Factors Influencing HIE by LTPAC Providers
• ARRA/HITECH made available funds that supported—
  ► Incentive payments for the meaningful use of certified EHR technology by eligible hospitals and professionals (aka “Eligible Providers” (EPs)) – an estimated $15 Billion from 2014 – 2019 will be available; and
  ► Development of a nationwide health IT infrastructure that allows for the electronic use and exchange of health information -- approximately $2 billion was made available to the Office of the National Coordinator for Health Information Technology (ONC) to carry out HITECH activities.
    o These funds primarily targeted Eligible Providers.

• Although ONC made some HITECH funds (approximately $7 million) available to support HIE by LTPAC providers, these funds/resources were not generally available to support the acquisition/use of health IT/EHRs by providers who were not eligible for the EHR Incentive Programs.
Achieving Better Care, Healthier People, & Smarter Spending

Why Post-Acute Care Matters:

- **32,617** Post-Acute Care (PAC) Facilities
- **6.8 million** Medicare Beneficiaries
- **$74 billion** Medicare Spending
- **500 billion** of Total Medicare Spending (PAC 14.8%)

**420** Long-Term Care Hospitals (LTCH)
- Services provided: Rehabilitation, respiratory therapy, pain management, and head trauma treatment

**15,000** Nursing Homes
- Services provided: Short-term Skilled nursing and rehabilitation services to individuals whose health problems are too severe or complicated for home care or assisted living

**12,311** Home Health Agencies (HHA)
- Services provided: Skilled nursing or therapy services provided to Medicare beneficiaries who are homebound

**1,166** Inpatient Rehabilitation Facilities (IRF)
- Services provided: Intensive rehabilitation therapy including physical, occupational, and speech therapy

**3,720** Hospices
- Services provided: Palliative and support services for beneficiaries with a life expectancy of 6 months or less
e-HIE is Needed but Limited in LTPAC

• Transitions in care between providers eligible for incentives and providers who are not eligible are common. For example:
  ► In 2008, almost 40 percent of all Medicare beneficiaries discharged from acute care hospitals received post-acute care; and of these beneficiaries, more than 15 percent were readmitted to the acute care hospital within 30 days of hospital discharge.

• Instances of shared care are also common between eligible and ineligible providers. For example:
  ► Medicare requires that both the physician and HHA sign a home health plan of care.

• National data is limited regarding the use of health IT/EHRs by LTPAC providers:
  ► Surveys of LTPAC providers use of technology are typically not national in scope.
  ► Data varies in their focus and definitions of technology.
    o Adoption rates vary from less than 10% to more than 40%.
    o Technology adoption rates for LTPAC providers cannot and should not be compared to adoption rates for EPs since they do not measure comparable EHR technology.

Nonetheless:
  ► Technology adoption rates are believed to be lower among LTPAC providers than among Eligible Providers.
  ► Electronic health information exchange by LTPAC providers is believed to be lower still
  ► Interoperable health information exchange by LTPAC providers is rare.

2. Devers, K. et al "Health Information Exchange in Long-Term and Post-Acute Care Settings." Prepared for the OASPE.
Factors Influencing HIE by LTPAC Providers

- The Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) sponsored research examining health information exchange on behalf of individuals who receive LTPAC services. Key findings include the following:

  ▶ Drivers of HIE between LTPAC providers and their trading partners include—
    - Availability of ONC grant funds
    - Payment and service delivery reforms, such as ACOs, bundled payments, hospital readmission penalties, increasing use of integrated delivery networks, market consolidation

  ▶ Barriers to HIE by LTPAC providers include—
    - Costs
    - Relatively limited requirements for Eligible Providers to exchange information with LTPAC providers in earlier stages of the meaningful use requirements
    - Technology challenges
    - Limited technical assistance

- Devers, K. et al “Health Information Exchange in Long-Term and Post-Acute Care Settings.” Prepared for the Office of the Assistant Secretary for Planning and Evaluation.
A bipartisan bill was introduced in March 2014. The U.S. House and Senate passed it on Sept. 18, 2014, and President Obama signed it into law Oct. 6, 2014.

The Act requires the submission of standardized assessment data by:
- Long-Term Care Hospitals (LTCHs): LTCH CARE Data Set (LCDS)
- Skilled Nursing Facilities (SNFs): Minimum Data Set (MDS)
- Home Health Agencies (HHAs): OASIS
- Inpatient Rehabilitation Facilities (IRFs): IRF-Patient Assessment Instrument (IRF-PAI)

The Act requires that CMS make interoperable standardized patient assessment and quality measures data to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes.
Why IMPACT? Why Now?

