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

Perspectives for States and Government Agencies

Webinar
December 14, 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 Health Information Exchange (HIE) and highlight demonstration projects and tools to implement exchange on behalf of medically complex/functionally impaired persons who receive care in LTPAC settings.

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

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• Evelyn Gallego, ONC Standards & Interoperability Framework
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OVERVIEW OF DRIVERS FOR HEALTH INFORMATION EXCHANGE
Drivers Changing the Healthcare System

➢ The Affordable Care Act:
  ➢ Supports implementation of new payment and service delivery models
  ➢ Requires a National Quality Strategy

➢ The HITECH Act:
  ➢ Requires development of a nationwide health IT infrastructure for the electronic use and exchange of health information
  ➢ Incentives for the Meaningful Use of certified EHRs
    ➢ Eligible Professionals (e.g., Physicians)
    ➢ Eligible Hospitals (e.g., acute care hospitals)
Implementation of HITECH

- 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”
Certification for Other Settings

- Certification ensures that the technology: can create, transmit, and incorporate clinical information in human and machine readable formats using accepted standards.


  “We agree that it makes good policy sense to support interoperability and the secure electronic exchange of health information between all health care settings. We believe the adoption of EHR technology certified to a minimal amount of certification criteria adopted by the Secretary can support this goal. 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
Maria.Harr@cms.hhs.gov

QIO 10TH 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)
# QIO Directed Special Innovation Project - States

<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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<tr>
<td>Pennsylvania (Quality Insights)</td>
<td>• QIO &amp; REC grant received</td>
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<td></td>
<td>• Collaboration with Keystone Beacon Community focusing on CCD exchange,</td>
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<td></td>
<td>communication tools, etc.</td>
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<tr>
<td>Colorado (Colorado Foundation for Medical</td>
<td>• Health Information Exchange Initiatives</td>
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<tr>
<td>Care)</td>
<td>• Strong Collaboration with CORHIO</td>
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<td></td>
<td>• Care Transitions Toolkit</td>
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</table>
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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<td>Designate a primary contact, who will have expertise and ready access to</td>
<td>Designate one person who, in a leadership capacity, can drive and support the organization’s</td>
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<td>resources, and tools</td>
<td>efforts</td>
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<td>Obtain endorsement from its Board, CEO, and Quality Director</td>
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<td>Meet on-site at the organization with the project team as appropriate</td>
<td>Participate in on-site visits</td>
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<tr>
<td><strong>QIOs will</strong></td>
<td><strong>Participating Organization will</strong></td>
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<td>------------------------------------------------------------------------------</td>
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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>
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<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>
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<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>
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<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>
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<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>
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<td>Promote accomplishments and lessons learned of project team organizations</td>
<td>Share experiences and outcomes with others</td>
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<tr>
<td>Maintain confidentiality around organizational data gathered through the project</td>
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Future Opportunities

• Work with stakeholders at national, state and local levels to identify for 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, RECs and Beacons.
Resources

• **Signed Participation Agreements by December 21\textsuperscript{st}, 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
Tools that Support LTPAC
Health Information Exchange
OVERVIEW OF DIRECT
Information Securely Follows Patients Whenever and Wherever They Seek Care

- **Find patient information to support unplanned care**
- **Send and receive patient information to support care coordination**
- **Patients aggregate use and share their own information**

**QUERY-BASED EXCHANGE**

**DIRECTED**

**CONSUMER-MEDIATED EXCHANGE**

© 2012
What is Direct?

A set of standards and services, that with a policy framework, enable simple, directed, routed, scalable transport over the Internet to be used for secure and meaningful exchange between known participants in support of Meaningful Use.
What is Direct? From A to B

Provider A creates a message in EHR; selects Provider B’s ‘Direct address’

HISP A routes message to Provider B’s HISP

Provider B uses HISP’s portal to view message

Provider A creates a message in EHR; selects Provider B’s ‘Direct address’

HISP A routes message to Provider B’s HISP

Provider B uses HISP’s portal to view message

Message is sent to Provider A’s HISP

Provider B
What’s a HISP?

