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

TABLE K-1. HIE Activities for Transitions of Care					
Transitions of Care					
Care Coordination Function	**Between Members of a Care or Service Team Within or Across Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Assessment/Referral					
Preadmission Assessment	Preadmission assessment process to gather information to evaluate the patient for appropriateness of admission & obtain clinical, demographic & financial information for communication with care team.		– In-person participation in discharge planning rounds – Telephone communication – Access to hospital EHR – Fax – Secure e-mail	– Demographic – Problem list – Medication list – Allergies – Progress notes (e.g., 3 days of narrative notes) – Vitals – Isolation precautions – Diet – Activity level – Labs – H&P – Operative reports – Relevant assessments/ evaluations including therapy, cognitive function, physical function – Supplies	Discharge planner/case manager hospital nurse manager exchanges information with LTPAC Admission Coordinator/ Liaison
Referral for Community Services	LTSS Care Coordinators assess patient needs, work with hospital discharge team, & identify HCBS that would assist the patient in a successful transition.		– In-person participation in discharge planning rounds – Telephone communication – Access to hospital EHR – Fax – Secure e-mail	– Patient goals & POC – Demographic & payer information – Cognitive (e.g., mini-mental exam) & functional status (e.g., ADL assessment) – Other referral information/forms needed by community services provider	LTSS Care Coordinator to community service provider
Patient input on Community Services		LTSS Care Coordinator obtains information from the patient on their discharge & HCBS plan/ preferences as well as past services utilized & successes.	– In-person face-to-face – Telephone – E-mail	– Patient goals & plan – Past services utilized & service providers	Patient/representative & LTSS care coordinator

TABLE K-1 (*continued*)					
Transitions of Care					
Care Coordination Function	**Between Members of a Care or Service Team Within or Across Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Transition of Care (transfer or discharge)					
Transfer/ Admission to LTPAC	Hospital or discharging organization provides information to transfer care to the LTPAC provider.		– Paper hard-copy – Fax/e-fax – Secure e-mail – HIEO	– Order for discharge to the LTPAC provider – Transfer summary – Medication orders – Treatment orders – Key lab results – Discharge summary – Recent progress notes – Updated MAR – Special nursing care instructions (e.g., ostomy, wound, catheter care, dressings, IV, trach, etc.) – Fall prevention – Rehab restorative care – Infection control/safety – Equipment supplies – Advanced directives and/or DNR order – Followup care contact information	Transferring provider (e.g., hospital) to LTPAC provider (admission/intake coordinator and/or nursing staff)
Transfer to Hospital from LTPAC	LTPAC organization transfers patient to hospital.		– Paper hard copies – Fax/e-fax for followup information – Hospital EHR and/or other referral applications	– Transfer summary which includes diagnosis/ problems, medication orders, treatment orders, allergies, vital signs, functional & cognitive assessment data – Pertinent recent labs – Recent narrative progress notes – Copies of current MARs – Advanced directive/DNR order	LTPAC provider (nursing staff) to hospital ED (typically sent with ambulance provider)

TABLE K-1 (*continued*)					
Transitions of Care					
Care Coordination Function	**Between Members of a Care or Service Team Within or Across Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Discharge from LTPAC to Another Provider	LTPAC organization discharges patient to another health care provider (e.g., another LTPAC provider).		– Paper hard copies – Fax/e-fax for followup information – Secure e-mail	– Transfer summary which includes diagnosis/ problems, medication orders, treatment orders, allergies, vital signs, functional & cognitive assessment data – Pertinent recent labs – Recent narrative progress notes – Copies of current MARs – Advanced directive/DNR order – Pertinent assessments such as MDS or OASIS	LTPAC provider (nursing staff) to other provider (typically nursing staff)
Discharge Information from LTPAC Provider to Patient		When patient is discharging home or discontinuing home health services, the LTPAC provider develops a POC & instructions for the patient.	– Paper hard-copy	– Discharge POC & instructions (medications, self-care instructions, followup care)	LTPAC provider to patient/caregiver
Discharge from LTPAC with Referral to Community Service Provider(s)	For patients discharging from LTPAC who requires community services, the LTPAC provider may followup.		– Phone – Fax/e-fax – Secure e-mail	– Patient goals & POC – Demographic & payer information – Cognitive (e.g., mini-mental exam) & functional status (e.g., ADL assessment) – Other referral information/ forms needed by community services provider	LTPAC provider to community service provider
ADT Event Data to HIE Network	ADT message to HIE to communicate admissions & discharge information. HIEs may use these messages to notifying other treatment providers of an ADT.		– Electronic message	– ADT message	LTPAC to HIE

