# APPENDIX A. SELECTED PROGRAMS AND INITIATIVES THAT SUPPORT CARE COORDINATION AND INFORMATION EXCHANGE FOR PERSONS RECEIVING LTPAC/LTSS SERVICES

| TABLE A-1. Selected Programs and Initiatives that Support Care Coordination and Information Exchange for Persons Receiving LTPAC/LTSS Services | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents | Focuses on long-stay nursing facility residents who are enrolled in the Medicare & Medicaid programs, with the goal of reducing avoidable inpatient hospitalizations. CMS will support organizations that partner with nursing facilities to implement evidence-based interventions that improve care & lower costs. | CMS Medicare-Medicaid Coordination Office & CMMI | QI Program | http://innovations.cms.gov/initiatives/rahnfr/ |
| Partnership for Patients | Supports physicians, nurses, & other clinicians working in & out of hospitals to make patient care safer & to support effective transitions of patients from hospitals to other settings. | CMMI | QI Program, involves Hospitals Engagement Networks | http://innovations.cms.gov/initiatives/Partnership-for-Patients/index.html<br><br>http://partnershipforpatients.cms.gov/ |
| Community-Based Care Transitions Program (CCTP) | The CCTP is designed to improve transitions of high-risk Medicare beneficiaries from hospitals to home or other care settings, improve quality of care, reduce readmissions, & document savings to the Medicare program. CCTP allows community-based health care & social services providers (e.g., CBOs, HCBS) to receive a Medicare FFS benefit payment for care transitions. | CMMI | Incentive Program | http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html |
| Quality Improvement Organization (QIO) Program--Integrating Care for Populations & Communities (ICPC) | ICPC brings together hospitals, SNFs, patient advocacy organizations, & other community stakeholders to implement process improvements related to medication management post-discharge followup, & plans of care for patients who move across health care settings. | CMS/CO Foundation of Medical Care | QI Program | http://www.cfmc.org/integratingcare/Default.htm |

| TABLE A-1 (*continued*) | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| State Action on Avoidable Rehospitalizations (STAAR) Initiative | STAAR seeks to reduce rehospitalizations in MA, MI, OH & WA, by engaging payers, state & national stakeholders, patients & families, & caregivers at multiple care sites & clinical interfaces. | IHI | QI Program | http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx |
| Medicaid MLTSS Programs | MLTSS is an arrangement between state Medicaid programs & contractors through which the contractors receive capitated payments for LTSS & are accountable for the delivery of services & supports that meet quality & other standards set in the contracts. | CMS Disabled & Elderly Health Programs Group | Incentive Program | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf<br><br>http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html |
| Beacon Community Programs | The HIE activities of Beacon Communities are considered to be "beacons" in the development of secure, private, & accurate systems of EHR adoption & HIE. All Beacon communities include HIE between providers, & some include LTPAC providers. | ONC | Grant Program | http://www.healthit.gov/policy-researchers-implementers/beacon-community-program<br><br>Sample profiles:<br>http://www.healthit.gov/policy-researchers-implementers/western-new-york-beacon-community |
| State HIE Challenge Grants | ONC awarded 4 Challenge Grants to state HIE programs to focus on HIE involving LTPAC providers. | ONC | Grant Program | http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3378 |

| TABLE A-1 (*continued*) | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Accountable Care Organizations (ACOs), including the Pioneer ACO | ACOs are groups of doctors, hospitals, & other health care providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve. The Pioneer ACO Model is an initiative launched by CMS to show how particular ACO payment arrangements can best improve care & generating savings for Medicare; & to test alternative program designs to inform future rulemaking for the Medicare Shared Savings Program. Designed for organizations with experience operating as ACOs or similar arrangements, it provides ACOs successful in achieving shared savings in the first 2 years the opportunity to move into a population-based payment in year 3. | CMS, CMMI | Payment Policy | http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html<br><br>http://innovations.cms.gov/initiatives/ACO/index.html |
| Hospital Readmissions Reduction Program | The goal of the program is to reduce avoidable inpatient hospitalizations. The Hospital Readmissions Reduction Program was enacted as part of the Affordable Care Act, effective October 1, 2012. Organizations with a high 30-day admission rates for acute myocardial infarction, heart failure, & pneumonia may see their annual hospital Medicare payments reduced by up to 1%. CMS proposed expanding the list of conditions in fiscal year 2015 to include patients admitted for an acute exacerbation of COPD; elective total hip arthroplasty & total knee arthroplasty. | CMS | Payment Policy | http://innovation.cms.gov/initiatives/CCTP/index.html<br><br>http://www.cms.gov/apps/media/press/release.asp?Counter=4454&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date<br><br>http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html |

