

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

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Executive Summary

Snapshot of Rush University Medical Center LTSS and HIE

- Organization Type: Hospital (1 of 4 hospitals in Rush System for Health).
- Size: 664 beds.
- Transitional Care Programs: Health and Aging Department with Transitional Care Services including the Bridge Program. Approximately 1,800 patients in program annually.
- Community Engagement: Founder and member of ITCC developer of the Bridge Model/Program.
- CMS Funding: ITCC is participating in the CMS funded CCTP.
- EHR: Epic Technical Support for Information Sharing:
 - Epic Care Anywhere -- HIE only for Epic clients (used primarily by hospitals and ambulatory care practices).
 - Allscripts -- Care management application to share information with other subscribers.
 - An HIEO is under development in Illinois and the Chicago area, but not operational at the time of the site visit.

A site visit was conducted to Rush University Medical Center (RUMC) to explore what, how, and with whom health information is exchanged including on behalf of persons receiving long-term services and supports (LTSS). RUMC is part of the Rush System for Health, an integrated delivery system with hospitals and ambulatory care practices. Rush is an urban hospital located in downtown Chicago, Illinois, with multiple programs focused on improving care transitions including improving transitions with skilled facilities, home health agencies (HHAs), reducing hospital readmissions and care coordination with community-based services.

A key component of Rush's Facility Transitions in Care and Bridge Programs is coordination with LTSS programs in the community. Through a patient-centered approach, Rush works to improve care transitions through intensive care coordination that starts in the hospital and continues into the community. The multidisciplinary health care team is extended beyond the hospital's physicians, nurses, pharmacists and case managers to also include the community resource team (therapists and community providers such as home health, skilled nursing facilities [SNFs], and other services). The team identifies and addresses the services and resources needed by the patient and works to eliminate barriers that will prevent them from safely transitioning back to the community and meeting their health care goals.

Rush University Medical System uses the Epic electronic health record (EHR) system for all patient care documentation in the hospital and ambulatory care sites. Epic

is a Meaningful Use (MU) of Certified EHR Technology having achieved MU Stage 2 certification for its ambulatory and inpatient applications.¹

Health information exchange (HIE) from hospital to long-term and post-acute care (LTPAC)/LTSS providers relied on multiple methods to communicate and exchange information including phone, fax/e-fax, secure e-mail, and the use a proprietary electronic referral application (Allscripts Care Management application). Some Chicago-area hospitals allowed LTPAC providers to access their EHR to facilitate communication and information sharing, however, Rush's policy limits EHR access to only staff and physicians and does not allow access to non-affiliated providers such as LTPAC and LTSS providers.

The Allscripts Care Management application facilitates the electronic exchange of some health information (e.g., unstructured narrative messages as well as medical record document attachments) between Rush and their community partners including LTPAC organizations. The community partners who subscribe to the Allscripts application can receive messages and attachments from Rush and pull some of the information into their EHR if they use an Allscripts application.

LTSS Provider Definition

Long-Term Services and Supports (LTSS) are services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS include institutional and community-based services such as nursing homes, care management, adult day care, home-delivered meals, transportation providers, and other services.

At Rush, HIE between the transitional care programs and LTSS typically occurs during four phases:

- Pre-discharge (prior to and at transition).
- At the point of transition.
- Immediate post-discharge (within 24-48 hours after transition).
- 30-Day followup after discharge (during shared care).

Clinical, demographic and service information is communicated by hospital case managers and care coordinators to community providers (HHA, nursing facilities, and/or home and community-based services [HCBS] providers). The lack of tools to facilitate exchange, such as a HIE organization (HIEO) is a challenge for Rush and their partners. Staff interviewed during the site visit identified a number of opportunities for improvement including:

¹ Epic MU Stage 2 Certification Details: <http://www.epic.com/software-certification.php>.

- Identifying the need for a HIEO available to all community partners.
- Finding the right balance in the amount of information sent versus the information needed between the hospital and their community partners.
- Developing standardized reports.
- Integrating LTSS needs in a patient-centered plan of care (POC).
- Redefining case management and care coordination to achieve a patient-centered, longitudinal care that includes partnerships with community partners.

Because of Rush's ongoing initiatives to improve transitions and coordination, they have pilot projects with HHAs and nursing facilities to improve processes and communication. These projects include ongoing multidisciplinary case management meetings on a regular basis to discuss care and process issues and work in partnership to improve outcomes.

Background on Rush University Medical Center Transitional Care Programs

About Rush System for Health and Rush University Medical Center

Rush System for Health is a not-for-profit academic medical center comprising RUMC (which we also refer to as Rush in this report), Rush University, Rush Oak Park Hospital, and Rush Health. Rush encompasses a 664-bed hospital, serving adults and children, including the Johnston R. Bowman Health Center. The Bowman Center provides acute inpatient and day rehabilitation services for older adults and people with short-term and long-term disabilities, and has apartments for moderate to low-income seniors.

The mission of Rush is to provide the very best care to patients. Their education and research endeavors, community service programs and relationships with other hospitals are dedicated to enhancing excellence in patient care for the diverse communities of the Chicago area now and in the future. The vision is for Rush to be recognized as the medical center of choice in the Chicago area and among the very best in the United States. Rush was named one of the nation's top 50 hospitals in 11 out of 16 specialty areas, including geriatrics in 2012-13 *U.S. News & World Report*.

Department of Health and Aging and Transitional Care Programs

Rush has a Department of Health and Aging under the direction of Robyn Golden, LCSW. Robyn has an extensive background in health care including acute care, LTPAC, and HCBS. In addition to her health care background, Robyn also has an in-

depth understanding of policy issues from her Fellowship on Capitol Hill working for Senator Hillary Clinton and collaborating with agencies such as the Centers for Medicare that Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation. She and her team strive to evolve practice by creating and testing new models of care by merging practice, research, policy and education.

The mission of Rush Health and Aging (RHA) is “to promote wellness by improving access to psychosocial and medical resources for patients, those who care for them and the community.” RHA conducts research, develops programs, and provides service to improve healthy aging. RHA services include:

- Health promotion and disease prevention.
- Social work services focusing on wellness through assessment and connections to resources.
- Transitional care for moving from the hospital to home and coordination of services for at-risk seniors.
- Resource centers with information on program, services and supports (Anne Byron Waud Resource Center for Health and Aging at the Johnston R. Bowman Resource Center and the Tower Resource Center at the Tower Hospital Building).
- Rush Generations (a membership program for individuals and caregivers who are concerned about aging well that provides tools and resources on healthy aging).
- Developing and testing new models of care and health care innovations.

