SBAR (Situation/Background/Assessment/Request) and Resident Transfer Form)

• Benefits
  – Re-use of electronic information:
    • Post-acute provider can reuse data received from hospital
    • SNF can reuse clinical data from INTERACT and MDS
    • Home Health can reuse OASIS data
  – Efficiency enables faster creation of summary document so it can be done with urgent ED transfers
  – Multiple users (nurse, social worker, clerk, etc...) can access a patient’s information online at same time
  – Subset can be printed for ambulance team or pt/family
LTPAC Communication Today – Paper!

- Hospital
- Home Health
- Non-standard EHR (OASIS)
- PCP
  - Billing Program (MDS)
- Nursing Facility
LAND & SEE fill in gaps

LTPAC Communication with LAND & SEE

- Land & SEE
- Non-standard EHR
- Land
- Billing Program
- PCP
- Hospital
- Nursing Facility
- Home Health
- CCD+
- OASIS
- MDS
<table>
<thead>
<tr>
<th>Dates</th>
<th>Activity</th>
</tr>
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<tbody>
<tr>
<td>9/2012 – 4/2013</td>
<td>Integrate pilot sites into Massachusetts’ HIE using LAND &amp; SEE</td>
</tr>
<tr>
<td>4/2013 – 9/2013</td>
<td>Evaluate hospital (re)admissions &amp; total cost of care</td>
</tr>
<tr>
<td>5/2013 – 6/2013</td>
<td>Make SEE available under Apache 2.0 Open Source License</td>
</tr>
</tbody>
</table>
Sharing LAND & SEE

**LAND**
- Orion Health’s Rhapsody Integration Engine
  http://www.orionhealth.com/solutions/packages/rhapsody
- We’ll make some standard configurations available

**SEE**
- Written in JAVA
- Baseline functionality software and source code that can connect to Orion’s HISP mailbox via API available for free starting ~June 2013 (Apache Version 2.0 open source license)
- Innovators can develop and charge for enhancements, for example:
  - Integration with other vendors’ HISP mailboxes
  - Automated CDA document reconciliation
Summary

• Focus on HIE Guiding Principles:
  – Provide **value** (Benefits > Cost)
  – Fit into real-world **workflows**
  – Earn the **trust** of the stakeholders

• LAND & SEE can facilitate HIE participation for Nursing Facilities, Home Care and other LTPAC providers
ONC STANDARDS & INTEROPERABILITY
LONGITUDINAL COORDINATION OF CARE INITIATIVES
WRAP UP AND Q&A
Request for Comment – Weigh In! Possible MU Stage 3 Requirements

• HIT Policy Committee Requests Your Comments on Stage 3 MU Definitions –
  – Comments due January 14, 2013
  – Areas under consideration include: care plan, transitions of care, advanced directives, enhanced patient engagement, and others

• Participate in S&I Sponsored Webinars on the RFC
  – http://wiki.siframework.org/Longitudinal+Coordination+of+Care

• For more information go to:

• To Submit a Comment:
  – http://www.regulations.gov
Upcoming ASPE-Sponsored Webinars – Web Replay Recordings Available

• All Audiences

  *Information Exchange Activities for LTPAC and BH Communities*
  – December 4 | 12:30–1:45 p.m. ET

• Providers and Affiliated Organizations

  *Implementing HIE in the BH Community*
  – December 4 | 2:30–3:45 p.m. ET

  *Implementing HIE in the LTPAC Community*
  – December 12 | 1–2:15 p.m. ET

• State and HIE Organizations

  *Implementing HIE in the BH Community*
  – December 5 | 12 Noon–1:15 p.m. ET

  *Implementing HIE in the LTPAC Community*
  – December 14 | 11:30–12:45 p.m. ET

To Register: https://www.ahimastore.org/ProductList.aspx?CategoryID=1324
Resources:

- **Assistant Secretary for Planning and Evaluation**
  - Health Information and Technology Reports ([http://tinyurl.com/ASPE-HIT](http://tinyurl.com/ASPE-HIT))
- **CMS EHR Incentive Program**
- **Center for Medicare & Medicaid Innovation**
- **Office of the National Coordinator**
  - [http://healthit.hhs.gov](http://healthit.hhs.gov)

- **Substance Abuse & Mental Health Services Administration**
  - [www.samhsa.gov](http://www.samhsa.gov)
  - [SAMHSA.HIT@SAMHSA.HHS.gov](mailto:SAMHSA.HIT@SAMHSA.HHS.gov)
  - Join the bi-monthly calls federal behavioral health HIT initiative

- **Standards and Interoperability Framework**:
  - Data Segmentation for Privacy
    - [http://wiki.siframework.org/DataSegmentation+for+Privacy](http://wiki.siframework.org/DataSegmentation+for+Privacy)
  - Longitudinal Coordination of Care
    - [http://wiki.siframework.org/Longitudinal+Coordination+of+Care](http://wiki.siframework.org/Longitudinal+Coordination+of+Care)
  - Transition of Care
    - [http://wiki.siframework.org/Transitions+of+Care+%28ToC%29+Initiative](http://wiki.siframework.org/Transitions+of+Care+%28ToC%29+Initiative)
Conclusion

- Health IT has the potential to transform LTPAC care
- There are many immediate challenges to be overcome and significant room for innovation
Thank you for attending.

QUESTIONS