CMS and ONC: Enabling Data Interoperability Across the Continuum

March 19, 2019

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Michelle Dougherty, RTI
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Acronyms in this Presentation

- CMS – Centers for Medicare & Medicaid Services
- CCD – Continuity of Care Document
- C-CDA – HL7 Consolidated Clinical Document Architecture
- CCDS – Common Clinical Data Set
- DCPAC – Division of Chronic and Post-Acute Care
- DEL – Data Element Library
- FHIR – Fast Healthcare Interoperability Resources
- HHA – Home Health Agency
- HIS – Hospice Item Set
- HIT – Health Information Technology
- HL7 – Health Level 7
- IMPACT – Improving Medicare Post-Acute Care Transformation Act
- IRF – Inpatient Rehabilitation Facility
- IRF-PAI – Inpatient Rehabilitation Facility Patient Assessment Instrument
Acronyms in this Presentation (Cont.)

- ISA – ONC Interoperability Standards Advisory
- LCDS – Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set
- LOINC – Logical Observation Identifiers Names and Codes
- LTCH – Long-Term Care Hospital
- MDS – Minimum Data Set
- OASIS – Outcome and Assessment Information Set
- ONC – Office of the National Coordinator for Health IT
- PAC – Post-Acute Care
- RELMA -- Regenstrief LOINC Mapping Assistant
- SNF – Skilled Nursing Facility
- SNOMED-CT – Systematized Nomenclature of Medicine - Clinical Terms
- SPADEs – Standardized Patient Assessment Data Elements
- USCDI -- U.S. Core Data for Interoperability
- VSAC – Value Set Authority Center
Agenda

• The patient story: Use cases for health information exchange and care coordination
• The Improving Medicare Post-Acute Care Transformation Act and the DEL
• Data interoperability: Benefits and challenges
• DEL next steps: FHIR®
Objectives

• Describe the CMS approach for development and implementation of the CMS Data Element Library.
• Describe how various users can utilize the CMS DEL functionality including search and reports.
• Define the goals of standardized CMS assessment content mapped to HIT vocabularies and exchange standards.
• Discuss the strategies and use cases for how assessment content can be re-used to support discharge planning, quality improvement, and reduce burden through interoperable health information exchange.
• Explore how the emerging FHIR standards can be used to enable exchange among providers and with patients and their care givers.
The patient story and value of post-acute care interoperable data exchange across the continuum
Why is Post-Acute Care Important?

PAC Setting

• Long-Term Care Hospitals (LTCH)
• Skilled Nursing Facilities (SNF)
• Home Health Agencies (HHA)
• Inpatient Rehabilitation Facilities (IRF)
• Hospices

• Approximately 33,000 PAC Providers in the U.S.
Episodes Requiring PAC Services after an Acute Hospitalization

MEDICARE BENEFICIARIES REQUIRING PAC SERVICES AFTER AN ACUTE HOSPITALIZATION IN 2014

- PAC Services: 45%
- No Services: 55%
The Most Frequent Sequences of Care

Acute Hospitalization

- HHA: 42.9%
- SNF: 18.2%
- HHA: 7.5%
- SNF: 6%

Physicians and specialists also coordinate on-going care with PAC settings.

Volume of Claims by Chronic Conditions in 2016

Source: 2016 Medicare Claims Data

2016 (n=59,818,481)
Distribution of Beneficiaries by Number of Chronic Conditions & Total Medicare Spending in 2015

Points of Failure

- **Poor communication across care providers, including outpatient**
  - Medication discrepancies such as drug omissions during transitions of care are common
  - Multiple modes of information transmission are often used
  - Delays in PAC services can lead to adverse events and preventable readmissions
  - Redundant information collection creates inefficiencies and burden

- **Reliance on patient recall during periods of high stress**
  - Recall of information can be unreliable
  - Increased patient / family stress

- **Increased Cost and Provider Burden**
  - Additional costs related to hospital stays from adverse events, readmissions
  - Additional administrative costs to locate, reconcile and coordinate information
  - Longer length of stays and higher resource utilization
ONC Data Brief: SNF & HHA EHR Adoption and Interoperability in 2017

- EHR adoption rates were higher among HHAs compared to SNFs in 2017

<table>
<thead>
<tr>
<th></th>
<th>EHR</th>
<th>No EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>78%</td>
<td>22%</td>
</tr>
<tr>
<td>SNF</td>
<td>66%</td>
<td>34%</td>
</tr>
</tbody>
</table>

- HHAs are more likely than SNFs to engage in each domain of interoperability.