Within the Department of Health and Aging is the Transitional Care Team under the management of Madeleine Rooney, MSW, LCSW. The transitions team is comprised of social workers who provide direct services to support the discharge planning process and coordinate services with community caregivers and programs.

Enhanced Discharge Planning Program

The Enhanced Discharge Planning Program (EDPP) was designed by the Rush transitional care team to aid in patients’ transitions from the hospital to their home (beyond the typical hospital discharge planning process). The transition services are coordinated by social workers who provide telephone followup and short-term (30 day) care coordination for recently discharged adults. The social workers conduct a bio-psychosocial assessment that includes a review of medical records, discharge plans and participation in pre-discharge interdisciplinary rounds.

The social workers interact, typically by telephone and some e-mail, with patients and caregivers after discharge to identify gaps in care and help address identified needs. The social workers are a resource for patients and caregivers. A randomized control trial showed a decreased in hospital readmission rate at 30, 60, 90, and 120 days post-discharge. Participants were more likely to make and keep followup appointments, had a better understanding of medication management, experienced reduced caregiver burden and had lower mortality rates as a result of the EDPP interventions.

Illinois Transitional Care Consortium

Rush is a member the Illinois Transitional Care Consortium (ITCC).² Originally convened by Rush, the Consortium was formed in 2008 to bring together leaders from area organizations who were struggling with issues related to care transitions. The stakeholders are described below and cut across the silos of health care to discuss their mutual challenges and strategies to address the problems. Some of the challenges the ITCC set out to tackle included:

- Improved access to information to support community-based organization (CBO) programs including better longitudinal data on the patient's history, past service utilization and access to relevant medical record information (such as the name of the primary care physician, followup appointments, demographic data, diagnoses, medications, and cognitive and physical function assessments).
- The need for improved funding models that supported transitions and coordination with community organizations.
- The need for improved relationships and recognition by hospitals of community providers and organizations to support the transition and care coordination process.

Over time the ITCC developed, tested, and refined concepts to address their mutual challenges. One of those concepts is known as the Bridge Model and was the foundation for a CMS Community-Based Care Transitions Grant (both described below). The Bridge Model concept was inspired by the Rush EDPP and then developed by the merging of best practices identified by the ITCC members.

The ITCC includes partners from CBOs, hospitals and research, evaluation and policy groups. ITCC includes the following partners:

² See <http://www.transitionalcare.org/>.

Community-Based Organizations

- **Aging Care Connections.**³ Aging Care Connections is a private, not-for-profit organization dedicated to serving older adults and their families through community-based services that promote dignity, self-respect and independence. Aging Care Connections is the suburban Chicago Area Agency on Aging (AAA) and Aging and Disability Resource Center (ADRC) and is the central administrator for ITCC. Services provided by Aging Care Connections include: information and assistance about resources, care coordination, education and training, chore keeping, transportation, home-delivered meals, respite, support groups and more.
- **Shawnee Alliance for Seniors.**⁴ Shawnee Alliance for Older Adults programs serve persons over the age of 60 and their caregivers. Programs provide access to services that enable older adults to maximize their independence and remain in the community, advocating for the rights of older adults and their quality of life in the community and in nursing homes, and protecting older adults from abuse, neglect, and exploitation. They have developed and administer preventive primary health and social services and also provide services such as case management and counseling.
- **Solutions for Care.**⁵ Solutions for Care serves the adult community and the people who for care for them. They work to find the resources that preserve independence and dignity, that lead to greater self-sufficiency and a higher quality of life. They work with individuals to access the resources available to manage their care.

Research, Evaluation and Policy Groups

- **Health and Medicine Policy Research Group.**⁶ The Health and Medicine Research Group is an independent, not-for-profit research and advocacy institute with a focus on Illinois public health and care for the poor and under-served.
- **University of Illinois at Chicago (UIC), School of Public Health.**⁷ The UIC School of Public Health works in partnership with community and governmental organizations to improve the health of the public and provide a learning experience for students and advance innovative research.

³ See <http://www.agingcareconnections.org/index.html>.

⁴ See http://www.shsdc.org/index.php?page=senior_services.

⁵ See <http://www.solutionsforcare.org/>.

⁶ See <http://www.hmprg.org/>.

⁷ See <http://publichealth.uic.edu/>.

Hospitals

- **Rush University Medical Center -- Health and Aging.**⁸
 - RHA offers innovative programs and services designed to measurably improve health and quality of life through its program, services, and innovative research. The RHA focuses on adults and caregivers as discussed earlier in this report.
 - Other Chicago Area Hospitals include Adventist LaGrange Memorial Hospital, Memorial Hospital of Carbondale, Herrin Hospital, and MacNeal Hospital.

The Bridge Model

The ITCC developed the Bridge Model to improve care coordination. It was originally developed with a focus on older adults, but is merging as a program for adults of all agencies with chronic conditions. Inspired by the EDPP noted earlier in the report, the Bridge Model⁹ is a social work based approach to transitional care that builds off of the aging network, designed to help older adults with chronic conditions discharged from an inpatient hospital stay to safely transition back to the community through intensive care coordination that starts in the hospital and continues after discharge to the community. The Bridge Transitional Care Program is a hospital and community partnership. There is physical office space at Rush for the Bridge Care Coordinators (BCCs) to receive referrals and access hospital and community records. The BCCs have expertise in geriatrics, strong clinical and advocacy skills, experience working in both community and hospital settings, and knowledge of state, federal and community resources. At Rush, the BCCs are their employees, but at other area hospital sites the Aging Care Connections and Shawnee Alliance for Seniors employ the care coordinators.

The Bridge Model was built and refined based on the experiences of the Consortium members and the challenges their patients' faced at care transition when they transitioned across various health care providers, payers and service delivery models. The ultimate goal was to coordinate existing systems (Figure H-1) to better serve older adults and their caregivers.

⁸ See <http://www.rush.edu/rumc/page-1099611550952.html>.

⁹ Illinois Transition of Care Consortium, Bridge Model. <http://www.transitionalcare.org/the-bridge-model>.

