HealthIT.gov
National Learning Consortium
Advancing America's Health Care

Care Coordination Tool for Transition to Long-Term and Post-Acute Care

Provided by

The National Learning Consortium (NLC)

Developed by

Health Information Technology Research Center (HITRC)

Contents

List of Exhibits

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and resources designed to support healthcare providers and health IT professionals working towards the implementation, adoption and Meaningful Use (MU) of certified Electronic Health Record (EHR) systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs (REC, Beacon, State HIE) and through the Health Information Technology Research Center (HITRC) Communities of Practice (CoPs).

The following resource can be used in the field today by "boots-on-the-ground" professionals, to support eligible professionals (EPs) and eligible hospitals (EHs) in care coordination for patients transitioning to long-term and post-acute care (LTPAC) settings.

Background

With the advent of the Medicare and Medicaid EHR Incentive Programs, EHR and HIE adoption by EPs and EHs has increased. However, incentive payments for adoption of certified EHR technology in ambulatory and acute care hospitals under ARRA HITECH do not currently extend to LTPAC settings. As a result, while the use of EHRs and HIE adoption is not widespread in LTPAC settings at present, almost all nursing home, home health, and inpatient rehab providers have the HIT capacity to capture and transmit standardized assessments for payment and quality reporting. That said, EPs and EHs who strive to meet Stage 2 Meaningful Use still may share patient information and coordinate care with LTPAC providers during transitions of care or referrals. In addition, emerging payment and delivery system changes driven by the Patient Protection and Affordable Care Act (ACA) will reward providers for demonstrating improved care coordination, quality, and reduced costs.

LTPAC providers deliver care to the highly vulnerable including the elderly, frail, and disabled. LTPAC patients typically have a wider range of conditions and more complex, chronic care needs that result in frequent transitions between their homes, acute, post-acute, and long-term care settings. In 2008, almost 40 percent (38.7%) of all Medicare beneficiaries discharged from acute-care hospitals received post-acute care. Of these beneficiaries, 15.5 percent were readmitted to the acute care hospital within 30 days[1].The range of LTPAC providers and care settings, and the frequent movement of patients among them, necessitates the exchange of relevant, timely care data. Care coordination ensures continuity of care and services needed for the recovery, rehabilitation, and health maintenance of the patient, and helps to reduce duplication of care services, conflicting health plans and medical errors and rehospitalizations that lead to cost savings. Coordination of care is essential, as is the need for systems to support information capture, use and exchange.[2]

As frequent providers of services for LTPAC patients, EPs and EHs need to work closely with LTPAC providers in

1 http://aspe.hhs.gov/health/reports/2011/pacexpanded/index.shtml

2 Long-Term and Post-Acute Care (LTPAC) Roundtable Summary Report of Findings.

Benefits of Care Coordination

- Improved quality of care and safety during transition
- Reduction in duplication of services
- Reduction in 30-day readmissions
- Reduction in ER visits
- Reduction in health care costs

coordinating care using the best practices from Meaningful Use Care Coordination specifications. When EPs/EHs support and customize care coordination, at the time of transition to LTPAC providers, patients receiving LTPAC services require fewer emergency room visits and readmissions resulting in lowered health care costs.

Description and Instruction

The Care Coordination Tool for Transition to Long-Term and Post-Acute Care (LTPAC) is designed to inform EPs and EHs of key clinical information for inclusion in summary of care records when transitioning patients to LTPAC facilities, specifically; nursing home, inpatient rehabilitation facility (IRF), home health, long-term care hospital and hospice. A transition of care is defined as the movement of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another, or from one EP to another. At a minimum, transitions of care include first encounters with a new patient and encounters with existing patients, where a summary of care record (of any type) is provided to the receiving provider. The summary of care record can be provided either by the patient or by the referring/transiting provider or institution.

This tool is intended for EPs and EHs use in determining pertinent content for summary of care records when transitioning patients to LTPAC within the context of Meaningful Use Stage 1 and Stage 2 Transitions of Care requirements. The suggested items for inclusion, identified by LTPAC providers, will enable maintenance of patients' quality of care and safety during transitions. This resource also includes the requirements for Stage 1 and Stage 2 Meaningful Use Transitions of Care and links to additional toolkits related to Summaries of Care and Medication Reconciliation.