<table>
<thead>
<tr>
<th></th>
<th>HHA</th>
<th>SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find</td>
<td>41%*</td>
<td>27%</td>
</tr>
<tr>
<td>Send</td>
<td>52%*</td>
<td>41%</td>
</tr>
<tr>
<td>Receive</td>
<td>53%*</td>
<td>41%</td>
</tr>
<tr>
<td>Integrate</td>
<td>36%*</td>
<td>18%</td>
</tr>
<tr>
<td>Outside Info Available</td>
<td>55%*</td>
<td>48%</td>
</tr>
</tbody>
</table>

Interoperability Challenges

- Lack of business case
- Lack of standards or consistent use of standards
- Limited understanding of interoperability and its value
- Lack of formalized workflows
- Frequent changes to payment models diverts resources from investment in interoperability
- Meeting CMS regulatory requirements diverts resources from investment in interoperability
- Lack of data transparency
- Data exchange between EHR systems is poor
- Staff recruiting and retention in PAC facilities
Interoperability Challenges (Continued)

• Accessibility is problematic for some patients
• Working physicians are not involved enough in standards development and software design
• Senior housing facilities do not employ any health IT infrastructure
• Assisted living facilities have been slow to adopt EHRs
• Post-acute utilization is high and increasing
• Internet connectivity for some health facilities is poor
• Patient matching is difficult, inaccurate, and hard to automate
• Data provided by ambulatory care are not timely
Potential Cost Savings related to Points of Failures

- Description and Financial Cost
  - Time PCP spends collecting information, faxing and re-faxing or sending information through another mode (1 hour of time): $107*
  - Average cost of adverse event during a hospital stay: $13,745 #
  - Average cost of a Home Health Agency Stay: $3,040 †
  - Average cost of an Inpatient Rehabilitation Facility Stay: $19,714 †
  - Average cost of a Skilled Nursing Facility stay: $18,174 †
  - Average cost of a Long-Term Care Hospital stay: $40,656 †

† MedPAC, A Data Book: Health care spending and the Medicare program, June 2018
IMPACT Act and CMS Data Element Library
IMPACT Act of 2014

• Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014

• The Act requires *standardized* patient assessment data elements for:
  • Long-term Care Hospitals (LTCHs)
  • Skilled Nursing Facilities (SNFs)
  • Home Health Agencies (HHAs)
  • Inpatient Rehabilitation Facilities (IRFs)

• The Act specifies that data “… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…”.

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
Data Element Interoperability

• IMPACT Act requires that post-acute care assessment data elements be interoperable to:
  • “allow for the exchange of data among PAC providers and other providers and the use by such providers of such data that has been exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes.”

• Interoperable data elements facilitate improvements to reduce overall provider burden by allowing the use and reuse of healthcare data

• Supports provider exchange of electronic health information to facilitate care coordination and person-centered care

• Supports real-time, data driven, clinical decision making
IMPACT Act Requirements

• Data Must be Interoperable

• Quality Measures
  – Functional Status
  – Skin Integrity
  – Medication Reconciliation
  – Incidence of Major Falls
  – Transfer of Health Information
  – Medicare Spending per Beneficiary
  – Discharge to Community
  – Potentially Preventable Hospital Readmissions

• Standardized Data Submission
  – Admission and Discharge
  – Functional status
  – Cognitive function and mental status
  – Special services, treatments, and interventions
  – Medical conditions and co-morbidities
  – Impairments
  – Other categories required by the Secretary
What are Post-Acute Care Assessments?

