U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

OPPORTUNITIES FOR ENGAGING LONG-TERM AND POST-ACUTE CARE PROVIDERS IN HEALTH INFORMATION EXCHANGE ACTIVITIES:

EXCHANGING INTEROPERABLE PATIENT ASSESSMENT INFORMATION

APPENDIX A:
STAKEHOLDER INTERVIEW SUMMARY

December 2011

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SUMMARY

Expert interviews were conducted via conference call in May and June 2010 to gather input from stakeholder groups pivotal to advancing the use and exchange of electronic clinical information in LTPAC settings. Participants in the interviews included:

- Post-acute and long-term care (LTPAC) providers.
- Integrated delivery system providers.
- Clinical information system software vendor representatives.
- Staff from the Centers for Medicare and Medicaid Services.
- Members of the federal advisory committees (FACAs) and workgroups addressing Health IT (i.e., the HIT Policy Committee and its committee workgroups and the HIT Standards Committee and its committee workgroups -- Participants did NOT speak for the FACA Committees, the Committee Workgroups, or the ONC).
- Representatives of state-level health information exchange initiatives.
- Staff and committee members from the National Quality Forum.

The following topics were addressed with all stakeholder groups and are detailed more fully in of this appendix:

- Meaningful Use
- Health Information Exchange
- CDA for Transfer of Care
- Data Re-Use
- CDA Tools
- Standards
- Quality Measures
- Functional Status

High level themes that emerged across the stakeholder interviews include:

1. There is an overall lack of readiness and ability to participate in electronic exchange of health information on the part of LTPAC providers.

2. The exclusion of LTPAC from federal HIT funding and mandates will result in a much slower uptake of technology in this care setting. Absent funding and mandates, LTPAC providers generally do not feel they have the capital to invest

in upgrading existing systems or acquiring new products that support electronic exchange of health information.

3. There are competing views regarding whether LTPAC providers will want to electronically exchange information if it cannot be reused in their systems. General consensus over several discussion groups was that, even if LTPAC providers are only able to view information, it is a starting point and there is value in the information exchange. However, the information must be efficiently consumable by the clinician.

4. LTPAC is an important component to achieving meaningful use (MU) and distributed health information exchange.

5. Although there are neither direct financial incentives nor MU requirements for LTPAC participation in electronic exchange of information, changing payment models (e.g., bundling, Accountable Care Organizations (ACOs)) and wider use of technology by Eligible Hospitals/Eligible Professionals will create other business drivers for HIT adoption in this care setting.

6. A number of LTPAC organizations operate multiple facilities located in different counties or states. When faced with exchanging electronic information with multiple HIEs, the importance of *standardized* information becomes critical to any scalability within these organizations.

A more detailed accounting of themes identified through the expert interview sessions are found in this appendix.

INTERVIEW PROCESS AND PARTICIPANTS

Expert interviews were conducted via a series of 60 minute conference calls in May and June 2010. The investigation team identified categories of stakeholders knowledgeable about advancing the use and exchange of electronic clinical data in LTPAC settings. Key experts from the various stakeholder groups were then identified and contacted to participate in the interview process. The stakeholder groups and interview participants are listed below in Table A-1.

TABLE A-1: Stakeholders and Interview Participants	
Stakeholder Group -- Post-Acute and Long Term Care (LTPAC) Providers	
Tom Check Senior Vice-President & Chief Information Officer Visiting Nurse Service of New York	John Derr, RPh Strategic Technology Consultant Golden Living
Peter Kress Vice President & Chief Information Officer ACTS Retirement-Life Communities, Inc.	Bill Russell, MD Vice-President & Corporate Medical Director Erickson Living
Renae Spohn, MBA, RHIA, CPHQ, FAHIMA, FNAHQ Director of Clinical Applications The Evangelical Lutheran Good Samaritan Society	Rustan (Rusty) Williams Vice President, Information Services/Technology Systems and Chief Information Officer The Evangelical Lutheran Good Samaritan Society
Stakeholder Group -- Integrated Delivery System (IDS) Providers	
Denni McColm Chief Information Officer Citizen's Memorial	Jim Walker, MD, FACP Chief Health Information Officer Geisinger Health System
Stakeholder Group -- Clinical Information System Software Vendors	
Andy Brigant Chief Product Officer Point Click Care	Dan Cobb Chief Technology Officer Health MedX
Robert C. Davis CEO Optimus EMR	Doc DeVore Vice President - Product Strategy MDI Achieve
Dave Wessinger Chief Technology Officer Point Click Care	
Stakeholder Group -- Centers for Medicare and Medicaid Services (CMS)	
Judy Tobin, MBA, PT Project Officer, CARE Instrument Development Office of Clinical Standards and Quality Quality Measurement and Health Assessment Group	