| TABLE A-1 (*continued*) | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Models for Dual Eligibles | Based on the Affordable Care Act, CMS is testing capitated & managed FFS financial alignment models to improve care & control costs for the dual eligible population (persons dually eligible for Medicare & Medicaid). Demonstrations change the payment approach & financing arrangements among CMS, the state, & providers. The capitated demonstrations use managed care plans to coordinate services for beneficiaries through a person-centered planning process. | CMS | Payment Model | http://www.medicaid.gov/affordablecareact/provisions/dual-eligibles.html<br><br>http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/<br><br>http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf |
| Patient-Centered Medical Home (PCMH) | Several provisions in the Affordable Care Act directed at establishing & promoting the PCMH, which is a team-based model of care led by a personal physician who provides continuous & coordinated care throughout a patient's lifetime to maximize health outcomes. This includes the provision of preventive services; treatment of acute & chronic illness; & assistance with end-of-life issues. This care model promotes improved access & communication; care coordination & integration; & care quality & safety. | Various federal agencies & departments | Payment Model | http://pcmh.ahrq.gov/<br><br>http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/FQHC_APCP_Demo_FAQsOct2011.pdf |

| TABLE A-1 (*continued*) | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Medicare Physician Fee Schedule (MPFS) rule-- Transitional care management (TCM) | CMS issued the final 2013 MPFS Rule. CMS is paying for TCM services supporting healthy transitions after hospital stays. It includes a new policy to pay a patient's physician or practitioner to coordinate care in the 30 days following a hospital or SNF stay. This rule recognizes the work of community physicians & practitioners in treating a patient following discharge from a hospital or nursing facility to ensure better continuity of care & help reduce patient readmissions. | CMS | Incentive Program | http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrephysFeeSchedfctsht.pdf<br><br>http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched |
| Medicare Physician Fee Schedule (MPFS) rule-- Complex chronic care management | Under the Medicare 2014 Physician Fee Schedule, CMS proposes to cover physician services to pay for non-face-to-face complex chronic care management services for Medicare beneficiaries who have 2 or more significant chronic conditions. Complex chronic care management services include regular physician development & revision of a POC, communication with other treating health professionals, & medication management. Under the proposal, the physician practice must use & demonstrate MU of an EHR. The practice also must have 1 or more advanced practice RNs or physician assistants whose job descriptions include care for beneficiaries with complex chronic conditions. | | | http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/ |

| TABLE A-1 (*continued*) | | | | |
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| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Balancing Incentive Program | The Balancing Incentive Program was created by the Affordable Care Act & authorizes grants to states to increase access to non-institutional LTSS. The program will help states transform their LTSS by lowering costs through improved systems performance & efficiency, creating tools to help consumers with care planning & assessment, & improving quality measurement & oversight. The program provides new ways to serve more people in HCBS. Federal Matching Assistance allows states to make structural reforms to increase SNF diversions & access to non-institutional LTSS. Enhanced matching payments are tied to the percentage of a state's LTSS spending. | CMS | Incentive Program | http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html |
| Picker/ Commonwealth Fund Long-Term Care Quality Improvement | The program seeks to improve the health care delivery system & spur innovation by raising the quality of LTPAC/LTSS, & improving care transitions for patients by integrating these services with the other care that they receive. | Commonwealth Fund | QI Program | http://www.commonwealthfund.org/Program-Areas/Archived-Programs/Delivery-System-Innovation-and-Improvement/Long-Term-Care-Quality-Improvement.aspx |
| Medicaid Transformation Grants | Funds to states for the adoption of innovative methods to improve effectiveness & efficiency in providing medical assistance under Medicaid. CMS encouraged states to look at how HIT & the exchange of health information could be leveraged to improve Medicaid services (e.g., reduce medical errors through the implementation of EHRs, clinical decision support tools, or eRx). | CMS | Incentive Program | http://www.medicaid.gov/index.html |