- CMS PAC Assessments:
- LTCH Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)
- Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
- Outcome and Assessment Information Set (OASIS)
- IRF Patient Assessment Instrument (IRFPAI)
- Hospice Item Set (HIS)*
PAC Assessment Content

• Administrative Content
  – Patient Name
  – Date of Birth
  – Race/Ethnicity
  – Marital status
  – Admission/Discharge dates
  – Admit from/Discharged to locations
  – Reason for admission
  – Provider NPI, CCN, Medicaid Provider #

• Standardized Patient Assessment Data Elements (SPADEs) across instruments
  – Function (e.g., self care and mobility)
  – Cognitive function (e.g., express & understand ideas; mental status, such as depression and dementia)
  – Special services, treatments & interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  – Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
  – Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
  – Other categories

• Clinical Content
  – Diagnosis/medical conditions
  – Mental/Cognitive Status (memory, orientation, consciousness, delirium, mood, behavior)
  – Communication (express needs, understanding verbal/non-verbal content, hearing and vision)
  – Functional Status (Self-care/ADLs, Mobility, Use of assistive devices)
  – Bladder and Bowel continence
  – Falls
  – Pressure ulcers and other skin conditions
  – Surgery
  – Nutritional and swallowing status
  – Medication information
  – Special treatments, procedures & programs
  – Height and Weight
  – Patient preferences and goals of treatment
  – Pain
  – Vaccinations
  – Therapy- PT, OT, SLT
  – Living arrangements/support availability
  – Care planning
SPADES: Standardized Assessment: Many Uses

Section GG | Functional Abilities and Goals

<table>
<thead>
<tr>
<th>GG0170. Mobility (3-day assessment period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).</td>
</tr>
<tr>
<td>Coding:</td>
</tr>
<tr>
<td>Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.</td>
</tr>
<tr>
<td>Activities may be completed with or without assistive devices.</td>
</tr>
<tr>
<td>06. Independent - Patient completes the activity by him/herself with no assistance from a helper.</td>
</tr>
<tr>
<td>05. Setup or clean-up assistance - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.</td>
</tr>
<tr>
<td>04. Supervision or touching assistance - Helper provides verbal cue and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</td>
</tr>
<tr>
<td>03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, assists with about half the effort.</td>
</tr>
<tr>
<td>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts, holds, assists with over half the effort.</td>
</tr>
<tr>
<td>01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity.</td>
</tr>
<tr>
<td>If activity was not attempted, code reason:</td>
</tr>
<tr>
<td>07. Patient refused</td>
</tr>
<tr>
<td>09. Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury.</td>
</tr>
<tr>
<td>10. Not attempted due to environmental limitations (e.g., lack of equipment, weather conditions)</td>
</tr>
<tr>
<td>11. Not attempted due to medical condition or safety concerns</td>
</tr>
</tbody>
</table>

Data Elements: Question and Response

Quality Reporting

Care Planning/Decision Support

Payment

Care Transitions
The Data Element Library (DEL)

• The DEL is a centralized resource for CMS assessment data elements (e.g. questions and response options), and their related mappings to nationally accepted health IT standards

• PAC Settings and Their CMS Assessments:
  o Long-term Care Hospitals (LTCHs) = LTCH Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)
  o Skilled Nursing Facilities (SNFs) = Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
  o Home Health Agencies (HHAs) = Outcome and Assessment Information Set (OASIS)
  o Inpatient Rehabilitation Facilities (IRFs) = IRF patient assessment instrument (IRF-PAI)
  o Hospices = Hospice Item Set

DEL Contents
• Assessment and version (e.g., MDS 3.0 v. 1.16)
• Item label (e.g.- GG0170)
• Item status (Published, Active, Inactive)
• Copyright information (if applicable)
• CMS usage (Payment, Quality Measure, Survey and Certification, etc.)
• Identification of skip pattern triggers and lookback periods
• Health IT standards (e.g., LOINC, SNOMED)

Visit the DEL here: https://del.cms.gov
DEL Homepage

• Overview
• Announcements
• Listserv

Visit the DEL here: https://del.cms.gov
Search Categories

Data Element Search by Assessment Instrument Version

* Indicates required field.

* Assessment Instrument: LCDS
* Assessment Version: 4.00

Search
## Data Element Search by Assessment Instrument Version

There are 163 records returned from the search.

* Indicates required field.