FIGURE H-1. Bridge Program Systems Targeted for Coordination



The Bridge Model assesses transition/discharge plans and issues related to home health, medical care, medication management, self-management and psychosocial complications using a proprietary accountability and communication tool called PERFECT (see Attachment H-1) to improve transitions to home care. The PERFECT form defines the mutually agreed upon expectations for care, documents the services identified and communicates problems and resolutions. A pilot project was conducted by the ITCC and anecdotal results found that PERFECT helps to identify risk elements for readmissions.

BCCs work with the discharge planners to screen for and coordinate post-hospital medical and community services for older adult care. BCCs often work out of dedicated Aging Resource Centers (ARCs) inside hospitals. The ARCs provide a dedicated space for older adults and their caregivers to explore community resources, health information and caregiving materials, and to develop community care plans prior to discharge. The Bridge Model is comprised of three phases:

- **Pre-Discharge.** BCCs within the hospital identify older adult patients who may be at risk for post-discharge complications. Referrals can originate with hospital discharge planners or be generated through an integrated risk screen in the Epic EHR. The BCCs meet with older adults and/or their caregivers in the hospital room or in the ARC to identify unmet needs and to set up services prior to discharge. BCCs may also prepare individuals for discharge by reviewing medical records or meeting with an interdisciplinary team within the hospital.

- **Post-Discharge.** Often new needs are frequently identified soon after an older adult returns home. BCCs call consumers within 24-48 hours after discharge to conduct a secondary assessment and intervene on identified needs. Areas of need include understanding discharge instructions, transportation issues, physician followup, burdened caregivers, problems with home health care, difficulty obtaining and/or understanding medications and others.
- **30-Day Followup.** The BCCs followup with patients at 30 days post-discharge to track their progress and address emerging needs and to ensure that people are connected to longer-term support services.

Evidence has shown a positive impact on readmissions, physician followup, understanding of discharge plans, understanding of prescribed medications, access and timeliness of community services, and mortality. Bridge community partners reported improvements in receiving more complete information at the point of transfer and understanding patient more completely before services are started.

Rush University Medical Center Case Management

Rush has case management services lead by Sandy McFolling, Hospital System, Director of Case Management. The director also oversees the utilization review and clinical documentation improvement functions as well as social workers who work in transplant and chemotherapy. The case management strategy is to develop partnerships in the community and build collaboration with the hospital.

The focus of LTSS programs at Rush relates to improving care transitions through a patient-centered approach that engages a multidisciplinary health care team to identify and address barriers in collaboration with community providers. Their multidisciplinary team includes: nursing, physicians, nurse and social work case managers, pharmacists and Bridge social workers.

Rush has multiple departments/business units and five programs focused on improving care transitions:

- **Facility Transitions in Care (July 2008 - Current).** The case management department makes a followup phone call within 24 hours to the receiving SNF to determine if pertinent information was received and correct, the patient presented as expected, and the patient/family was satisfied with the plan. The goal is to resolve issues immediately and establish a basis for collaborative problem solving and process improvement between case management, nurses, physicians and facilities. Since the program started, Rush reported readmissions to the hospital within 30 days of discharge decreased from 43.9% in 2007 to 11.9% in 2012.
- **Skilled Facility Rush Coordinated Care -- Rush Physicians and Nurse Practitioners (2012 - Current).** A program at four SNFs is aimed to improve

coordination of care through engagement of Rush nurse practitioners and physicians. With this program, the patient is seen by the physician or nurse practitioner post-hospital discharge at least twice in the first week and then weekly until they are stable. The nurse practitioner works closely with the nursing home staff through face-to-face discussions, bedside teaching and ongoing availability by cell phone. Quarterly meetings are held with the Rush Coordinated Care Director, each skilled facility owner/administrator, and Case Management Director. Monthly data is tracked to identify areas of success and need for improvement.

- **HHAs Care Transitions (2010 - Current).** Since 20% of persons discharged from Rush are discharged to HHA services, this project was initiated to improve coordination. There are a number of initiatives that are underway with HHAs that provide services to Rush patient's to improve the coordination of care, patient quality and safety around the following common goals:
 - Increase patient satisfaction;
 - Decrease hospital readmissions;
 - Provide patient/family centered care;
 - Perform accurate and timely medication reconciliation;
 - Provide timely referrals;
 - Improve hand-offs and provision of discharge services; and
 - Decrease frequency of Bridge social work followup calls related to issues.

The HHAs that are part of the CMS Community-Based Care Transitions Program (CCTP) also participate in a pilot project where the care team holds a weekly care conference to monitor the patient's clinical and social status to identify issues and implement timely interventions to prevent readmissions and/or address chronic problems such as poorly controlled pain. The goal is to operationalize the best practices that emerge from the CCTP grant at Rush and with community partners.

- **Inpatient Collaborative Care Model (August 2010 - Current).** This pilot project developed and tested a standardized set of interdisciplinary care coordination protocols on one medical unit to promote patient satisfaction, reduce readmissions and decrease fragmented care. The program utilized concepts from the Bridge Program and Project Better Outcomes for Older Adults through Safe Transitions (BOOST).
- **Readmission Reduction Project RED Pilots (October 2012).** The goal of this project was to maintain an overall readmission rate of less than 12.32% at Rush. Under this project, Rush is developing and implementing processes and maintenance metrics to achieve a reduction of 20% in the overall readmission rate. At the time of the site visit, Rush completed initial meetings, identified a bundle of 12 reinforcing interventions, and started a pilot. Next they will

implement daily risk reports and use a new discharge advocate flow sheet in Epic to analyze results.

- **The Bridge Program.** Described above.

The success of Rush's care transition and community engagement programs is dependent on having the right people, processes and information available. The section titled "Health Information Exchange Information Flow" will describe the information needed at key points of transition and shared care. These programs have been recognized for their innovation and success having won awards from the Case Management Society of America and URAC (an organization that promotes health care quality through accreditation, education and measurement programs).

Policy Drivers for Increased Focus on Transitional Care Programs

There were two Federal Government programs that provided opportunities to expand programs to improve transitional care processes, improve performance, or test new models of delivery and payment that involved LTSS as described above. They include funding under a CMS 3026 Grant for Community-Based Transitions Program and the Hospital Readmission Reduction Program.