- HISP = Health Information Service Provider
- Enable their members to communicate using Direct.
- HISPs must...
  - Route (send/receive) Direct messages
  - Manage trust relationships (who you can send to / receive from)
  - Publish digital certificates (to enable encrypted, secure communication)
- HISPs often/may...
  - Provide Direct addresses (frequently)
  - Store Direct messages (either temporarily or long-term)
  - Serve as a Registration Authority and/or Certificate Authority (verify provider identity and/or issue digital certificates)
  - Offer other services / enhancements (webmail client, APIs / edge protocols, directories, etc.)
What may be sent via Direct?

• Direct is ‘payload agnostic’
• It’s a standard for transport, not content
• Short answer: anything / everything
• Caveats:
  – If the sender can’t generate a specific type of content, they can’t send it.
  – If the receiver can’t view/handle a specific type of content, there’s no reason to sent it.
  – Organizational or governmental policies / regulations may preclude certain ‘sharing’
  – ‘If it fits, it ships’ – certain HISPs may have message size limitations
Direct Communication

Communication Pathways

Between People

Between Machines

Between People & Machines

Communication Content

I've attached the study of Mr. Author. Thanks for seeing him.

Readable by People

I've attached an x-ray and electronic record for Mr. Author.

Readable by Machines

EVN|A28|20060501140008|||000338475^Author^Arthur^~4^532^~
^Regional
MPI&2.16.840.1.113883.19.201&ISO^L|20060501140008<cr>
PID|||000197245^^^NationalPN&2.16.840.1.113883.19.3&ISO^PN~4
532^^
Value to LTPAC

- LTPAC providers can quickly and easily send and receive secure messages and electronic attachments with others in their network
- Low cost HIE solution for LTPAC providers with or without an EHR
- HIPAA Compliant
- Provides opportunities for providers to communicate more easily with patients
- Facilitates referrals and transitions of care
Direct High Value Use Cases

“In California, RedWood MedNet is leveraging Direct to give hospitals and long term care facilities a means to share clinical care summaries when patients are sent to or discharged from the hospital, demonstrating Stage 2 Meaningful Use requirements for the electronic transmission of care summaries during transitions of care.”

Source: ONC Direct Adoption Bright Spots Report
Other Direct Use Cases

* Reduce fax burden

Benefits of Direct:

– Reduced support effort, technology hassle
– Reliable - Always On
– Workflow enhancement for paper-based providers
– Faster Communication
– Potential for cost savings - lower long distance charges
– More secure than fax
Getting started with Direct - Practical Implications

• Focus on individual, organizational needs
• Leverage the power of "networks effects"
• Supported onboarding
  - Clear process needed
  - Assistance through application and implementation process
• Users should experience the innovation
#### Direct Implementation by State

<table>
<thead>
<tr>
<th>State / Territory</th>
<th>Direct Approach (Contractual(^1), Hybrid(^2), Marketplace(^3))</th>
<th>Go live date(^4)</th>
<th>Sign-ups(^5)</th>
<th>PCP</th>
<th>Specialists</th>
<th>Public health</th>
<th>Labs</th>
<th>Behavioral health</th>
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***State Self-Reported Data as of May 2012. Generally only includes Direct activities within a state's HIE program.***
Direct Implementation by State (cont)

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Source: ONC Direct Adoption Bright Spots Report
Brian Yeaman, MD
Principle Investigator
BYeaman@yeamanandassociates.com

OKLAHOMA CHALLENGE GRANT- USE CASES OF DIRECT
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.
Challenge Grant taxonomy

Vendor Use Case Taxonomy – Phase I Clinical Documentation Tool

- Patient Change in Condition
  - Patient transferred in ED
  - Patient arrives in ED and is evaluated and treated by MD
  - Hospital Clash Prints Direct Message and Clinical Summary from SMRTNET
  - Admission process
    - Yes: Patient admitted
    - No: Follow up on patient

- Case Tracker
  - Nurse completes SBAR form
  - Nurse enters ER button to contribute data in SMRTNET

- Direct
  - Nurse Complete: nurse completes transfer forms via Direct Message
  - Nurse prepares, sends and submits transfer forms via Direct Message
  - Nurse Direct Message transferred to ER

- Paper Process
  - SMRTNET
    - SMRTNET contains 3.2 million patient records and will be contributed by nursing homes on monthly and discharge basis
Vendor use cases

Acute Care Hospital  - Discharge
Patient
Long Term Care
Patient
Admit
Acute Care Hospital