1 Meaningful Use Transition of Care Requirements

1.1 Stage 1 (Menu Measure 8)

Measure

The EP, EH or critical access hospital (CAH) that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than *50 percent* of transitions of care and referrals.

1.2 Stage 2 (Core Measure 15) *Must Complete All 3 Measures*

Measure 1

Same as Stage 1 measure; provide summary of care for more than *50 percent* of transitions of care or referrals.

Denominator

Number of transitions of care and referrals during the EHR reporting period for which the EP, EH or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

Numerator

The number of transitions of care and referrals in the denominator where a summary of care record is provided.

Measure 2

The EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than *10 percent* of such transitions and referrals either:

- By electronically transmitting using Certified EHR Technology (CEHRT) to a recipient;

OR

- Where the recipient receives the summary of care record via exchange facilitated by an organization that is an NwHIN[3] Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

Denominator

Number of transitions of care and referrals during the EHR reporting period for which the EP, EH or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

Numerator

The number of transitions of care and referrals in the denominator where a summary of care record was:

a. Electronically transmitted using CEHRT to a recipient.

b. Where the recipient receives the summary of care record via exchange facilitated by an organization that is an NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

NOTE

To count in the numerator of measure 2, the summary of care record must be received by the provider to whom the sending provider is referring or transferring the patient.

Measure 3

An EP, EH or CAH must satisfy one of the two following criteria:

- Conducts one or more successful electronic exchanges of a summary of care document, which is counted in measure 2, with a recipient who has EHR technology designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2);

OR

- Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
- Attestation requirement: YES/NO measure.

NOTE

Summary of Care data requirements for Stage 2 are listed in Exhibit 1.

3 *NwHIN is now known as eHealth Exchange.*

EXHIBIT 1

MU Stage 2 Objective-Specific Data Requirements for EPs

- Patient name
- Demographic information (preferred language, sex, race**, ethnicity**, date of birth)
- Current medication allergies list**
- Current medication list**
- Current problem list (EPs or hospitals may also include historical problems at their discretion)**
- Care plan field, including goals and instructions
- Laboratory test results**
- Procedures**
- Smoking status**
- Vital signs (height, weight, blood pressure, BMI)
- Referring or transitioning provider name & office contact information (EP only)
- Reason for referral (EP only)
- Encounter diagnoses**
- Functional status including (activities of daily living, cognitive and disability status)
- Immunizations**
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Discharge instructions
- Vital signs (height, weight, blood pressure, BMI)
- Referring or transitioning provider name & office contact information (EP only)
- Reason for referral (EP only)
- Encounter diagnoses**
- Functional status including (activities of daily living, cognitive and disability status)
- Immunizations**
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Discharge instructions

*** Data requirements marked with a double asterisk also have a defined vocabulary which must be used.*

NOTE

The three fields below cannot be blank. Information on these three fields could be obtained from previous records, transfer of information from other providers, diagnoses made by the EP or hospital, new medications ordered by the EP or hospital or through querying the patient.

- Current problem list
  - *At a minimum a list of current, active and historical diagnoses. We do not limit the EP to just including diagnoses on the problem list.*
- Current medication list
  - *A list of medications that a given patient is currently taking.*
- Current medication allergy list
  - *A list of medications to which a given patient has known allergies.*

NOTE

If the patient has no current or active diagnoses, is not currently taking any medications, or has no known medication allergies, confirm that there are no problems, the patient is not on any medications, or does not have medication allergies.

NOTE
Care Plan is defined as the structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

NOTE
In order to meet this objective and measure, the EP, EH or CAH must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (g)(1), and (g)(2).

For step-by-step guidelines and activities to meet these Meaningful Use requirements for Care Transition Summary please review the complete toolkit at http://hitrc-collaborative.org/meaningful-use/resources/care-transition-summary-toolkit-eligible-professionals

1.3 Definition of Terms

eHealth Exchange
Formerly known as the Nationwide Health Information Network (NwHIN), eHealth Exchange uses a set of standards, services, and policies that enable secure health information exchange over the Internet. It provides the foundation for secure exchange of health information across diverse entities, within communities and across the country, helping to achieve goals of the HITECH Act. This will enable health information to follow the consumer, be available for clinical decision-making, and support appropriate use of healthcare information beyond direct patient care to improve population health. The eHealth Exchange uses CONNECT, an open-source software program that supports health information exchange. Healtheway is a nonprofit, public-private partnership that serves as the business arm of the eHealth Exchange.