### Assessment Instrument:
- LCDS

### Assessment Version:
- 4.00

### Search

### List of Data Element Search Results

<table>
<thead>
<tr>
<th>Assessment Instrument</th>
<th>Item ID</th>
<th>Section Name</th>
<th>Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>LCDS</td>
<td>A9554</td>
<td>Section A: Administrative Information</td>
<td>Type of transaction</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6109</td>
<td>Section A: Administrative Information</td>
<td>Facility/provider) numbers</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6109A</td>
<td>Section A: Administrative Information</td>
<td>National Provider Identifier (NPI)</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6109B</td>
<td>Section A: Administrative Information</td>
<td>CMS Certification Number (CCN)</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6109C</td>
<td>Section A: Administrative Information</td>
<td>State (facility/provider) Medicaid number</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6209</td>
<td>Section A: Administrative Information</td>
<td>Type of (facility/provider)</td>
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<tr>
<td>LCDS</td>
<td>A6210</td>
<td>Section A: Administrative Information</td>
<td>Assessment reference date</td>
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<tr>
<td>LCDS</td>
<td>A6220</td>
<td>Section A: Administrative Information</td>
<td>Admission date</td>
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<tr>
<td>LCDS</td>
<td>A6229</td>
<td>Section A: Administrative Information</td>
<td>Reason for assessment (record)</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6270</td>
<td>Section A: Administrative Information</td>
<td>Discharge date</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6509</td>
<td>Section A: Administrative Information</td>
<td>Legal name of (patient/resident)</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6509A</td>
<td>Section A: Administrative Information</td>
<td>(Patient/resident) first name</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6509B</td>
<td>Section A: Administrative Information</td>
<td>(Patient/resident) middle initial</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6509C</td>
<td>Section A: Administrative Information</td>
<td>(Patient/resident) last name</td>
</tr>
<tr>
<td>LCDS</td>
<td>A6509D</td>
<td>Section A: Administrative Information</td>
<td>(Patient/resident) name suffix</td>
</tr>
</tbody>
</table>
# Detailed Data Element Information

<table>
<thead>
<tr>
<th>Item Name</th>
<th>Item Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item ID:</td>
<td>A2110</td>
</tr>
<tr>
<td>Assessment Instrument:</td>
<td>LCDS</td>
</tr>
<tr>
<td>Assessment Instrument Version(s):</td>
<td>2.01.3.00.4.00</td>
</tr>
<tr>
<td>Section Name:</td>
<td>Section A: Administrative Information</td>
</tr>
<tr>
<td>Short Name:</td>
<td>Discharge Location</td>
</tr>
<tr>
<td>Question Text:</td>
<td>Discharge Location</td>
</tr>
<tr>
<td>Valid Response Values (Code, Text):</td>
<td>01 Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care) 02 Long-term care facility (LTC) 03 Skilled Nursing Facility (SNF) 04 Hospital emergency department 05 Short-stay acute hospital (PPS) 06 Long-term care hospital (LTCH) 07 Inpatient rehabilitation facility or unit (IRF) 08 Psychiatric hospital or unit 09 Intellectually Disabled/Developmentally Disabled (ID/DD) facility 10 Hospice 11 Discharged Against Medical Advice 99 Other = Voluntarily skipped</td>
</tr>
<tr>
<td>Skip Pattern Trigger:</td>
<td>N</td>
</tr>
<tr>
<td>Lookback Period (days):</td>
<td>0</td>
</tr>
<tr>
<td>Status:</td>
<td>Active</td>
</tr>
<tr>
<td>Status Date:</td>
<td>10-01-2014</td>
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<td>*</td>
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<tr>
<td>Collection Time Period(s)/Item Subset(s):</td>
<td>LCDS Planned Discharge, LCDS Unplanned Discharge</td>
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<td>Parent Item ID:</td>
<td>*</td>
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<td>HIT Information (Standard Name, Version, Code):</td>
<td>LOINC 2.63.05416-6</td>
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<td>Owning Organization:</td>
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<td>*</td>
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<tr>
<td>Owning Organization WebLink:</td>
<td>*</td>
</tr>
</tbody>
</table>
OASIS D Health IT Codes
### Helpful Documents

- Introduction to the CMS Data Element Library (DEL) webinar recording, July 11, 2018: [Link](#)
- Data Element Library Introductory Webinar - July 11, 2018: [Link to PDF](#)
- DEL User Guide: [Link to PDF](#)