CCD
Patient Medical Summary

INTERACT
Web Portal
Advanced Directives
MEDS
ADL

Care Tracker Kiosk

Data Warehouse
Direct Messaging

SMRTNET

Surescripts
Rx

Challenge Grant Care in Transitions
Vendor Use Case
Logic model

Activities
- Facility Analysis and Workflow
- Facility Measurement- 5 Star Rating
- Quality Measurement- Pre-Implementation
- Paper build of INTERACT Toolkit
- CDT Development

Governance:
- Medical Director/Admin Advisory Board
- Oversight Committees
- Patient/Family
- Approval of Process Changes

Facility Measurement:
- CDT review
- Discharge Summary
- Initial Baseline pilot
- Remasure clinical@conclusion

Director/Admin Advisory Board
- Oversight Committees
- Patient/Family
- Approval of Process Changes

Quality Measurement:
- Post- Implementation
- Nodefact Quality Improvement Tool
- Review
- Re-Addmission Rates with impact

Dissemination Planning and Actions

Inputs
- Process Workflow Improvements at LTCF
- INTERACT Components
- CDT in LTCF with MDS interfaces
- Advanced Directives
- CDT/HIE Integration
- Direct Messaging for AC to LTCF (Bidirectional) casemanagers and intake coordinators

Outputs
- HIE data to providers/ medical directors
- Expanded CDT data- approved governance for discharge transactions
- Updated CDT to improve documentation
- HIE data to include up to date LTCF information to AC on d/c
- Pharmacy data available from discharge/interaces to Surescripts

Outcomes- Impact

Short-Term
- Improved Documentation
- Enhanced Process Workflow
- Refined Communication
- Governance Processes to Facilitate Project

Intermediate
- Improved Direct & CCD transactions
- Real-time data available
- Improved Data Flow to/from LTCF and Hospitals
- Patient and Patient Advocate Feedback
- ADirect eaoistry

Long-Term
- Decreased Re-admission and Return to ER rates
- Improved Clinical Outcomes for Chronic Conditions
- Developed standards for CCD/HIE interaction, templates and workflows for transitions of care

© 2012
LTC EHR- CareTracker

Resident Documentation
SBAR

Need to know message
SBAR Report

05/02/2012 10:47:48 AM

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 to

Background

Primary diagnosis and/or resident is at the nursing home: Parkinson's
Pertinent history [e.g. recent falls, fever, decreased intake, pain, SOB, other]: Increased SOB, Lethargy, Increased Leedema
Vital Signs
BP: 146/94  HR: 122  RR: 22  Temp: 102.2
Pulse Oximetry: 85% On RA: 92  02 at 2  1 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/lighthearted]: 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: Sulfa
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

LPN Response:

The resident appears [e.g. SOB, in pain, more confused]: N/A

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:

☐ IV or SC fluids
☐ New orders:
☐ Other (specify):
☐ Transfer to the hospital

Staff Names: Valerie Bloomer, RN
Reported to: [Name] T. Merrill, MD
If to MD/NP/PA, communicated by: Email
Resident Name: John T. Smith

Progress Note:

Signature: ____________________________ RN/LPN  Date: __/__/__  Time: ___ AM/PM

Return call/new orders from MD/NP/PAs: ____________________________  Date: __/__/__  Time: ___ AM/PM
Universal transfer form

Heads Up

ENR: 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 Septisemia.
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 myalgias and painful urination. Resident looks confused.
Principle Diagnosis at Discharge/Transfer: UTI

Nursing Evaluation:

Mental Status at Discharge/Transfer:
- [ ] Alert, oriented, follows instructions
- [ ] Alert, disoriented, but can follow simple instructions
- [ ] Alert, disoriented, but cannot follow simple instructions
- [ ] Not Alert

Functional Status at Discharge:
- [x] Ambulates independently
- [ ] Ambulates with assistance
- [ ] Ambulates with assistive device
- [ ] Not ambulatory

Pain Assessment:

Pain: Yes
Pain Score: 8 out of 10
Pain Scoring System Used: Numeric Scale
Location/s: Urathra when urinating
Pain Medication/s: Acetaminophen 500mg.
Script/s went: Yes
Other treatment modalities: N/A

Isolation/Precaution:
- [x] 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
Sign Language:
- [ ] N/A
Health Information Exchange