| TABLE A-1 (*continued*) | | | | |
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| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Bridge Model (See Rush University Medical Center site visit summary in Appendix H for more information) | The Bridge Model (Bridge) is an evidence-based, social work- based transitional care model designed for older adults discharged home from an inpatient hospital stay. Bridge helps older adults to safely transition back to the community through intensive care coordination that starts in the hospital & continues after discharge to the community. | ITCC | Transitional Care Model | http://www.transitionalcare.org/the-bridge-model<br><br>http://www.naswil.org/news/chapter-news/featured/social-work-and-the-bridge-model-the-key-to-successful-transitional-care/ |
| Minimum Data Set (MDS) & OASIS--Continuity of Care Document (CCD) Transformer, called KeyHIE Transform™ | The software is designed to enable LTPAC providers such as SNFs & HHAs to participate in HIE regardless of whether they use an EHR. KeyHIE Transform™ is an all-inclusive, web-based service that MDS & OASIS into HL7 CCD & ADT registration message, & publishes the CCD & registration message to KeyHIE for direct delivery. | Partnership between Geisinger System Services & BridgeGate International | IT solution for LTPAC, low cost | http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits<br><br>http://www.bridgegateintl.com |
| Medicare QIO Technical Assistance (e.g., Health IT for Post-Acute Care Special Innovation Project) | One of the QIO programs provides technical assistance to LTPAC & other providers in CO, MN, & PA through the Health IT for Post-Acute Care Special Innovation Project, to help LTPAC providers optimize their use of HIT to support medication management & care coordination in transitions of care, & advancing HIE. Selected QIO resources related to care transition improvement efforts are available from state QIO sites. | CMS | Evidence-Based Interventions, Education, Data, Networking, Assistance | http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html<br><br>http://www.cfmc.org/integratingcare/provider_resources.htm |
| Project Re-Engineered Discharge (RED) Toolkit | The toolkit includes 5 tools that provide step-by-step instructions to provide a springboard for hospitals to proactively address avoidable readmissions. It helps hospitals reduce readmissions rates by replicating a discharge process that resulted in 30% fewer hospital readmissions & ED visits. | Boston University School of Medicine, Department of Family Medicine, funded by AHRQ | Evidence-Based Intervention & Toolkit | http://www.bu.edu/fammed/projectred/presentations.html<br><br>http://www.bu.edu/fammed/projectred/toolkit.html<br><br>http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html |

| TABLE A-1 (*continued*) | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Interventions to Reduce Acute Care Transfers (INTERACT & INTERACTII) | INTERACT CORIkit is for SNF staff to reduce avoidable hospital admissions. Under the existing licensing agreement, the INTERACT materials cannot be incorporated into software, including EHR systems. An electronic version, eINTERACT, is in the development & testing phase for partners that wish to embed the INTERACT program & tools within their EHR. | INTERACT program, developed by the INTERACT interdisciplinary team, led by Dr. Joseph Ouslander, with input from many direct care providers & national experts in projects based at FL Atlantic University, supported by the Commonwealth Fund. | Evidence-Based Intervention & Toolkit | http://interact2.net<br><br>http://interact2.net/tools.html |
| Medications at Transitions & Clinical Hand-offs (MATCH) Toolkit | Provides a step-by-step guide to improving medication reconciliation process. | Northwestern Memorial Hospital, Chicago, IL | Evidence-Based Interventions & Tools | http://www.ahrq.gov/qual/match/match.pdf |
| Reducing Avoidable Readmissions Effectively (RARE) Campaign | Participating hospitals in the RARE Campaign can choose to participate in 1 of the 3 different RARE sponsored learning collaborative, focused on making improvements in the 5 key areas known to reduce avoidable readmissions. | Institute for Clinical Systems Improvement, the MN Hospital Association, & Stratis Health | Evidence-Based Interventions & Collaborative | http://www.rarereadmissions.org/ |
| Home Health Quality Improvement (HHQI) National Campaign | Seeks to reduce avoidable hospitalizations & improve medication management for home health patients by uniting home health & other providers across multiple health care settings. | WV Medical Institute | Evidence-Based Interventions, Education, Data, Networking, Assistance | http://www.homehealthquality.org |
| Care Transitions Program | Supports patients & families; increases skills among providers; enhance the ability of HIT to promote HIE across care settings; implements system level interventions to improve quality & safety; develops performance measures & public reporting mechanisms; & influence health policy at the national level. | Division of Health Care & Policy Research, University of CO School of Medicine | Evidence-Based Interventions & Tools | http://www.caretransitions.org |

| TABLE A-1 (*continued*) | | | | |
|---|---|---|---|---|
| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Patient Safety Tool: Transitions of Care Checklist | This checklist provides a detailed description of effective patient transfer between practice settings. | National Transitions of Care Coalition Advisory Task Force | Evidence-Based Interventions & Tools | http://www.beckersasc.com/asc-accreditation-and-patient-safety/patient-safety-tool-transitions-of-care-checklist.html |
| Quality Health First Program | Helps physicians to identify, prevent & manage diabetes, heart disease, breast cancer, asthma, & other conditions in their patients; utilizes information from the IN Network for Patient Care to assemble lab results, immunizations, diagnoses, cardiology & radiology reports, procedures & medication information. This information is organized in easy-to-read patient summaries that can be used before, during or after patient visits to make the best use of physicians' time. | IN HIE | QI Program | http://www.ihie.org/Solutions/quality-health-first-program.php |
| Direct | Direct support the use of standards-based protocols for an easy-to-use, secure, & scalable method of sending encrypted & authenticated health information over the Internet such as clinical summaries, CCDs, & laboratory results, to other providers who also own a DIRECT address. Direct supports simple use cases in order to speed adoption, & seeks to replace slow, inconvenient, & expensive methods of exchange & provide a future path to advanced interoperability. | ONC | IT Solution | http://directproject.org |