### Frequently Asked Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is a data element?</td>
<td>In the context of the CMS Data Element Library and post-acute care, data elements are discrete questions and responses that are found in the patient/resident assessment instruments that post-acute care providers use to submit data to CMS.</td>
</tr>
<tr>
<td>I am a PACE provider, does the DEL change how I submit data now?</td>
<td>No- the DEL is a repository of CMS assessment data elements (questions and responses). It does not affect provider data submission processes. Providers and vendors must still follow the submission specifications required for submitting data to CMS electronically.</td>
</tr>
<tr>
<td>Is my facility still DEL?</td>
<td>Yes, it's still part of the CMS Data Element Library.</td>
</tr>
</tbody>
</table>

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**Training/FAQs**

[Image of CMS.gov website](#)
Alignment and Interoperability: Advancing interoperability by aligning assessment content with industry standards and mapping content to vocabularies, terminologies and code sets
Guiding Principle: Data Needs to Follow the Person

Support data availability in real-time. Electronic information is exchanged and used by health IT systems without special effort on the part of the user.
Making PAC Assessment Data Elements Standardized/Aligned and Interoperable

Relevant interoperable assessment data (such as functional status, cognitive status, etc.) can be used to populate documents.

Align Data Questions and Responses in Federal Assessment Instruments

IRF-PAI  LCDS  MDS  OASIS

HIT Content Standards (e.g.):
- LOINC, SNOMED CT

HIT Exchange Standards (e.g.):
- HL7 C-CDA Documents/Emerging standards (FHIR)

Documents:
- Care Plan, Transfer
- Summary, Consultation
- Note, Referral
CMS Data Element Library HIT Workgroup Focus

- Vision for Interoperable Assessment Content
- Opportunities for Burden Reduction
- Use Cases for Interoperable Assessment Content
- Aligning with National Standards
- Mapping to Relevant Vocabulary & Terminology Standards
- Use of Interoperable Assessment Content by Implementers
Vision for Interoperable Assessment Content

• Strategy: Leverage standardized data that is collected on almost all PAC patients to advance interoperability, reduce burden, and improve patient care.

• Models:
  • Identify single code to represent the assessment question and response and re-use data in relevant exchange documents (current focus)
  • Identify a value set of codes that could be used to support completion of an assessment item (future)
Opportunities for Burden Reduction and Improved Communication

• Real-time data availability improves patient care
• Machine processable data reduces provider burden:
  • Eliminates duplicative data entry
  • Minimizes searching medical record for relevant content
• Experiences of Early Adopters - Faster Data Entry
  • Valuable to have common data standards across provider types
  • Data from exchange documents (e.g. CCD) populates the patient record
Use Cases for Interoperable Assessment Content

• Care coordination between multiple providers / proxy / family members
  • Appointments, readmissions, sharing care plan, chart sharing, transportation

• Transitions of care referrals
  • Intake, info queries, transition out, follow-up activity coordination
  • Medication reconciliation
  • Clinical decision support

• Admission / Discharge information notifications
  • Helps all parties to track patient status

• Population Health Management Administration
  • Quality management, at risk dollars, who is high risk and why

• Changing relationship between patient and caregivers
  • Connective devices, patient engagement, monitoring, telehealth

• Getting providers engaged
  • Quality compared to peers, financial metrics, cost of care

• Advanced directives
  • Sharing and notifications
Aligning With National Standards

• ONC Interoperability Standards Advisory
  • DEL Health IT standards align with national policy
  • LOINC and SNOMED-CT for assessment content

• Analyzed Common Clinical Data Set/U.S. Core Data for Interoperability (USCDI)
  • Identified opportunities for alignment of assessment content to USCDI
  • Provided comments on future candidate data types important to support PAC for USCDI expansion

• ONC Common Clinical Data Set: https://www.healthit.gov/public-course/interoperability-basics-training/lsn1069/010110---a.htm
• Draft USCDI: https://www.healthit.gov/sites/default/files/draft-uscdi.pdf
Mapping to Relevant Vocabulary & Terminology Standards

- Selected codes aligned with national policy and utilized in exchange standards (e.g. C-CDA templates)
- Mapped assessment content to LOINC and SNOMED
  - LOINC codes represent the question and answer
  - SNOMED codes represent the answer meaning
- LOINC codes are available for PAC assessments on the DEL