"2.7 Million Lives across 28 Hospitals"

SMRTnet
SECURE MEDICAL RECORDS TRANSFER NETWORK

Norman Regional
HEALTH SYSTEM

Nursing Home
Hospital

HL7

PATIENT-CENTERED HEALTHCARE
WELLNESS

NIPHO

HIE

Preventive Services Reminder System
Department of Family and Preventive Medicine
Tulsa University of Health Sciences College of Medicine
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
**SBAR Report**

**Patient:** John T. Smith  
**Age:** 62  
**DOB:** 01/01/1950  
**Address:** 123 Main St.  
**Phone:** 555-555-5555

**SBAR:**
- **Situation:** Last night, John was admitted with chest pain.  
- **Background:** John has a history of heart disease.  
- **Assessment:** CCU nurse noted an increase in heart rate.  
- **Recommendation:** Monitor closely; consider a stress test.

---

**Medications:**
- Aspirin
- Nitroglycerin

**Allergies:** None

---

**Procedures:**
- Pacemaker insertion
- Coronary angiography

---

**Problem List:**
- Coronary Artery Disease
- Hypertension

---

**Laboratory:**
- Blood Pressure: 140/90
- Heart Rate: 80

---

**Diagnosis:**
- Acute Coronary Syndrome

---

**Notes:**
- John is scheduled for a cardiac catheterization tomorrow.

---

**Diagnosis/Prognosis:**
- John is in stable condition but at risk for cardiac events.

---

**Events:**
- Discharge summary
-转会 to cardiology

---

**Provider:** Dr. Jane Smith

---

**Nursing:**
- John is on NPO status.

---

**EMR:**
- Epic

---

**Facilities:**
- Long Term Care
- Physician Office
- Norman Regional Health System

---

**Information:**
- EHR integration
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

Pilot Site Learning Collaborative

Value
• Understand importance of care transitions

Trust
• 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

Useable
• Satisfy data needs of receivers
• Ensure that data collection and transfer leverages existing data and efficiently fits into workflows
• 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.

Fewer than 5 data elements were missing

- Yes: 92%
- No: 8%
Getting Connected:
LAND & SEE
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)
- Billing Program (MDS)
- PCP
- Nursing Facility
LTPAC Communication with LAND & SEE

LAND & SEE fill in gaps
## Next Steps for LAND & SEE

<table>
<thead>
<tr>
<th>Dates</th>
<th>Activity</th>
</tr>
</thead>
<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
EXCHANGING LTPAC INFORMATION THROUGH A REPOSITORY – THE KEYSTONE BEACON APPROACH
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
**MDS3.0 Human-readable form**

**Section B: Hearing, Speech, and Vision**

**B0100. Comatose**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Persistent vegetative state/no discernible consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No → Continue to B0200, Hearing</td>
</tr>
<tr>
<td>1</td>
<td>Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance</td>
</tr>
</tbody>
</table>

**B0200. Hearing**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Ability to hear (with hearing aid or hearing appliances if normally used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Adequate - no difficulty in normal conversation, social interaction, listening to TV</td>
</tr>
<tr>
<td>1</td>
<td>Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or softly)</td>
</tr>
<tr>
<td>2</td>
<td>Moderate difficulty - speaker has to increase volume and speak distinctly</td>
</tr>
<tr>
<td>3</td>
<td>Highly impaired - absence of useful hearing</td>
</tr>
</tbody>
</table>

**B0300. Hearing Aid**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Hearing aid or other hearing appliance used in completing B0200, Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**B0600. Speech Clarity**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Select best description of speech pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Clear speech - distinct intelligible words</td>
</tr>
<tr>
<td>1</td>
<td>Unclear speech - slurred or mumbled words</td>
</tr>
<tr>
<td>2</td>
<td>No speech - absence of spoken words</td>
</tr>
</tbody>
</table>

---

**MDS3.0 CMS file (XML)**

```
<observation classCode="OBS" moodCode="EVN">
  <id nullFlavor="NI"/>
  <code code="B0600-0" codeSystem="2.16.840.1.113883.6.1"/>
  <translation code="B0600" codeSystem="2.16.840.1.113883.4.340"/>
  <status code="completed"/>
  <value xsi:type="CD" codeSystem="LIS005-6" codeSystem="2.16.840.1.113883.6.1">C</value>
  <translation code="C" codeSystem="1.2.6.1.4.1.12005.10.1.52"/>
</observation>
```