Health information exchanges (HIEs)
Mobilization of healthcare information electronically across organizations within a region, community or hospital system. HIE provides capability to electronically move clinical information among disparate healthcare information systems while maintaining meaning of the information being exchanged. Goal of HIE is to facilitate access to and retrieval of clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care. HIE is also useful to public health authorities to assist in analyses of the health of the population. In 2010, the Office of the National Coordinator for Health IT (ONC) established a State HIE Cooperative Agreement program in 56 states and territories to rapidly build capacity for exchanging information both within and across states.

2 Key Summary of Care Information for Transition to LTPAC

2.1 Universal Summary of Care Items for Transition to LTPAC

Caregivers in LTPAC settings need specific information about patients who are transferring, in addition to the required Summary of Care data for Meaningful Use 2. The items listed in Exhibit 2 are data identified as important information for inclusion in Summary of Care records when transitioning patients to Nursing Homes, Long Term Care Hospitals, Skilled Nursing Facilities, Inpatient Rehabilitation Facilities or Home Health. The items are suggested for inclusion in Summary of care documents when transitioning patients to any of these LTPAC settings.

EXHIBIT 2

List of Transfer of Care items for Transition to LTPAC

Demographics	• Name* • Gender* • Race* • Ethnicity* • Preferred Language* • Date of birth*	• Contact information for clinician at sending site who is available to answer questions • Referring or transitioning provider and contact information* • Receiving Clinician and contact information*
Patient Specific Medical Information	• Allergies • Diet • Current active clinical conditions • Past medical history • Social history • Chief complaint • Precautions or alerts (fall, seizure,)	• Reason for transfer • History of present illness* • History of major surgeries • Hospital admissions in past 12 months • Issues requiring ongoing management • Isolation • Physician signed Plan of Care (for Assisted Living facilities)
Physical Findings	• Vital signs* • O2 saturation	• Pain scale • Mental status at discharge
Cognition*	• Memory • Orientation • Concentration	• Judgment • Altered level of consciousness/ alertness • Acute onset of mental status change

EXHIBIT 2

List of Transfer of Care items for Transition to LTPAC *(continued)*

Functional Status	• Mobility • ADL assistance* • Bathing • Transfers • Eating • Balance during transitions and walking • Fall risk	• Ambulation • Limitations in ROM • Mobility devices • Toileting • Continent (bowel and bladder) • Swallowing status • Limitations and disabilities*
Immunizations*	• Immunization name • Date administered	
Medications	• Allergies* • Current medication list* • Use of High-Risk Medications in the Elderly listed reviewed (recommended 2014 CQM)	• Date and time last administered • Pre-admission medication list (home medications prior to admission)
Pain Assessment and Treatments	• Pain score • Location • Medications	
Pressure Ulcers/ Skin Condition	• Location • Stage • Wound care	
Summary of Expectations for Care	• Advance directives/ Living Will Copied • Medical Power of Attorney Identified • Signed Physician Orders Transmitted › Do not resuscitate – DNR › Do not artificially ventilate (mouth-to-mouth, bag valve mask, positive pressure, etc.); › Do not administer chest compressions; › Do not administer cardiac resuscitation drugs › Do not intubate › Do not defibrillate › Do not call EMS/transfer › Do not hospitalize	

*** Data requirements marked with a double asterisk also have a defined vocabulary which must be used.*

2.2 Summary of Care Items for Specific LTPAC Settings

There is additional information needed by receiving caregivers when patients transition into certain LTPAC settings. Specific items pertinent to Home Health, Hospice and I npatient Rehabilitation Facility are listed in Exhibits 3, 4 and 5.