GG0100 as Shown on IRF-PAI
Use of Interoperable Assessment Content by Implementers

- Best practices for data element design to support interoperability
- Ensure health IT content vocabularies Use in HIE standards
- Leverage DEL’s content with other industry tools such as:
  - Value Set Authority Center (VSAC)
  - Regenstrief LOINC Mapping Assistant (RELMA)
- Convene Advisory Group (industry and HHS)
  - Input on future direction for DEL and health IT priorities
  - Identify priority use cases that leverage existing standards and address gaps. Tailor implementation guides and coordinate testing.
Industry Expert Roundtable on CMS Data Element Library

• Provided feedback on the CMS Data Element Library:
  – Inform healthcare policies
  – Advance interoperability
  – Support transfer of care, coordination of care, quality measurement, and research

Suggested clarifying scope of DEL and how it should be used by stakeholders; Ideas for future development.

Identified priority use cases for transfer summary and care planning; Suggested ways the DEL to support outreach & testing.

Become a resource to connect industry standards – align with other tools, identify/point to relevant standards, fill gaps.
Health Data Exchange Through FHIR
We’re Building the Future with FHIR

1) Participate in HL7 Working Groups
2) Create sustainable PAC Interoperability Working Group
3) Identify tightly-scoped use case to implement for a connect-a-thon
4) Develop FHIR Implementation Guides for use case data models
5) Review and harmonize FHIR Implementation Guides with key stakeholders
6) Host connect-a-thon to test FHIR Implementation Guides
7) Build industry consensus around FHIR Implementation Guides
8) Identify next agile part of use case to implement, and repeat steps 4 through 8.
Outpatient → EMS → Inpatient → Home Health
EMS → Inpatient → SNF

Ambulance

Current symptoms are recorded by EMT in an H&P and a copy handed to the ED

Patient recalls PMH

Doctor

Patient recall PMH

Consent completed

Consent completed

SW takes information from the EHR and uploads it into naviHealth

SW

naviHealth

RN

Paper discharge paperwork placed on patient

Ambulance hands paperwork to SNF, but SNF misfiles information

Non urgent transport

The SNF liaison communicates through naviHealth with the inpatient SW

SNF
Proposed Timeline for FHIR Work (Publish Dec 2019)

1 October 2018

30 Jun, 2019
NOTICE OF INTENT TO BALLOT - DEADLINE

Jul 2019
BALLOT CONTENT

Sep 2019
2019 WGM AND CONNECTATHON IN ATLANTA

Nov 2019
RECONCILIATION

Dec 2019
PUBLISH FHIR IMPLEMENTATION GUIDE

LANDSCAPE ANALYSIS

28 Nov, 2018
TAG

Mar 2019
PROJECT SCOPE STATEMENT

Aug 2019

Nov 2019

Dec 2019

PUBLISH FHIR IMPLEMENTATION GUIDE

Oct 2019
NEW FISCAL YEAR

31 March 2020
Call to Action: How to Participate

- **Health IT developers**
  - Build on existing health IT systems
  - Try out new projects/systems
- **PAC providers**
  - Analyze how and where assessment data fits in clinical workflow
  - Provide feedback on development priorities

- **Ways to contribute:**
  - Subject matter expertise
  - Scalability of implementing the eventual solution
  - Assist in the delivery of key deliverables and project artifacts
  - Development of testing tools, testing implementations, etc.

To participate in PAC Interoperability workgroup and FHIR connect-a-thon contact: Dave Hill, dwhill@mitre.org
Wrap Up and Question & Answer Session
Resources

- For more information on the IMPACT Act, visit the IMPACT Act webpage

- For more information on Post-Acute Care Quality Reporting Programs, visit:
  - Home Health Agencies
  - Hospice Agencies
  - Inpatient Rehab Facilities
  - Long-term Care Hospitals
  - Skilled Nursing Facilities

- For DEL updates, sign up for the listserv here
- For DEL feedback or questions, contact: DELHelp@cms.hhs.gov
Thank You

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CMS Contractors supporting the DEL:

NIC/Telligen
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