TABLE K-1 (*continued*)					
Transitions of Care					
Care Coordination Function	**Between Members of a Care or Service Team Within or Across Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Followup Post Transfer/Discharge					
LTSS Care Coordinator followup with Community Service Provider & Patient	LTSS care coordinator follows up with community provider to ensure services were started & assess progress.	LTSS care coordinator follows up with patient/ caregiver to ensure services were delivered, assess progress, & determine if changes are required.	– Phone – E-mail	– Service delivery – Additional information as needed	Care coordinator to community service provider & patient

TABLE K-2. HIE Activities for Shared Care					
Shared Care					
Care Coordination Function	**Between Members of a Care or Service Team in Either an Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Assess Needs and Goals					
Initial Assessments & Development of Admission Plan	Nurse, therapist & other interdisciplinary team members assesses patient & develops & admission POC.		– Review hospital/ other provider records sent at transfer of care (paper printouts, scanned images on network drives). – HIEO – Telephone (care managers)	– Discharge summary – H&P – OP report – Recent labs – Summary of care records – Past assessments	Nurse, therapist and/or other members of interdisciplinary team to Hospital/physician nurse or care managers.
Coordination with physician at Start of Care including Medication Reconciliation & Orders, Evaluation/ Certification & Plan of Care	Review admission transfer form & identify physician orders. Complete medications reconciliation of pre-hospital medication regime with post-hospital medications with attending physician to determine LTPAC plan. Develop POC (home care) & therapy evaluation/certification (SNF).		– Phone – Fax – Mail – HIEO to assist with medication history – Physician portal to LTPAC EHR for signature	– LTPAC physician orders or home care POC (485) – Therapy evaluation/ certification (SNF)	LTPAC Nurse and/or therapist to Attending physician for review & signature
Communicate Physician Orders & Medications to Pharmacy (SNF & hospice)	Communicate admission orders & medications to pharmacy.		– Pharmacy communication protocol	– Complete orders	LTPAC nurse to pharmacy
Communicate orders for labs, radiology & special tests to service provider & return of test results	Communicate lab, radiology & other specialized test orders to provider & return of results.		– Phone – Special portal/protocol as specified by service provider – Results delivered based on method established with provider via mail, fax, dedicated printer, through HIE, etc.	– Order – Diagnosis – Patient demographics (face sheet) with payer information – Test result report	LTPAC nurse or to service provider Results returned to LTPAC nurse from service provider
Admission Physician Visits/ Evaluation (SNF)	Attending physician and/or NP visit nursing facility patient after admission (within 3o days or more frequently as determined by organization protocol & patient condition).		– On-site access to facility medical records – Electronic access to hospital/IDS EHR – Access to HIE Network	– Order – Medications – Progress notes – Past medical history data – Physician progress note developed at time of visit	LTPAC Facility Nurse & attending physician/NP