TABLE A-1 (*continued*)	
Stakeholder Group -- Federal Advisory Committees (FACAs) and Their Workgroups Addressing Health IT	
Christopher G. Chute, MD, Dr PH Professor & Chair, Biomedical Informatics Mayo Clinic College of Medicine *Member, Health IT Standards Committee*	John Derr, RPh Strategic Technology Consultant Golden Living *Member, Health IT Standards Committee*
Scott White Assistant Director, HIT Policy Labor Representative 1199 SEIU Training and Employment Fund *Member, Health IT Policy Committee*	Larry Wolf, MS Health IT Strategist Kindred Healthcare *Alternate for Richard Chapman (Kindred Healthcare), Health IT Policy Committee*
NOTE: These participants did NOT speak for the FACA Committees, the Committee Workgroups, or the ONC.	
Stakeholder Group -- State-Level Health Information Exchange (HIE) Initiatives	
Phil Magistro Deputy Director, Program Implementation State Government HIT Coordinator Governor's Office of Health Care Reform Pennsylvania	Chris Manning Director of External Affairs Delaware Health Information Network
Andrew VanZee, MHA, FACHE Statewide Health IT Director Indiana	
Stakeholder Group -- National Quality Forum (NQF)	
Don Casey, MD, MPH, MBA, FACP Chief Medical Officer and VP Quality Chief Research and Academic Officer Atlantic Health	David Gifford, MD, MPH Director of Health Rhode Island Department of Health
Howard Goldberg, MD Director, Clinical Informatics Development Partners Healthcare	Gerri Lamb, PhD, RN Emory University Nell Hodgson Woodruff School of Nursing Atlanta, GA
Larry Wolf, MS Health IT Strategist Kindred Healthcare	

The investigation team identified the following topics to be addressed with all stakeholder groups:

- Meaningful Use
- Health Information Exchange
- Clinical Document Architecture (CDA) Standard for Transfer of Care
- Data Re-Use
- CDA Tools
- Standards
- Quality Measures
- Functional Status

Investigators anticipated that the nature and focus of the discussions would vary across each stakeholder group. Thus, a slate of open-ended questions related to these topics

was then crafted to capture the unique perspectives of each stakeholder group (see Table A-2 for a sample slate of questions). The topics and questions were presented to the participants for their review prior to the interview.

TABLE A-2: Sample Slate of Interview Topics and Questions: Providers

Topic	Questions
Meaningful Use	• Do you anticipate that hospital and physician requirements for MU measures will impact LTPAC? - If so, how?
Health Information Exchange	• How do you see that HIT can best help your institution(s) streamline information exchange and reporting? • What information is important for an LTPAC organization to exchange (send and receive)? • What are the barriers/challenges that keep LTPAC from exchanging information with unaffiliated providers and/or HIE organizations now? - What steps/activities are needed to overcome these barriers/challenges?
CDA for Transfer of Care	• Do you currently send and receive electronic clinical and summary documents? If yes, are they standardized for exchange? • Have you thought about standardizing transfer of care patient summary documents? - Do you think it is important to use a CDA template/CCD for the creation and exchange of a transfer of care summary document with other providers? - To what extent does your EHR have a CDA application? - If no current CDA application, what priority is this being given?
Data Re-Use	• Should MDS or OASIS data be reused in a transfer of care CDA/CCD? - If yes, which content in an MDS/OASIS would be most relevant to reuse in a transfer of care CDA/CCD? If no, why not? • Should EHR data be reused in a transfer of care summary CDA/CCD? - If yes, which EHR data content would be most relevant to reuse in a transfer of care CDA/CCD? If no, why not? • Can you reuse transfer of care/summary information that you've received from another provider in the EHR? - In the MDS/OASIS? Which content?
CDA Tools	• What technical assistance and/or other support do you need for the interoperable exchange of assessments and summary documents?
Standards	• Are there gaps in the CCD standard that impedes the exchange of important LTPAC content for a transfer of care summary? • What are the areas where LTPAC needs assistance/guidance in implementing a CCD? • In your view, are there gaps in HIT standards for LTPAC that need to be addressed? • In your view, what are the barriers to implementing existing HIT standards for LTPAC?
Quality Measures	

TABLE A-2 (*continued*)	
Topic	**Questions**
Functional Status	• What are your current challenges to capturing functional status information? - What steps/activities are needed to overcome these barriers/challenges? • What are your current challenges to capturing cognitive function information? - What steps/activities are needed to overcome these barriers/challenges? • What type of functional status/cognitive function information do you want to see in a CCD? • In addition to questions from the MDS or OASIS, what additional functional status information do you use or need? • In addition to questions from MDS or OASIS, what additional cognitive status information do you use or need? • Is there a framework for representing functional status and cognitive functioning concepts? • Given that there is no single definition of functional status and that multiple concepts are used, what steps are needed to identify a nationally accepted definition of "functional status" and advance the interoperable exchange of content related to functional and cognitive status?