CMS Community-Based Care Transitions Program (3026 Program)

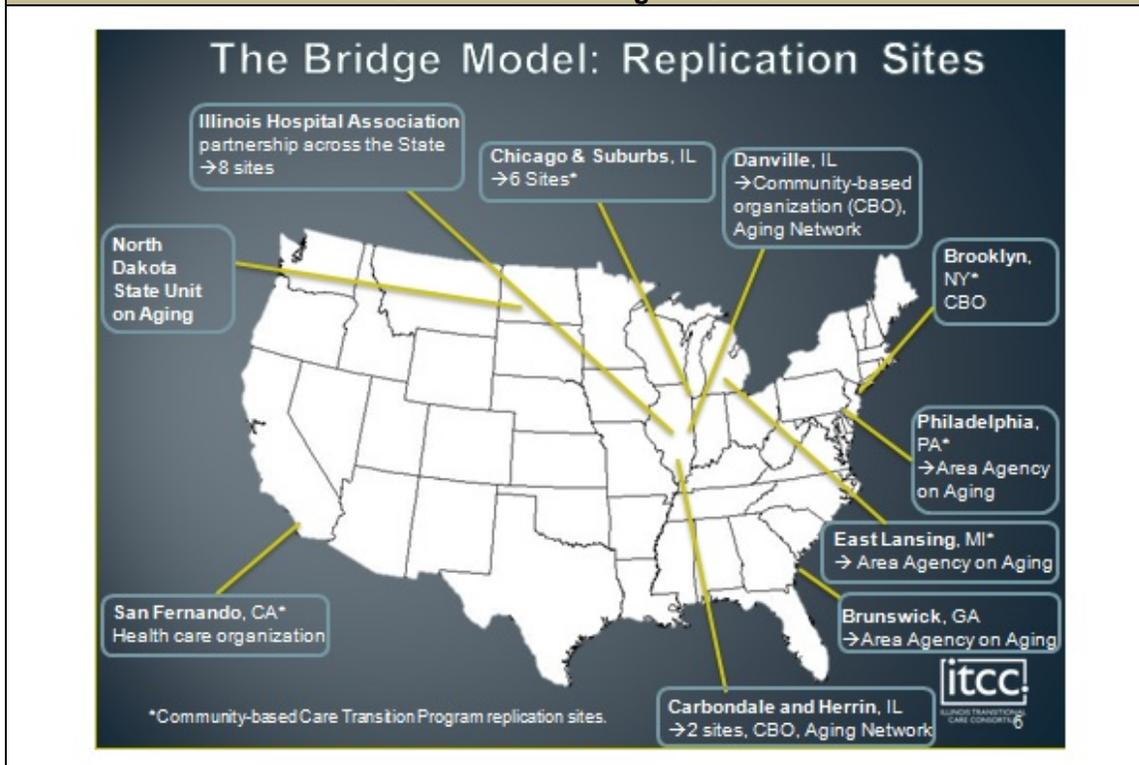
The ITCC is currently participating in the CMS funded CCTP. ITCC members -- Aging Care Connections and Health and Medicine Policy Research group -- provide program management support and AgeOptions serves as the central administrator.

The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.¹⁰ In the Rush system eligible individuals for the Bridge Program are Medicare beneficiaries who have at least one chronic condition that requires followup care and meet certain risk criteria for rehospitalization (e.g., over 60 years of age, has at least one chronic condition, lives alone and/or goes home with home health or discharged to a SNF participating in the 3026 Program). The Bridge program serves approximately 1,800 patients. The Bridge Model is a core component of the ITCC CMS CCTP contract.

The ITCC plan (separate from the CCTP) is expanding its use and replication the Bridge Model. Expansion and replication of the Bridge Model beyond the Chicago area is also a component of the CCTP. Figure H-2 Identifies the replication sites around the country -- expansion into five sites were related to the CCTP and twelve others were funded by their community or individual hospital resources.

¹⁰ See <http://innovation.cms.gov/initiatives/CCTP/>.

FIGURE H-2. Replication Sites for Bridge Model and Community-Based Care Transition Program Sites



Hospital Remission Reduction Initiatives

Rush has focused on improving the transition of care through various initiatives starting in 2007. As a result of the CMS Hospital Readmission Reduction Initiative,¹¹ Rush began a readmission reduction project in 2012.

Other Emerging Payment Models such as ACOs

Rush is not currently involved in any of the new payment models such as an ACO or bundled payment, however they are exploring new accountable care arrangements. Dr. Julio Silva is a vice president and the CMIO at Rush reported that Rush is applying for a Medicare Shared Savings plan in the Fall 2013. There is a Medical Home Network, the interviews with staff did not indicate that LTSS programs were integrated into the Medical Home Network and services.

¹¹ Readmission Reduction Program. CMS Web site: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html> (accessed May 20, 2013).

Overview of Health Information Exchange to Support Long-Term Care Services and Supports at Rush University Medical Center

The availability, use and exchange of information are crucial to providing LTSS. As noted in the programs above, Rush has been dedicated to improving the transition of care process for a number of years. To accomplish this goal they have engaged various departments/staff within the hospital system, affiliated providers such as physician practices owned by Rush, and non-affiliated providers.

This section describes the non-affiliated providers that were interviewed during the site visit, describes the technical infrastructure at Rush including the availability of a community HIEO, and describes the health information exchanged at transition of care and during shared care using a framework designed under this project.

Rush University Medical Center LTSS-Related Non-Affiliated HIE Partners

During the site visit, three community (non-affiliated) partner organizations were interviewed to discuss the types of HIE/sharing that occurs as well as the challenges and opportunities. They are not the only LTSS community partners, but selected for study purposes.

- **Health Resource Solutions (HRS) Home Care.**¹² HRS, a Medicare-certified HHA, serves the Chicago area (an 11 county region) providing nursing and therapy services including: 24-hour telemonitoring, geriatric care, psychiatric care, neonatal care, pediatric care, pediatric infusions, IV therapy, high tech infusions, physical therapy, occupational therapy, social work, and disease statement management.

Specific to this project and LTSS, HRS is the preferred home care provider for the 3026 Grant (CMS CCTP) and Rush HHA Transitions in Care Program. They actively participate in pre-discharge planning at the hospital with the interdisciplinary team for high-risk Medicare beneficiaries. Under the Bridge Program they utilize the PERFECT tool to improve the success of transitions. In addition, HRS has found that their use of telemonitoring for select cardiology conditions has reduced hospital readmissions resulting in preferred provider status for RUMC and other Chicago-area hospital cardiologists.