TABLE K-2 (*continued*)					
Shared Care					
Care Coordination Function	**Between Members of a Care or Service Team in Either an Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Request for additional medical record information from hospital to assist with admission assessment & care planning process	LTPAC interdisciplinary team request additional information from hospital to complete an assessment.		– Written request for information from hospital if not available through other means (e.g., authorized access to hospital EHR or through an HIEO)	– Request based on what was not available & sent at time of transfer. – Information requested may include the discharge summary, operative report, final lab results, special assessments/ evaluations.	LTPAC HIM to hospital
Communication with patient and/or family/caregiver for additional information & advanced directives		LTPAC interdisciplinary team interview patient/ family for information to complete initial assessment & determine goals for the development of the care plan	– In-person interview – Phone	– Advanced directives – Goals, past history (e.g., medical, social, functional, cognitive)	LTPAC interdisciplinary team to patient and/or family/caregiver
Create and Maintain Plan of Care					
Create & Maintain Patient's Plan of Care & Orders	Develop & maintain patient's interdisciplinary POC & physician orders. Reviewed by physician & signed if required.		– Mail – Fax – Physician Portal to LTPAC EHR	– Care plan – Physician order recap (SNF)	Nursing to attending physician
Care Plan Update with Patient/Family		LTPAC interdisciplinary team updates to patient & family POC.	– In-person participation in care conference or communicated at home care visit – Phone – Mail	– Care plan	LTPAC representative (e.g., nurse, therapist, social worker to patient and/or family
Care Management/ Community Care Team Meetings	Regularly scheduled care management meetings between all care managers including LTPAC providers (e.g., primary care managers for PCMH, hospital case managers, CCT managers, LTPAC care managers).		– Sharing information on key indicator/risk data – Verify protocols followed	– Patient status information – Recent test results – Vitals – Telehealth monitoring data	Care managers from different organizations within affiliated organization
Monitor, Followup, and Respond to Change					
Transmission of telehealth data from patient		Transmit telehealth data each day from patient home to telehealth nurse for monitoring and/or followup.	– Electronic transmission from telehealth device to base station to cloud-based application.	– Blood pressure – Weight – Blood sugar – Pulse – O2 saturations – Responses to individualized questions	Patient Telehealth Nurse

TABLE K-2 (*continued*)					
Shared Care					
Care Coordination Function	**Between Members of a Care or Service Team in Either an Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Routine physician order review & recertification	Regular review & update of physician orders, home care POC/recertification, and/or therapy recertification.		– Paper copies available for review & signature (mailed or maintained on-site if applicable – Physician Portal to LTPAC EHR	– Physician order recap (SNF) – Home care POC/recertification – Therapy recertification (SNF)	LTPAC nursing and/or therapist to attending physician review & signature
Change in condition/status update and/or order change request to attending physician	Change in condition, status updates with or without order changes.		– Phone – Fax – Text – Secure e-mail – Physician Portal to LTPAC EHR for order signature	– Physician orders – Lab & other test results – Summary of condition changes	Nursing and/or therapist to physician. Physician signature for order changes.
Communicate Physician Orders changes to pharmacy & order medications (SNF & hospice)	Communicate order changes & medications to pharmacy as applicable to setting.		– Phone – Fax – Pharmacy web portal/ dedicated terminal	– Patient identification – Medication and/or other physician order content (e.g., drug, dose, route, frequency, timeframe, date, physician)	LTPAC nurse to pharmacy
Pharmacy printing & delivery of monthly physician order recap, medication & treatment administration records	When pharmacy provides the patient's monthly physician order recap, MAR & treatment record forms to LTPAC providers (e.g., SNFs), the forms are sent at the end of each month for the next month.		– Forms mailed, delivered or sent by courier	For each patient: – Monthly physician order recap – Monthly MAR – Monthly treatment administration record	Long-term care Pharmacy to LTPAC provider where applicable (e.g., some SNFs that use the pharmacy to provide this information)
Change in Condition/Status update to Patient/ Family/Caregiver		Change in condition, status updates & order changes communicated to patient and/or family/ caregiver.	– Phone – E-mail	– Summary of change, results, & plan	Depending on topic: nursing, therapy, social service or other interdisciplinary team member to patient/family
Ongoing physician visits/evaluation (SNF)	MD/NP visit facility patient for regular scheduled visits & as needed to meet medical needs of patient.		– On-site access to facility medical record – Electronic access to Rush EHR as needed.	– Order – Medications – Progress Notes	MD/NP & LTPAC nurse
Specialist visit/evaluation (SNF)	Specialist visit (surgeon, neurologist, dentist, psychologist, etc.).		– Copies sent with patient – Mail – Phone	– Referral – Medication list or administration record – Face sheet	LTPAC nurse to Specialist