A separate 60 minute conference call was conducted for each stakeholder group interview (a total of eight calls were conducted). A member of the investigation team facilitated participants' discussion of the slate of topics and open-ended questions. Follow-up questions from investigation team members and interview participants were encouraged.

DISCUSSIONS BY TOPIC

Topic: Meaningful Use

Stakeholders were asked to discuss their opinions regarding the impact on the LTPAC provider community of the CMS Meaningful Use (MU) requirements for Eligible Hospitals (EH) and Eligible Professionals (EP).

Themes from stakeholder group discussions are as follows:

TABLE A-3: Meaningful Use

Stakeholder Group	Discussion Themes
LTPAC Providers	Although Stage 1 MU criteria do not require EP/EH to electronically exchange information with LTPAC providers, opportunities exist for: • LTPAC providers to solicit information exchange with hospitals/physicians if the interoperability standards required by MU are deployed by the LTPAC clinical information system. • LTPAC providers to work with acute care providers, HIEs, and hospital/ambulatory EHR vendors to gain agreement on relevant information to be made available electronically during transitions of care across provider settings.
IDS Providers	While there is no direct financial incentive to electronically exchange information in the LTPAC setting: • As EP/EH adopt technology, there will be more requests for LTPAC providers to exchange information electronically. • Efficiencies experienced by participants in electronic exchange of information will push the curve for adoption. • As a by-product of MU, there will be more electronic exchange of data at transfers of care with providers not affiliated with the IDS -- both in-bound and out-bound. • New, low-cost exchange models will emerge that recognize the benefits to providers of intermediate steps in information exchange (e.g., providers can view information even if they don't contribute information to the exchange; clinic notes can be typed in Word and submitted to an HIE to apply a CCD wrapper).
Software Vendors	• The exclusion of LTPAC providers from MU will have a negative impact on the adoption of technology in this care setting. - LTPAC providers are a very pragmatic group -- most actions are the result of a mandate, an incentive, or a compelling business driver. - The fastest way to promote electronic exchange of information is with money and education. • Despite the absence of federal incentives for adoption of technology, forward looking LTPAC providers will recognize the need to prove viability in a changing landscape: - Participation in electronic exchange of information is an indicator of a progressive provider. - Deployment of technology will impact the ability of a provider to recruit younger staff (who will expect and want computers). - Efficiency is critical with the ever increasing demands to do more with fewer dollars. • There are competing views regarding whether LTPAC providers will want to electronically exchange information if it cannot be reused in their systems. Even if LTPAC providers are only able to view information, it is a starting point and there is value in the information exchange.

TABLE A-3 (*continued*)	
Stakeholder Group	**Discussion Themes**
CMS	• The readiness of LTPAC providers to participate in electronic information exchange is very low. - Information garnered through the Continuity Assessment Record and Evaluation (CARE) Health Information Exchange Project (HIEP) -- a project engaging three advanced health information organizations (HIOs) with many members -- shows there is very little exchange of data amongst providers. ▪ HIO members were surveyed regarding readiness to exchange information and what type of data they had the ability to either send or consume. Results showed minimal readiness or ability to exchange information. • The exclusion of LTPAC from federal HIT funding and mandates will result in a much slower uptake of technology in this care setting. - Absent funding and mandates, LTPAC providers generally do not feel they have the capital to invest in upgrading existing systems or acquiring new products that support the electronic exchange of health information.
FACAs	• LTPAC is an important component to achieving the advantages of meaningful use and distributed health information exchange such as: - avoiding errors, - reducing complications, - anticipating treatments and interventions, - reducing resource expenditures (e.g., re-hospitalization, Emergency Room utilization and similar types of metrics) • Absent federal financial incentives, it is important to look for other motivators or enablers that promote HIT adoption and electronic exchange of information by LTPAC providers such as: - New payment models (e.g. Accountable Care Organizations (ACOs), payment bundling) necessitate accurate and timely communication of health information for efficient and effective coordination of care. - Resources such as the open-source versions of all IHE (Integrating the Healthcare Enterprise) components which allow vendors to easily embed those technologies in their products and reduce the cost of product development. - Incremental deployment of technology, (e.g., deploying the ability to receive and read a CCD even though a system does not have the data and/or ability to create a CCD).
State-Level HIEs	Though LTPAC providers are excluded from meaningful use, inclusion of these providers in electronic information exchange is important due to: • The significant impact of LTPAC on health care costs and quality (e.g. re-hospitalizations, Emergency Room visits). • The need to support MU criteria such as medication reconciliation, transfer of care record and certain quality measures that where LTPAC data is needed for computation of the measure.
NQF	• Though LTPAC providers are excluded from meaningful use, inclusion of these providers in electronic information exchange is important due to: - MU criteria that look at the exchange of information, - National focus on transitions of care - Payment reform models that look at bundled payments, ACOs, etc. • While process metrics that measure the occurrence of CCD/information exchange are likely for the foreseeable future, the metrics need to transition to outcome measures to be truly meaningful.