An HRS staff member is at the hospital receiving referrals, assessing the patient, and interacting with hospital case management staff. HRS uses Allscripts EHR for home care and receives their referral information through the Allscripts Care Management tool for sharing relevant information at the point of transfer from the hospital to home with home care services (such as demographics, financials, referral, medication information, equipment needed and clinical information related to care needs). Some of the information in the Allscripts Care

¹² See <http://www.healthrs.net/>.

Management tool can be integrated into the HRS EHR such as demographics. Other information is printed and scanned into the Allscripts EHR.

- **Warren Barr Pavilion.**¹³ Warren Barr is a SNF that has partnered with Rush in their Skilled Facility Rush Coordinated Care Program. They provide sub-acute rehabilitation services, orthopedic rehabilitation, a specialized chronic heart failure transitional cardiac care program, advanced wound care, IV therapy, and other specialized skilled nursing service.

At the time of the site visit Warren Barr was just in the process of implementing an EHR system -- Point Click Care (PCC). They used Allscripts Care management for referrals from Rush which also provided relevant information (history and physical [H&P], labs, therapy, progress notes, social work notes, durable medical equipment [DME], demographics and financial data). Because information in Allscripts Care management is not interoperable and PCC does not support interoperable information exchange, information from Allscripts Care management cannot be automatically incorporated into the PCC system -- it must be re-entered if it is to be incorporated into Warren Barr's EHR. Warren Barr utilizes the Interact tools including the Situation, Background, Assessment and Recommendation Report (on paper now, but electronic once PCC implemented).

When Warren Barr sends patients to the hospital (typically through the emergency department) they send by hard-copy a packet of information (demographics, diagnosis, medication list, labs, H&P, etc.). Warren Barr does not create an electronic, interoperable transfer form to support the transition. They have found that information often does not make it to the medical unit where the patient eventually stays. Another challenge is finding the patient in the hospital and ensuring that the staff are aware that they are a Warren Barr patient.

A Rush physician and nurse practitioner sees patients at the SNF and will document in the SNF's EHR. For Rush patients these clinicians will also have to document in the Rush EHR system. The physician can access the Rush EHR to obtain any information needed for shared care.

- **Aging Care Connections.**¹⁴ Aging Care Connections (the suburban Chicago AAA, and ADRC) offers programs and social services to adults age 60 and older and their family members to enhance their ability to remain as independent as possible in their own community. There are over 80 different programs and services available in these categories:
 - Information and assistance coordinated point of entry (resources, benefits, assessment, etc.);

¹³ See <http://www.warrenbarr.com/>.

¹⁴ See <http://www.agingcareconnections.org/index.html>.

- Comprehensive care coordination;
- Homemaker services;
- Transportation;
- Home-delivered meals;
- Community Care Program;
- Respite;
- Elder Abuse (authorized by Illinois Department of Aging and AgeOptions, the AAA in suburban Cook County, to conduct case work services to investigate reports of suspected abuse, neglect or exploitation);
- Benefits assistance;
- Support groups; and
- Caregiver support program.

Aging Care Connections is funded in part by federal and state government agencies, the local AAA, local municipalities and townships as well as private funding like the United Way. They maintain an electronic client management information system (CMIS) and paper-based client records to records (but not an EHR). The information system maintains client records such as demographic records, results of screenings/qualifications for services, limited medical information such as medications and assessments, and service utilization records. The CMIS is not integrated with other community partner information systems/EHRs. In their role to investigate Elder Abuse, they must maintain a specific computer to access the state database to upload reports.

When Bridge social workers and/or case managers identify the need for the HCBS listed above, they share via phone, fax and e-mail demographic information, and other initiation of service information. The social workers spend significant time moving information manually, following up by phone or e-mail to make sure information was received, and following up to make sure services were implemented. Aging Care Connection has data sharing agreements to access medical record information at some area hospitals to support the transition planning process. Where agreements are in place, staff at the Aging Care Connection may access the hospital EHR to review relevant information such as the discharge plans, diagnosis, medications and assessments.

Rush University Medical Center's Technology Infrastructure

To understand the technology infrastructure and future plans, Dr. Julio Silva was interviewed during the site visit. In addition to Dr. Julio Silva being a vice president and the CMIO at Rush, he is also the Medical Director for MetroChicago HIEO which is under development.

Electronic Health Record System

Rush University Medical System has a tag line for the EHR -- “one patient-one record.” Both the hospital and ambulatory care practices use Epic EHR system for all patient care documentation in the hospital and ambulatory care sites. There are approximately 1,000 physicians in the Rush system -- 6% are employed by Rush and 40% are affiliates. Rush also extends Epic on a fee-for-services basis to some non-Rush physicians and manages the IT infrastructure for a management fee. Epic supports the Care Transition Program by providing the ability to route information to staff or affiliated provider (e.g., results delivery, routing to an in-box). Rush utilizes Epic’s HIE platform Care Anywhere. Care Anywhere is only available to Epic EHR system users, however, and the use of Epic is limited in the LTSS community.

The Patient Care Managers at Rush use a different application document their narrative care management notes. At this time there is not an interface between the care managers’ application and the Epic EHR. Rush is working on an electronic Bridge template in the EHR system. This template would enable the electronic incorporation of the BCCs documentation including their assessment of post-discharge risk elements in the Epic EHR and viewable by all authorized users of the system.

Health Information Exchange Organization

The State of Illinois is developing a federated HIE model with a record locator services that will reach out to regions and bundle and route information. One of the regions in Illinois is the Chicago area. There is currently not an operational HIEO in the Chicago area; however, there has been a big push to support HIE in the region since many different EHR systems are deployed -- none of which talk to one another. As a result, a MetroChicago HIEO is under development with Dr. Silva serving as the Medical Director.

A Metropolitan Council comprised of 120 hospitals and communities are working together to establish the HIE. The Council began with addressing governance. In April 2013, they selected a HIE vendor. Dr. Silva indicated during the interview that the MetroChicago HIE platform will support care coordination efforts. The HIE will have functionality to support Direct messaging, event notification for primary care providers, results routing, referral management, and eventually population management, analytics and case management.