TABLE K-2 (*continued*)					
Shared Care					
Care Coordination Function	**Between Members of a Care or Service Team in Either an Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Order changes for lab, radiology & special tests & return of test results	Request new lab or radiology/ ultrasound or other specialized test & return of results.		– Phone – Special portal/protocol as specified by service provider – Results delivered based on method established with provider via mail, fax, dedicated printer, through HIE, etc.	– Order – Diagnosis – Patient demographics (face sheet) with payer information – Test result report	LTPAC nurse or to service provider. Results returned to LTPAC nurse from service provider
Referral to Community Care Team (home care if available)	Referral to CCT if patient is not meeting goals & additional services are needed.		– Phone	– Progress notes – POC	Home care nurse to manager to CCT manager

TABLE K-3. Other Health Information Exchange Activities					
Other					
Care Coordination Function	**Between Members of a Care or Service Team in Either an Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Quality Measure Reporting					
Electronic submission of mandatory data sets which includes quality measures	Submission of mandatory assessment data sets which includes CMS required quality measure data.		– Electronic submission via CMS required portal	– OASIS – MDS – Required Hospice Data	LTPAC provider to CMS
ACO Measures	ACO required measure reporting from all ACO partner organization whether (both affiliated & non-affiliated organizations).		– EHR and/or Electronic excel spreadsheet	– 33 Pioneer ACO Measures	LTPAC provider to ACO data repository
Mandatory Reporting					
Public health & state registries for reportable conditions	Reportable event data such as immunization data to public health authority as required.		– As defined by public health authority & states	Examples: – Immunization result data – Diabetic test results for diabetic registry (if required)	LTPAC provider to public health authority and/or state registries
Elder Abuse Reporting	Required elder abuse reporting if concerns identified.		– Electronic reporting to state agency/authority	– Data as defined by state	LTPAC/LTSS representative to state agency
Payment					
Eligibility Determinations with Payer	Eligibility determinations & utilization review for Medicaid through HIEO, accesses state Medicaid provider database & patient database.	Portals. MMIS.	– Phone – Web portal	– Demographic & payer – ID data – MMIS – Assessments – Care plans – Service delivery	LTPAC contacts payer to verify eligibility when required Medicaid officials LTSS provider
Communication with Payer Case Manager	LTPAC clinical liaison provides updates to payers regarding initial & continued coverage.		– Phone – Fax – Mail	– Medical record information relative to coverage	LTPAC clinical liaison to payer case manager
Communication with Patient/ Representative of Medicare Coverage Ending		LTPAC provider liaison notifies the patient/ representative in writing with the Medicare end of coverage date & reason along with their appeal options. Telephone and/or in-person discussions may occur to understand the coverage decisions.	– Mail notification letter – Phone or in-person for further discussion	– Letter notifying patient/ representative that Medicare coverage will end, reasons & appeal process.	LTPAC liaison (e.g., Medicare Nurse) to Patient/Representative notifying them of coverage ending date & reason.

TABLE K-3 (*continued*)					
Other					
Care Coordination Function	**Between Members of a Care or Service Team in Either an Non-Affiliated or Affiliated Organization**	**Between Staff in an Organization and Patient/Family Members**	**Type of Exchange**	**Data**	**Sender and Receiver**
Payer Medical Record Requests	Remittance, medical review, or RAC request for medical records.		– Electronic billing system – Fax – Mail	– Relevant medical record documentation	LTPAC HIM & billing to payer

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