Topic: Health Information Exchange

Stakeholders were asked to discuss their opinions regarding what information was important to exchange and the benefits/challenges to exchanging the information. Themes from stakeholder group discussions are as follows:

TABLE A-4: Health Information Exchange	
Stakeholder Group	**Discussion Themes**
LTPAC Providers	• Standards are needed to support the exchange of information of particular interest to LTPAC providers such as: - Reason for referral - Treatment goals - Actual treatment orders • While exchange of medication information is a high-value action, challenges related to data messaging and data content still exist that preclude automation of the reconciliation process such as: - Differences in the completeness of data made available when different versions of NCPDP standards are used by providers, pharmacies, data aggregators, etc. to transport medication information - Lack of information on medications that are not part of the pharmacy enterprise (e.g., OTC medications purchased out-of-pocket) - NDC codes
IDS Providers	• Points of divergence regarding the value of exchanging computable information versus human readable information: - Making human-readable information available gets you 85% of the value of an electronic exchange proposition -- most clinicians feel a human-readable, current document is far better than nothing. - Questionable value to receiving an electronic "viewable only" form of information that is currently provided as hardcopy. If all the provider receives is electronically viewable information, it stills needs to be reduced to paper/printed for inclusion in the resident record in accordance with standards of practice for recordkeeping.
Software Vendors	• Currently there is very little electronic information exchange -- especially with transfers of care. • Providers see the value of information exchange -- the sell needs to be on "standardized" exchange. Vendors get many requests for one-off interfaces. • High value information to exchange for LTPAC providers includes: - demographics, - medications, - reason for hospitalization (diagnoses), and - plan/orders for services on discharge • Barriers to LTPAC participation in electronic information exchange include: - Technical complexity and ambiguity of some aspects related to exchange of a CCD. *(**NOTE**: Since the interviews were conducted initiatives are underway such as the Green CDA to reduce the complexity)* - Lack of a standardized approach for electronic information exchange across individual HIEs becomes very problematic for large multi-state national chains. - Vocabulary standards are currently inadequate and not readily deployable.
CMS	• Proof of concept trial launched with Regenstrief, Healthbridge, and MedVirginia to move Continuity Assessment Record and Evaluation (CARE) data from an HIE to CMS. - A subset of CARE data is exchanged using HITSP C83. - Data collection for the demonstration slated for June through December 2010.

TABLE A-4 (*continued*)	
Stakeholder Group	**Discussion Themes**
FACAs	• Regarding incremental interoperability (such as a Level 1 CDA with an embedded pdf), the following philosophies from the Mayo Clinic Beacon project were shared: - Exchanged electronic data must be put in front of the physician in the context of their native EMR, which means the data must be machineable, manipulatable, and manageable. - Physicians involved in routine primary care are fearful of receiving non-standard, difficult to interpret, unfamiliar layout, information. - High value information such as labs, meds, allergies and problems, MAY be appropriate to exchange in a human readable format -- but it must be efficiently consumable by the clinician.
State-Level HIEs	• New efforts underway in Delaware, Indiana and Pennsylvania to explore how LTPAC providers can be included and serviced by the HIEs.

Topic: CDA to Transfer of Care

Stakeholders were asked to discuss the use of CDAs for transfer of care. Themes from stakeholder group discussions are as follows:

TABLE A-5: CDA to Transfer of Care	
Stakeholder Group	**Discussion Themes**
LTPAC Providers	• LTPAC providers need to closely look at how electronically exchanged information is identified, reconciled, and incorporated into the workflow of the interdisciplinary team. In the instance of a CCD, three key use cases to address in relation to workflow are: - Transfer of care - Shared care - Exchange with the consumer
Software Vendors	• LTPAC clients have not requested CCD functionality from participant vendors. • One of four participating vendors had the capability of generating a CCD -- all other vendors had road mapped the functionality.