Allscripts Care Management System and Web Referral

To communicate with LTSS providers, LTPAC providers and some community partners, Rush uses the Allscripts Care Management application for communication/referrals with community partners. The secure communication includes non-structured messages and attachments for information such as demographics, financials, services recommended, medication information, equipment needed and limited clinical information related to care needs. Subscribers have full access to

information exchanged while non-subscribers could access some minimal limited amount of information. For providers who have the Allscripts EHR program, some information such as demographics can be integrated/populated into the EHR application. Otherwise information must be printed and scanned or re-entered into the EHR application. Users of the Allscripts Care Management application find that it has significantly helped with the timely transfer of information to support transition of care. However, communication is not bi-directional. Information is sent only one way from the hospital. Some of the challenges of the system include the limited content exchanged and the cost for community partners to subscribe.

About 80% of patients are not in the Rush network of providers (or preferred partners) who use Epic and/or Allscripts Care Management, resulting in the majority of communication around transitions occurring by phone, faxing and e-mail.

Health Information Exchange Information Flow

Table H-1 describes the information exchange activities for Rush and their LTSS services as they coordinate transition planning services. The exchange scenarios are not limited to electronic exchange.

HIT Standards Used

It was not possible to determine the level or type of health information technology (HIT) standards used to facilitate exchange. Epic is a certified EHR application and therefore meets the applicable standards required for Stage 1. Allscripts Care Management does not appear to use interoperability standards (such as a continuity of care document or clinical document architecture) since content and attachments could not be incorporated. However, it appears that Health Level 7 v2 messaging standards for demographics are used to move data from Allscripts Care Management into Allscripts EHR.

HIE Related Measures

Rush did not report or discuss any specific HIE measures, but they do collect data in their EHR and other systems to track outcome measures. They have metrics related to outcomes with transition and coordination of care under the case management department, which may be related to their exchange of information:

- Rates of readmission (readmission to any hospital in 30 days over the total number of hospital discharges);
- Increased physician followup (completed visits by 30 days post-discharge);
- Increased understanding of medications and discharge POC;
- Decreased patient and caregiver stress; and
- Nursing home placement.

TABLE H-1. HIE by Care Coordination Function and Partners, Rush University Medical Center Bridge Program

Transitions of Care						
Care Coordination Function	Across Members of the Care Team Within Affiliated Organization	Between Staff in an Organization and Other Non-Affiliated Care Providers Including Community Services	Between Staff in an Organization and Patient/Family Members	Type of Exchange	Data	Sender and Receiver
Assessment/Referral						
Referral for Community Services	Patient is assessed for risk factors, discharge plans are being evaluated. A referral for LTSS evaluation is made.			<ul style="list-style-type: none"> - Access Rush EHR - Verbal - Communication during multidisciplinary team meetings - Paging/Text - Paging physicians 	<ul style="list-style-type: none"> - Epic daily reports to support transition - Risk Screen (meds, diagnosis, pain, fall risk, psychosocial needs, depression, ADLs, cognitive, etc.) - Demographics - Problem List - Medication List/Orders - H&P - Op Report - Case management notes in Maxus system (not Epic) 	Case Managers to Bridge Social Workers
		Case managers make referral to appropriate HHA provider.			<ul style="list-style-type: none"> - Demographics - Problem List - Medication - Allergies - Supplies - List/Orders - H&P - Op Report 	Case Manager to HHeA Nurse
		Case managers make referral to appropriate facility provider (e.g., SNF).		<ul style="list-style-type: none"> - Allscripts Care management - Phone - E-fax - E-mail - (Depending on Provider) 	<ul style="list-style-type: none"> - Demographics - Nurse snapshot (last 3 days of vitals, med administration, orders, diet, activity level, isolation, allergies) - Medications - Labs - Therapy Notes 	Case Manager to SNF Nurse

TABLE H-1 (continued)

Transitions of Care

Care Coordination Function	Across Members of the Care Team Within Affiliated Organization	Between Staff in an Organization and Other Non-Affiliated Care Providers Including Community Services	Between Staff in an Organization and Patient/Family Members	Type of Exchange	Data	Sender and Receiver
Referral for Community Services <i>(continued)</i>		BCCs social worker assesses patient to determine services needed. Makes referral to community service provider if need is determined and/or followup to ensure services in place--pharmacy, DME, counseling, etc.		<ul style="list-style-type: none"> - Phone - E-fax - E-mail 	<ul style="list-style-type: none"> - Demographic information - Service requests - Additional information relevant for the service requested - ADL Assessment - Mini-Mental Exam 	BCC to Home & Community Service Provider
Transfer/Admission to LTPAC/LTSS	Obtain physician order or communication for discharge, services, and/or followup.			<ul style="list-style-type: none"> - Rush EHR - Verbal Communication during multidisciplinary team meetings - Paging/Text - Paging 	<ul style="list-style-type: none"> - Physician order or--physician progress note 	Case Manager and/or BCC to Hospital Attending Physician
	Prior to discharge, a pharmacy student reviews the discharge instructions sheet & completes a pre-discharge medication reconciliation.			<ul style="list-style-type: none"> - Rush EHR 	<ul style="list-style-type: none"> - Discharge instructions - Physician orders 	

TABLE H-1 (continued)

Transitions of Care

Care Coordination Function	Across Members of the Care Team Within Affiliated Organization	Between Staff in an Organization and Other Non-Affiliated Care Providers Including Community Services	Between Staff in an Organization and Patient/Family Members	Type of Exchange	Data	Sender and Receiver
Transfer/Admission to LTPAC/LTSS (continued)		Patient transferred to HHA.		<ul style="list-style-type: none"> - Allscripts Care management - Paper printouts 	<ul style="list-style-type: none"> - Demographics - H&P - Op Report - DC Summary - Key Labs - MD Followup Contact - Advanced Directives - Physician Orders (including medications, treatments, & special skilled service orders) - Special nursing care (ostomy, wound, Catheter care, dressings, IV, trach, etc.) - Fall prevention - Rehab restorative care - Infection control/safety - Equipment/Supplies 	Hospital nursing staff to HHA Nurse
		Patient transferred to SNF.		<ul style="list-style-type: none"> - Allscripts Care management - Paper printouts 	<ul style="list-style-type: none"> - Demographics - H&P - Op Report - DC Summary - Key Labs - MD Followup Contact - Advanced Directives - Physician Orders (including medications, treatments, & special skilled service orders) - Special nursing care (ostomy, wound, Catheter care, dressings, IV, trach, etc.) - Fall prevention - Rehab restorative care - Infection control/safety - Equipment/Supplies 	Hospital nursing staff to facility Nurse

TABLE H-1 (continued)