EXHIBIT 3

List of Transfer of Care Items Specific to Home Health

Home Health	• Name of referring physician, primary care Physician & physician managing HHA episode • D/C summary from hospital prior to SNF • Specific orders for PT/OT/ST/ Skilled • Nursing • Home health setting evaluation date • Signed face-to-face attestation form	• O2 and other supply vendor information • Were supplies ordered, quantity, anticipated delivery date • Name of identified learner for education • Caregiver support/Living arrangements • Receiving Clinician and contact information*

EXHIBIT 4

List of Transfer of Care Items Specific to Hospice

Hospice	• Preferences: › Hospitalization preferences › Spiritual/Existential	• Opioid schedule • Comfort/palliative care interventions • End of life arrangements – funeral home • Spiritual/religious point of contacts

EXHIBIT 5

List of Transfer of Care Items Specific to Inpatient Rehabilitation Facility

Inpatient Rehabilitation Facilities (IRF)	• Therapy evaluations and treatment • Prior functional status	• Prior living arrangements

3 Summary of Care Transmission Options

There are multiple ways that EPs and EHs can transmit the summary of care records to LTPAC facilities. The EP/EH selection of a transmission method may be dependent upon the sending and receiving facilities' use medical records. Transmission options suggested for EPs/EHs transitioning patients to LTPAC providers using EHRs and when EHRs are not used are presented in Exhibits 6 and 7.

EXHIBIT 6

Transmission Options for Electronic Exchange of Information

Transmission Option	Requirements	Process
Direct Secure Messaging* **Note** *Both sender and receiver must have Direct Secure Messaging addresses and know how to use Direct.*	The EP/EH transitioning the patient and the receiving LTPAC provider must have Direct Secure Messaging addresses that are obtained through a Health Information Services Provider (HISP). The summary of care record will be "pushed" from the EP/EH to the LTPAC provider in secure fashion. Start with your state or local HIE for more information on how to enroll with a HISP.	The EP/EH needs to know the receiver's DSM address and how to log in/use Direct Secure Messaging directly from their EHR or through a web portal. Your state or local HIE can help. The sender will push the summary of care record to the receiver's DSM address, similar to sending an email. DSM differs from regular email in that it is specifically designed for the secure electronic transmission of PHI.
Health Information Exchange (HIE) - Full Query* **Note** *Both sender and receiver must be participating organizations in an HIE with full query capability.*	Both the sending EP/EH and the receiving LTPAC provider must be an HIE participant that has full query capability.	If the EP/EH and the LTPAC provider both participate in a Full Query HIE, the LTPAC can query the HIE for the patient's summary of care record at any given time. HIEs have different models for how full query records are displayed, received or transmitted. In this scenario, the EP/EH transitioning the patient would not need to "push out" the summary of care record. The records are already available to participants in the HIE, unless the patient has opted out of the system.

*** Meets Measure 2: Transmit a Summary of Care Record (Stage 2 Requirement)*

EXHIBIT 7

Transmission Options When LTPAC Facility Does Not Have an EHR

Transmission Option	Requirements	Process
Fax	A secure fax at the receiving LTPAC facility.	The summary of care report may be faxed directly from the EHR to a secure fax at the LTPAC facility or the record can be printed and faxed. The faxing method will depend on the EHR system.
Provision of hard copy of summary of care record		EP/EH prints the summary of care record and gives to the patient, family or transport personnel when the patient is transferred to LTPAC.

4 Resources

EXHIBIT 8

Resources

Resource Name	URL
The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs: Stage 2 Toolkit	http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Toolkit_EHR_0313.pdf
Meaningful Use Stage 2 Summary of Care and Medication Reconciliation Toolkits	http://www.healthit.gov/providers-professionals/step-5-achieve-meaningful-use-stage-2
Meaningful Use Stage 1 Medication Reconciliation and Transition of Care Summary Toolkits	http://www.healthit.gov/providers-professionals/step-5-achieve-meaningful-use-stage-1
Improving Massachusetts Post-Acute Care Transfers (IMPACT)	http://mehi.masstech.org/what-we-do/hie/impact

APPENDIX

Case Scenario

Care Transition From Acute Hospital to Inpatient Hospice Facility

Mr. Jones is a 90 year old male admitted, two weeks ago to the hospital for shortness of breath and back pain. His past medical history includes 50 year smoking history; quitting at the age of 70 and allergy to NASAIDs. Previous surgery includes coronary artery bypass at age 60. At the time of admission his current medications included Coumadin and a beta-blocker. Prior to his hospitalization he had been living independently with his 85 year old wife.