Topic: Data Reuse

Stakeholders were asked to discuss the reuse of MDS/OASIS data for transfer of care summaries. Themes from stakeholder group discussions are as follows:

TABLE A-6: Data Reuse	
Stakeholder Group	**Discussion Themes**
Software Vendors	• Concern was voiced over the latency of MDS data - If MDS content is used in populating the CCD, the MDS **date** would need to be front and center so that recipient would be clearly aware if the information was 3 months old. - If MDS question(s) are replicated elsewhere in EMR system, there - may be a more current response to use in populating the CCD - MDS questions could be useful for CCD but probably not sufficient

Topic: Standards

Stakeholders were asked to discuss any gaps or other issues that impede the deployment of HIT standards. Themes from stakeholder group discussions are as follows:

TABLE A-7: Standards	
Stakeholder Group	**Discussion Themes**
LTPAC Providers	• A number of LTPAC organizations operate multiple facilities located in different counties or states. When faced with exchanging electronic information with multiple HIEs, the importance of *standardized* information becomes critical to any scalability within these organizations.
Software Vendors	• LTPAC vendors and providers will require guidance and assistance with the deployment of standard terminologies such as LOINC and SNOMED.

Topic: Quality Measures

In light of the quality measures incorporated into the Meaningful Use rule, participants were asked to discuss the state of quality measures in the LTPAC setting. Themes from stakeholder group discussions are as follows:

TABLE A-8: Quality Measures	
Stakeholder Group	**Discussion Themes**
National Quality Forum (NQF)	• Current LTPAC quality measures based on federal assessment instruments do not adequately reflect the more global perspective of patient-centered care across providers. - NQF Care Coordination principles can serve as a foundation for looking more globally across an episode of care that is not defined by the health care setting, but by the success of interventions to achieve better health. The principles are listed in the 2006 NQF document "NQF Endorsed Definition and Framework for Measuring Care Coordination" available at : http://www.qualityforum.org/projects/care_coordination/2006_care_coordination_framework.aspx The NQF Care Coordination web page is available at: http://www.qualityforum.org/projects/care_coordination.aspx

OPPORTUNITIES FOR ENGAGING LONG-TERM AND POST-ACUTE CARE PROVIDERS IN HEALTH INFORMATION EXCHANGE ACTIVITIES: EXCHANGING INTEROPERABLE PATIENT ASSESSMENT INFORMATION

Files Available for This Report

Main Report [54 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf

APPENDIX A: Stakeholder Interview Summary [13 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-A.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-A.pdf

APPENDIX B: Background Report on Intellectual Property Issues and the Dissemination of Standardized Federally-Required Patient Assessments [89 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-B.htm
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APPENDIX C: Rosetta Stone Mapping Guidelines and Heuristics [19 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-C.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-C.pdf

APPENDIX D: Rosetta Stone MDS and OASIS and Value Sets for MDS [518 PDF pages]

Full Appendix
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D.pdf

Toolkit Overview, Model of Use, Model of Meaning, and Supporting EHR Observation [135 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D1.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D1.pdf
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D1.xlsx

MDS Value Sets (Separate Excel files accessible through links within HTMLs and PDFs) [381 PDF pages]

Alzheimer's Disease through Cirrhosis [184 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D2a.htm
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Coronary Artery Disease through Wound Infection [197 PDF pages]
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http://aspe.hhs.gov/daltcp/reports/2011/StratEng-D2b.pdf

APPENDIX E: Rosetta Stone OASIS [71 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-E.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-E.pdf
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-E.xlsx

APPENDIX F: Current Standards Landscape for Exchanging Interoperable Patient Assessment Information [9 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-F.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-F.pdf

APPENDIX G: LTPAC Interoperability Toolkit for Exchanging Interoperable Patient Assessment Instruments [9 PDF pages]

Overview http://aspe.hhs.gov/daltcp/reports/2011/StratEng-G.htm
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Several attachments are listed separately at the end of this Appendix.

APPENDIX H: Standards Development and Adoption Recommendations [6 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-H.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-H.pdf

APPENDIX I: Functional Status Standardization Recommendations [13 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-I.htm
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-I.pdf

APPENDIX J: Overview of Patient Assessment Summary [23 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-J.htm
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APPENDIX K: Rosetta Stone MDS Summary [162 PDF pages]
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APPENDIX L: Rosetta Stone OASIS Summary [127 PDF pages]
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http://aspe.hhs.gov/daltcp/reports/2011/StratEng-L.xlsx

APPENDIX M: Terms and Acronyms [6 PDF pages]
http://aspe.hhs.gov/daltcp/reports/2011/StratEng-M.htm
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