Transitions of Care						
Care Coordination Function	Across Members of the Care Team Within Affiliated Organization	Between Staff in an Organization and Other Non-Affiliated Care Providers Including Community Services	Between Staff in an Organization and Patient/Family Members	Type of Exchange	Data	Sender and Receiver
Discharge from LTPAC to Another Provider		Patient transferred from facility back to hospital.		– Paper	– Transfer Form – Recent narrative progress notes – Copies of MAR – DNR order	Facility Nurse to hospital
Followup Post Transfer						
LTSS Care Coordinator followup with Community Service Provider & Patient		Case Management makes followup contact within 24-48 hours on all home health & SNF transfers to assist in assuring services started, answer questions, etc.		– Phone	– Clarifies any issues/questions – Additional information shared as needed	Case Manager to HHA or Facility
		Patient Care Coordinators and/or BCCs followup with referrals made for community services.		– Phone – E-mail	– Verifies that services were delivered; follows up on issues. – Provides additional information as needed	Care Coordinator to Community Service Provider

TABLE H-2. Shared Care Information Exchange Activities

Shared Care						
Care Coordination Function	Across Members of the Care Team Within Affiliated Organization	Between Staff in an Organization and Other Non-Affiliated Care Providers Including Community Services	Between Staff in an Organization and Patient/Family Members	Type of Exchange	Data	Sender and Receiver
Assess Needs and Goals						
Admission Physician Visits/Evaluation (NH)		Rush physician & NP visit SNF patient 2 times during first week after admission & weekly until stable.		<ul style="list-style-type: none"> - On-site access to facility medical record - Electronic access to Rush EHR as needed 	<ul style="list-style-type: none"> - Order - Medications - Progress Notes 	Rush physician/NP & SNF Nurse
Create and Maintain Plan of Care						
Care Management/ CCT Meetings		Weekly case management meetings between Rush & HHA Provider.		<ul style="list-style-type: none"> - Sharing information on key indicator/risk data - Verify protocols followed from PERFECT 	- PERFECT form	Rush Care Coordinators, BCCs, Home Health Care Managers
<i>(continued)</i>		Quarterly meeting between Rush & Facility Provider (part of SNF Rush Coordinated Care Program).		<ul style="list-style-type: none"> - Sharing information on key indicator/risk data; verify protocols followed 		Rush Coordinated Care Director, Facility Representative, Case Management Director
Monitor, Followup, and Respond to Change						
Ongoing physician visits/ evaluation (NH)		Rush MDs & NPs visit SNF patient for regular scheduled visits & as needed to meet medical needs of patient.		<ul style="list-style-type: none"> - On-site MD access to SNF medical record - MD remote electronic access to view Rush EHR as needed. 	<ul style="list-style-type: none"> - Order - Medications - Progress Notes 	Rush MD/NP & SNF Nurse

TABLE H-3. Other Information Exchange Activities

Shared Care						
Care Coordination Function	Across Members of the Care Team Within Affiliated Organization	Between Staff in an Organization and Other Non-Affiliated Care Providers Including Community Services	Between Staff in an Organization and Patient/Family Members	Type of Exchange	Data	Sender and Receiver
Mandatory Reporting						
Elder Abuse Reporting		Elder Abuse Reporting by Rush Partner Aging Care Connection		– Electronic reporting to State Agency	– As defined by state	Aging Care Connections Coordinator to State Agency.

Barriers and Opportunities for Improved Health Information Exchange Practices

Over the course of the two-day site visit, a number of issues were identified related to information exchange in support of care transitions and engagement of LTSS programs. Rush staff and community partners interviewed offered observations on both barriers and opportunities to improvement in improved HIE, communication and coordination practices.

Barriers

- Need for an HIE Network Available to All Community Partners:
 - The lack of a referral application (that is affordable to all) to share information between the hospital and next care providers is a significant issue since 80% of Rush’s discharges do not go to a provider within the system (or a preferred provider). Allscripts Care Management has been very helpful, but its use is limited to certain providers (i.e., those who have chosen to invest/acquire this software). Allscripts Care Management is also limited because it does not allow bi-directional communication. Clinicians report a need for an electronic system that would allow routing of transition in care/shared care information to additional non-affiliated provider types.
 - The Chicago-area HIE has not considered how to engage community partners such as home and community service providers in the HIE. They are planning for supporting transition of care processes with providers such as HHAs and nursing facilities, but had not identified community service providers as target for the HIEO.
 - Home and community service providers find it a barrier that they cannot electronically access information from other providers EHRs, medical records, or client service records for implementation of services, assessment and care planning activities. Information (such as a mini-mental exam) completed by the various providers, if electronic and available on an HIE, would provide valuable information and reduce duplication.
 - An HIEO could provide the foundation for a longitudinal (community) care plan that would be invaluable for communicating patient goals and coordinating services across multiple care providers. Providers would have important information available reducing the need to “start from scratch” with each encounter, streamlining communication and aligning services.

- Need to Redefine Traditional Case Management and Recognize Care Coordination Roles:
 - The traditional view of case management from a hospital discharge perspective needs to change to achieve a patient-centered approach to coordination and collaboration that extends beyond discharge, engages community partners and helps to support the patient in meeting their health care goals.
 - Rush representatives expressed a concern that current payment models did not cover care coordination/case management roles needed by some patients and include the provision of LTSS programs and HCBS. They saw an opportunity as new care delivery and payment models emerged (such as ACOs).
 - There were concerns expressed about the limited understanding of the importance of partnering and including LTSS and HCBS services in new payment models. Inclusion of LTSS and HCBS is beginning to emerge in some ACOs as a strategy to manage costs and improve outcomes.

Opportunities

- Balancing the Amount of Information Sent Versus Information Needed:
 - Senders and receivers of information are often challenged to get the right information and the right amount of detail to support their clinical purpose. Either too much information is sent creating an overload for the receiving provider (“sleuthing”) or too little information is sent -- it is often all-or-nothing. Redundant data is also common. Staff would like to see a portal that would allow a receiver to control the amount and type of information they can access to support the transition and shared care processes. This would be addressed with an HIE if it includes the information needed by receiving providers. Depending on its structure and governance, this request could be accommodated via the forthcoming Chicago-area HIE.
- Development of Standardized Reports:
 - HIE tools such as Allscripts Care Management currently do not have standardized reports that for tracking and trending of data based on clinical content, risk assessment tools or other reporting requirements between Rush and their community partners.
 - Rush Case Management Department is talking to Epic about developing standard reports for their referral sources. Currently the capability is not available.