---

**Translated to CCD (XML)**

```
<observation classCode="OBS" moodCode="EVN">
  <id nullFlavor="NI"/>
  <code code="B0600-0" codeSystem="2.16.840.1.113883.6.1"/>
  <translation code="B0600" codeSystem="2.16.840.1.113883.4.340"/>
  <status code="completed"/>
  <value xsi:type="CD" codeSystem="LIS005-6" codeSystem="2.16.840.1.113883.6.1">C</value>
  <translation code="C" codeSystem="1.2.6.1.4.1.12005.10.1.52"/>
</observation>
```

---

**Functional Status Assessment**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech clarity</td>
<td>Clear speech - distinct intelligible words</td>
</tr>
<tr>
<td>Makes self understood</td>
<td>does make self understood (finding)</td>
</tr>
</tbody>
</table>

---

**Human-Readable (HIE Viewer)**

```
<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech clarity</td>
<td>Clear speech - distinct intelligible words</td>
</tr>
<tr>
<td>Makes self understood</td>
<td>does make self understood (finding)</td>
</tr>
</tbody>
</table>
```
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
Long-Term Care Clinical Summary (MDS extract) 12/10/2012

**History of encounters**

<table>
<thead>
<tr>
<th>Type of provider:</th>
<th>Nursing home (SNF/NF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry/discharge reporting:</td>
<td>Discharge assessment - return not anticipated</td>
</tr>
<tr>
<td>Type of entry:</td>
<td>Admission</td>
</tr>
</tbody>
</table>

**Functional Status Section**

<table>
<thead>
<tr>
<th>Bed mobility: self-performance:</th>
<th>Extensive assistance - resident involved in activity, staff provide weight-bearing support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer: self-performance:</td>
<td>Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance</td>
</tr>
<tr>
<td>Locomotion on unit: self-performance:</td>
<td>Extensive assistance - resident involved in activity, staff provide weight-bearing support</td>
</tr>
<tr>
<td>Eating: self-performance:</td>
<td>Supervision - oversight, encouragement or cueing</td>
</tr>
<tr>
<td>Toilet use: self-performance:</td>
<td>Extensive assistance - resident involved in activity, staff provide weight-bearing support</td>
</tr>
<tr>
<td>Urinary continence:</td>
<td>Always continent</td>
</tr>
<tr>
<td>Bowel continence:</td>
<td>Always continent</td>
</tr>
</tbody>
</table>

**BIMS res interview: summary score:**

- 15.

**PHQ res: total mood severity score:**

- 02.

**Psychosis: hallucinations:**

- no.

**Psychosis: delusions:**

- no.

**Appliances: indwelling catheter:**

- no.

**Appliances: external catheter:**

- no.

**Appliances: ostomy:**

- no.

**Appliances: intermittent catheterization:**

- no.

**Height (in inches):**

- 62.
<table>
<thead>
<tr>
<th>Height (in inches):</th>
<th>62.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (in pounds):</td>
<td>97.</td>
</tr>
</tbody>
</table>

**Problems (only positive findings are displayed)**

- Heart failure
- Hypertension

**Social History**

Lifetime occupation(s): AUTO MECHANIC.

**Plan of Care**

**Immunizations**

**Procedures (only positive findings are displayed)**

---

**NOLDER, NNNNNA**

Gender: Female   DOB: 08/25/1961

**Author Information**

Authored by: NOT SPECIFIED on December 10, 2012

Maria Joseph Manor
KeyHIE Transform™

Dec 2012 Vendor contracted

Dec 2012 HL7 Approval

Jan 2012 Development & Testing

Feb 2013 Production pilots

Apr 2013 General availability
Evelyn Gallego, MBA, CPHIMS
S&I LCC Initiative Coordinator
evelyn.gallego@siframework.org

ONC STANDARDS & INTEROPERABILITY
LONGITUDINAL COORDINATION OF CARE INITIATIVES
Overview

• S&I LCC Workgroup Overview
• Standards Priorities being advanced through the LCC Workgroup
• Accomplishments to date
• Continuing Work
• Invitation to Collaborate & Participate
S&I LCC Workgroup