Diagnostic testing revealed Mr. Jones has inoperable Stage 4 lung cancer with metastasis to the bone. No other medical treatment options are available. The treatment team discussed with Mr. Jones and his wife palliative care treatment options. Mr. Jones advanced directives were also reviewed and validated that his choice for palliative care was in alignment with his medical and end-of-life choices.

Mr. Jones is now ready for transfer to an inpatient hospice facility for palliative and end of life care. His current treatment orders include comfort measures only, DNR (do not resuscitate), DNI (do not intubate), and NO artificial nutrition (gastric tubes) or hydration (IVs). His level of alertness is quickly deteriorating and he is only oriented to person. He has also physically de-habilitated and requires a 1-2 person heavy assist for transfer to beside commode. His pain is being managed with Morphine 7mg every 4 hours and he is being turned and repositioned with pillows and other body props as needed to keep him comfortable. These help alleviate pain and keeps him at about a pain scale of 3. His skin is intact however he is starting to redden on the left shoulder; he prefers to lay on his left side. Liquids and puree food are as tolerated however he is not requesting much these days other than his favorite "shake" which is 30 ounces of pureed pumpkin butter and bread. His wife remains by his side as well as their two adult children and several grandchildren. He enjoys listening to the television play Citizen Kane or music by Frank Sinatra. He has requested that his family remain with him during his last hours. He is also having daily visits with the pastor from his local Lutheran church. He finds comfort in the spiritual support.

Care Coordination Tool (Exhibits 2 and 4)

Based on the above, what elements from Mr. Jones personal, medical, surgical and hospitalization history should be communicated at the time of transition?

A. Demographics and Patient Specific Medical Information

B. Cognition and Functional Status

C. Immunizations and Medications

D. Pain Assessments and Treatments

E. Physical Findings and Skin Assessment

F. Expectations of Care and Advance Directives

G. Personal spiritual preference,

H. Comfort care and end- of-life arrangements

I. All of the Above

Summary of Care Data Elements (Exhibit 1, 2 & 4)

Based on the above, these are the specific details which support the major categories listed within the care coordination tool exhibits and should be communicated at the time of transition.

- Diagnosis – inoperable Stage 4 lung cancer with metastasis to the bone
- Demographics – 90 year old married male admitted to hospital two weeks ago for shortness of breath and back pain
- Allergy – NSAIDs
- Medication reconciliation – OLD Coumadin and a beta-blocker and NEW Morphine 7mg every 4 hours
- Medical History – includes 50 year smoking history; where he quit smoking at the age of 70
- Surgical History – coronary artery bypass at age 60
- Family/Caregiver Support – Wife's name and contact information
- Expectations of care – DNR, DNI & no artificial nutrition or hydration
- Cognition – oriented to person
- Functional – requires a 1–2 person heavy assist for transfer to beside commode
- Diet – Liquids/puree as tolerated, preference 30 ounces of pureed pumpkin butter and bread
- Pain assessment – pain scale prior to morphine administration and pain scale after medication = 3
- Skin assessment – Intact with redness to left shoulder (prefers to lay on left side)
- Spiritual – Lutheran church pastor name and contact information
- Comfort – repositioning with pillows and body props, movie Citizen Kane, music Frank Sinatra and family by his side

The Outcomes

Care coordination that includes input from a patient's medical team, care givers, family and spiritual leaders will help ensure quality end-of-life care. If the information is not communicated at the time of transition in a summary of care document what type of adverse events could occur?

A. Mr. Jones could be inappropriately resuscitated

B. Mr. Jones could needlessly suffer from a fall if not transferred appropriately

C. Mr. Jones could be inadvertently given an NSAID and suffer from an allergic reaction

D. Mr. Jones could needlessly suffer in pain if he does not receive his medication in a timely manner

E. Mr. Jones could die uncomfortably and in isolation if his family is not present

F. Mr. Jones could feel helpless and loss of control and suffer if he does not have access to his spiritual advisor

G. Mr. Jones medical treatment preferences could be violated

H. The hospice facility could be put at risk for not adhering to the careplan as ordered

I. All of the Above