- Integration of LTSS Needs in a Patient-Centered POC:
 - Early screening and identification of patients who may require LTSS is crucial. The lack of consistent screening across all relevant admissions can be problematic. Hospitals could address this by implementing a screening tool of the psychosocial elements and risk factors to determine early during a hospital stay which patients may need services. Establishing a care plan prior to discharge is crucial to ensuring appropriate services are set up and consistent with the discharge and teaching plans. This is very challenging when the referral is made after discharge. Similarly, implementation of such screening tools and shared care planning mechanism prior to a hospital stay; for example, in emerging service delivery reform models (e.g., ACOs) might also improve care and decrease costs.
 - Community care coordinators/social workers often establish a community care plan, but it is not integrated with a larger plan for the patient. A patient may have many care plans established by various providers that are not coordinated or reconciled with each other.
 - A sustainable vision for aging and disability services is needed that includes improved integration.

Conclusion

Rush has developed a number of programs and processes to improve care transitions and coordinate with community providers. Their LTSS programs are integrated into interdisciplinary teams and community providers are engaged in the discharge planning process. Almost all of the participants in the transition process report an opportunity for improved communication and efficiency through technology. Some tools such as Allscripts Care Management have been helpful in facilitating information exchange, but they are not consistently applied across all community providers and services. Coordination and deployment of services is at the heart of the LTSS programs at Rush. Staff spend a significant time with communication tasks (making calls, followup, sending faxes, verifying receipt) to share information with service providers. Technology and improved tools could be beneficial in supporting the work of LTSS providers.

Attachment H-1. PERFECT Form

Patient Name: _____ Discharge Date: _____ SOC Date: _____

Home Health Agency: _____ SOC RN Contact #: _____

HH Case Manager Contact # (if different): _____ Telemonitoring Available? Yes No

The **PERFECT Form** is a communication and accountability tool developed to encourage collaboration after hospital discharge between home health partners and the clinical team at RUSH. The information provided by the admitting RN in the field provides a critical snapshot of the patient in their home environment and helps us define care expectations for a successful transition from hospital to home.

How to use the PERFECT form:

- Please check **yes** or **no** for each of the care expectations listed
- Utilize the interventions column as a guide for addressing problem areas
- Use the comments section to provide any additional information
 - Actions taken to resolve a problem
 - Additional information about a situation
- Please contact Madeleine Rooney, MSW at RUSH at 312-942-6995 within 48 hrs. if any issues remain unresolved **or if any delay in care is present**
- Fax completed form to 312-563-6548 within 72 hrs. of admission to the agency
- Attach additional comments on separate pages as needed

Hand off communication is essential to assure quality coordination of care.

	Care Expectations	Interventions	Additional Information
PLAN OF CARE	<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Plan of care discussed with pt. & family/consent for care signed? 	<ul style="list-style-type: none"> • Plan reviewed with pt/family • Schedule left with pt/family 	Note any special orders: <hr/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Health literacy issues identified at SOC? 	<ul style="list-style-type: none"> • Emergency contact info provided • Teaching initiated for at risk Dx. • BRIDGE MSW contacted to discuss health literacy concerns &/or scheduling barriers 	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Barriers to scheduling visits present? 	<ul style="list-style-type: none"> • Interdisciplinary communication established 	
EQUIPMENT/SUPPLIES	<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Provided within expected timeframe? 	<ul style="list-style-type: none"> • Dressings &/or supplies provided at initial visit 	DME Provider#: <hr/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Additional DME needs? 	<ul style="list-style-type: none"> • Teaching initiated • Pre-discharge equipment obtained 	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • Telemonitoring needed? 	<ul style="list-style-type: none"> • Post D/C DME ordered 	

Patient Name: _____

	Care Expectations	Interventions	Additional Information
RECONCILIATION OF MEDICATIONS	<input type="checkbox"/> Yes <input type="checkbox"/> No • Pt has dc instructions?	• BRIDGE MSW contacted to fax dc instructions	Pharmacy #: _____ Who fills the pillbox? _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No • D/C list match meds found in home?	• Meds reconciled	
	<input type="checkbox"/> Yes <input type="checkbox"/> No • RN contacts patient w/in 24 hrs-missing meds obtained	• At risk meds identified	
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Pt. able to obtain meds w/out barriers?	• Teaching initiated	
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Pillbox in home?	• Provide Pillbox	
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Are medications adequately managed?	• Missing meds obtained/reported to MD and BRIDGE MSW w/in 1 day	
FOLLOW UP MD	<input type="checkbox"/> Yes <input type="checkbox"/> No • MD appt scheduled within 10 days?	• Confirm pt's MD follow-up appt & plan to attend	PCP #: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Can pt physically get to the appt?	• Notify BRIDGE MSW of scheduling or transportation barriers	MD Appt: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Is transportation available for f-up appt.?	• Arrange Home Physician as needed	MD Appt: _____
EXPECTATIONS	<input type="checkbox"/> Yes <input type="checkbox"/> No • Is patient satisfied with discharge plan and services provided?	• 48 hour quality assurance call completed	
CAREGIVER & SUPPORT	<input type="checkbox"/> Yes <input type="checkbox"/> No • Is primary caregiver available?	• Assess caregiving stressors	Caregiver: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Community resources needed?	• CNA ordered	Pt Support: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No • Were community resources arranged prior to d/c?	• MSW ordered	Contact#: _____
THERAPY	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> None	<input type="checkbox"/> Therapies provided w/in 72 hrs unless otherwise ordered? <input type="checkbox"/> Contact MD if additional orders needed	

Was RN visit performed 24 hrs post D/C? Yes No (check reason below)

- | | | |
|---|---|---|
| <input type="checkbox"/> Patient/family declines care | <input type="checkbox"/> Unsafe environment | <input type="checkbox"/> Family refuses out of network co-pay |
| <input type="checkbox"/> Care exceeds capacity | <input type="checkbox"/> No skilled need | <input type="checkbox"/> Patient re-hospitalized before first visit |
| <input type="checkbox"/> Unable to locate patient | <input type="checkbox"/> Patient not discharged from hospital | <input type="checkbox"/> Insurance out of network |
| <input type="checkbox"/> Cancelled by referral source | <input type="checkbox"/> Another agency providing services | <input type="checkbox"/> Referred to another agency |

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

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

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

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

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>