COMMUNITY-LED INITIATIVE

Longitudinal Coordination of Care Workgroup
- Providing subject matter expertise and coordination of SWGs
- Developing systems view to identify interoperability gaps and prioritize activities, and align identified standards with the EHR MU Program

Longitudinal Care Plan SWG
- Identify standards for an interoperable, longitudinal care plan which aligns, supports and informs person-centric care delivery regardless of setting or service provider

LTPAC Care Transition SWG
- Identify the key business and technical challenges that inhibit LTC data exchanges
- Define data elements for long-term and post-acute care (LTPAC) information exchange using a single standard for LTPAC transfer summaries

Patient Assessment Summary (PAS SWG)
- Engage directly with HL7 to establish the standards for the exchange of patient assessment summary documents
- Inform the development of the Keystone Beacon PAS Document Exchange

© 2012
Standards Priorities Advanced through LCC Workgroup

1. Information Exchange Standard for ‘Summary Care Records’

2. Information Exchange Standards for Patient Assessment Summaries
   • Questionnaire Assessments
   • Patient Questionnaire Assessment Summaries (LTPAC Assessment Summary Document)

3. LTPAC Transitions of Care Standard

4. Home Health Plan of Care Standard
Accomplishments To-Date

1. Information Exchange Standard for ‘Summary Care Records’. Supported and advanced, with HL7, refinements to C-CDA data elements for interoperable exchange of:
   - Functional Status,
   - Cognitive Status
   - Pressure Ulcer
   - Inclusion in MU Stage 2: Functional Status & Cognitive Status
Accomplishments To-Date (cont’d)

2. **Information Exchange Standards for Patient Assessment Summaries.** Supported and advanced, with HL7, two new document types; IGs will be published end of Dec.:
   - **Questionnaire Assessments.** Vocabulary standards for a subset of the CARE instrument items in a Clinical Document Architecture (CDA)
   - **Patient Questionnaire Assessment Summaries** (now called LTPAC Assessment Summary Document). Subset of MDS/OASIS data elements for transitions and instances of shared care across NH or HHA. New document type added to C-CDA.
Continuing Work

• **LTPAC Transitions of Care Standard.** Led through the IMPACT Project and supported by Lantana. Standards analysis and high level IG development for 480+ data elements needed by receiving clinicians to safely and appropriately care for patients at times of transitions of Care.

• **Care Plan Terms, Structure & Components for MU Stage 3.** Developed definitions for key terms, structure, and components of a care plan to support coordination of care. These terms/components apply to both the ‘care plan’ and ‘plan of care’:
  - Health concern
  - Goals
  - Instructions
  - Interventions
  - Team member

• **Home Health Plan of Care Standard.** Data elements identified for provider-to-provider data exchange for HH-POC.
Participate & Collaborate!

• Become an LCC WG Committed Member: http://wiki.siframework.org/Committed+Members
• Participate in one of S&I LCC Upcoming Webinars on Stage 3 MU & Care Plans
  – Dec. 14th and 20th
  – Jan. 8th and 9th
• Comment on LCC WG Care Plan Glossary
• Build and use platforms for exchange
  – Functional and Cognitive Status
  – LTPAC Assessment Summaries
  – Care Plans
  – ToC Data Elements
• Be ready to capitalize on MU3 requirements
S&I Longitudinal Coordination of Care Workgroup

http://wiki.siframework.org/Longitudinal+Coordination+of+Care

Evelyn Gallego-Haag, S&I LCC Initiative Coordinator

evelyn.gallego@siframework.org
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

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)

- **ONC Challenge Grants**

- **State HIE Resource**
  - [http://statehieresources.org/](http://statehieresources.org/)

- **Standards and Interoperability Framework - Longitudinal Coordination of Care**
  - [http://wiki.siframework.org/Longitudinal+Coordination+of+Care](http://wiki.siframework.org/Longitudinal+Coordination+of+Care)

- **Save the Date! 2013 LTPAC Health IT Summit**
  - June 17-18, 2013
  - Hyatt Baltimore Inner Harbor
  - Information to be posted in Jan 2013 at: [http://www.ltpachealthit.org/](http://www.ltpachealthit.org/)

- **Stratis Health HIT Toolkits**
Thank you for attending.

QUESTIONS