- The lack of comparable information across PAC settings undermines the ability to evaluate and differentiate between appropriate care settings for and by individuals and their caregivers.

- Standardized PAC assessment data will allow for continued beneficiary access to the most appropriate setting of care.

- Standardized PAC assessment data allows CMS to compare quality across PAC settings (longitudinal data).

- Standardized and interoperable PAC assessment data allows improvements in hospital and PAC discharge planning and the transfer of health information across the care continuum.

- Standardized PAC assessment data will allow for PAC payment reform (site neutral or bundled payments).

- Standardized and interoperable PAC assessment data supports service delivery reform.
• Achieving standardization (i.e., alignment/harmonization) of clinically relevant data elements improves care and communication for individuals across the continuum:
  ▶ Enables shared understanding and use of clinical information
  ▶ Enables the re-use of data elements (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.)
  ▶ Supports the exchange of patient assessment data across providers
  ▶ Influences and supports CMS and industry efforts to advance interoperable health information exchange and care coordination

• While data element standardization is required for certain assessment domains/categories in the IMPACT Act, unique data elements specific to PAC settings will also persist.
The IMPACT Act requires that CMS make post-acute care assessment data elements 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.”
Opportunities to Re-Use Standardized and Interoperable Assessment Data Elements

• Leveraging and mapping PAC assessment data elements to **nationally accepted** Health IT standards supports:

  ▶ Information exchange and re-use with and by—
    o Acute care hospitals and primary care providers
    o LTPAC providers
    o Home and community-based providers (HCBS)
    o Other providers
    o HIE Organizations

  ▶ Use and re-use of assessment data in a variety of document types, including—
    o Transfer documents
    o Referral documents
    o Care plans
    o LTPAC assessment summary documents

• CMS will make available public reports of PAC Assessment Data Elements mapped to health IT standards.
The IMPACT Act requires a quality measure on—

- The transfer of individual health information and care preferences of an individual to the individual, family care caregivers, and service providers when the individual transitions from:
  - Hospital or critical access hospital (CAH) to another setting including Post-Acute Care (PAC) provider or home
  - PAC provider to another setting, including a different PAC provider, a hospital or CAH, or home
• The CMS Medicaid Data and Systems Group and ONC Office of Policy have partnered to update the guidance on how states may support health information exchange and interoperable systems to best support Medicaid providers in attesting to Meaningful Use Stages 2 and 3.
• This updated guidance will allow Medicaid HITECH funds to support all Medicaid providers that Eligible Providers want to coordinate care with.
• Medicaid HITECH funds can now support HIE onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, and so on.
• It may also support the HIE on-boarding of laboratory, pharmacy or public health providers.
ONC 2015 Edition
Health IT Certification

• Contains new and updated vocabulary, content, and transport standards for the structured recording and exchange of health information

• Establishes a Common Clinical Data Set to encourage the exchange of a core set of data across the care continuum

• The ONC Health IT Certification Program is “agnostic” to settings and programs, but can support many different use cases and needs.

• This allows the ONC Health IT Certification Program to support multiple program and setting needs, such as—
  ► EHR Incentive Programs
  ► Long-term and post-acute care
  ► Chronic care management
  ► Behavioral health
  ► Other public and private programs
Delaware, Illinois, and Colorado are implementing use of the KeyHIE Transform tool to translate home health and SNF patient assessment data into standardized CCDA template.

Rhode Island is sending HL7 ADT alerts via mobile phone or message to LTPACS, individuals, and family members.

New Jersey (NJ) is sending ADT messages between NJ Transitions of Care Services to LTPACs.

Several States are increasing adoption of HIE and exchange of TOC documents among LTPACs by implementing Direct mailboxes and query-based exchange.

Utah is developing filters to push out discharge summaries from hospital to LTPAC in a timely manner.

Measuring the extent to which providers are leveraging data exchanged by incorporating summary of care records into workflow.

Reducing readmission from the LTPAC to the hospital.
Challenges for the LTPAC Setting

• Difficulty engaging with LTPAC Facilities
• Challenges with meeting facilities on differing levels of adoption spectrum (no adoption → high adoption)
• No agreed-upon content
• Unclear if the sending site has what the receiving site needs
• No compelling business case
• Limited or no financial support
• Identifying workflows and connections that inhibit patient information from flowing to the right place at the right time
• Many LTPACs are unable to contribute anything to the State or Local HIE, due to view-only capabilities.