| TABLE A-1 (*continued*) | | | | |
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| **Program/ Initiative Name** | **Description** | **Program Office** | **Initiative Type** | **Link** |
| Local Adaptor for Network Distribution (LAND) & Surrogate EHR Environment (SEE) | LAND & SEE are available for public use. LAND allows organizations with fully implemented EHRs capable of generating the newly specified transition of care & care plan data elements to create, transmit, & receive these new document types. SEE, intended for organizations without an EHR & lacking the ability to create these documents, allows providers to use their web browser to access their SEE mailbox, & view, edit/update, & send these documents to the receiving facility via Direct message transmission from the browser to the next care provider. | MA IMPACT Project | IT Solution | http://mehi.masstech.org/what-we-do/hie/impact/land-and-see |
| LeadingAge Center for Aging Services Technology (CAST) | EHR for Long-Term & Post-Acute Care: A Primer on Planning & Vendor Selection 2013. | | Assist LTPAC in EHR selection. The primer shows which EHR vendors have met ONC certification. | http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/2013_CAST_EHR_For_LTPAC_A_Primer_on_Planning_and_Vendor_Selection.pdf |
| **NOTES**: This appendix provides selected initiatives, programs, tools and resources and is not intended to represent all of the current initiatives, programs, tools, and resources.<br><br>CO = Colorado; FL = Florida; IL = Illinois; IN = Indiana; MA = Massachusetts, MI = Michigan, MN = Minnesota; OH = Ohio; PA = Pennsylvania; WA = Washington; WV = West Virginia | | | | |

# LONG-TERM AND POST-ACUTE CARE PROVIDERS ENGAGED IN HEALTH INFORMATION EXCHANGE: Final Report

## Files Available for This Report

**MAIN REPORT**

| | |
|---|---|
| Executive Summary | http://aspe.hhs.gov/daltcp/reports/2013/HIEengagees.shtml |
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.pdf |

**APPENDIX A**. SELECTED PROGRAMS AND INITIATIVES THAT SUPPORT CARE COORDINATION AND INFORMATION EXCHANGE FOR PERSONS RECEIVING LTPAC/LTSS

| | |
|---|---|
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendA |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/HIEengageA.pdf |

**APPENDIX B**. FRAMEWORK TO CHARACTERIZE HEALTH INFORMATION EXCHANGE TO SUPPORT CARE COORDINATION FOR PERSONS RECEIVING LTPAC/LTSS

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|---|---|
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendB |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/HIEengageB.pdf |

**APPENDIX C**. ENVIRONMENTAL SCAN AND LITERATURE REVIEW SOURCES

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|---|---|
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendC |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/HIEengageC.pdf |

**APPENDIX D**. PROMISING COMPONENTS AND INTERVENTIONS TO REDUCE READMISSIONS

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|---|---|
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendD |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/HIEengageD.pdf |

**APPENDIX E**. SUMMARY OF LITERATURE ON HEALTH INFORMATION EXCHANGE OUTCOMES AND RELATED MEASURES

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|---|---|
| HTML | http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendE |
| PDF | http://aspe.hhs.gov/daltcp/reports/2013/HIEengageE.pdf |

**APPENDIX F**. EXAMPLES OF COMMUNITY-BASED CARE TRANSITION PROGRAM WITH LTPAC/LTSS PARTICIPATION

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendF
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageF.pdf

**APPENDIX G**. HEALTH INFORMATION EXCHANGE INTERVENTIONS AND ACTIVITIES IDENTIFIED THAT SUPPORT CARE COORDINATION FOR PERSONS RECEIVING LTPAC/LTSS

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendG
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageG.pdf

**APPENDIX H**. SITE VISIT SUMMARY: RUSH UNIVERSITY MEDICAL CENTER, CARE TRANSITIONS PROGRAM, BRIDGE PROGRAM

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendH
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageH.pdf

**APPENDIX I**. SITE VISIT SUMMARY: BEACHWOOD HOMES

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendI
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageI.pdf

**APPENDIX J**. SITE VISIT SUMMARY: EASTERN MAINE HEALTH SYSTEM, EASTERN MAINE HOME CARE

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendJ
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageJ.pdf

**APPENDIX K**. SUMMARY OF INFORMATION ROUTINELY EXCHANGED BY THE THREE SITES VISITED, BY CARE COORDINATION FUNCTION

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendK
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageK.pdf

**APPENDIX L**. STANDARDS AVAILABLE TO SUPPORT HEALTH INFORMATION EXCHANGE OF LONG-TERM AND POST-ACUTE CARE DATA

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendL
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageL.pdf

**APPENDIX M**. GLOSSARY

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendM
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageM.pdf