ToC and VDT Listening Session Questions

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Provider Listening Sessions

ToC Panel

- Has your vendor installed or upgraded you to their Stage 2 certified product for ToC or have they installed or upgraded you to parts of the requirements?
  - Create and transmit a care/referral summaries-*Yes*
  - Receive, display and incorporate transition of care/referral summaries- *We can receive and display in human readable form, but have not implemented the technology to incorporate the electronic data yet. To date we have been approached by one facility that requested our Direct Secure email for the purpose of electronically sending a TOC. To my knowledge, we have not received any TOC summaries. We are partnering with a few skilled nursing facilities and home health agencies who are interested in Direct secure messaging our individual providers to aide in patient care with their clients.*
- If so, what has your experience been with the ToC tools? - *Our specific tool functions within the scope of the 2014 certification standards required for use. I believe the certification standards and measure specifications (required data fields) limit our ability to customize our template to include the required data fields and information our clinicians deem as clinically relevant for the next provider of care while keeping the document to an appropriate size. There are many required (if the data exists) data points set forth in the regulation. Some of the information that is required by CMS to be included in the minimum list of data elements exists in a variety of forms and in a variety of sources that do not all lend themselves easily to inclusion in the outbound summary. To both get just the elements that our referral centers want and also meet the metrics while keeping the summary to an acceptable length would require a significant a change in our documentation practices. . If existing sources were all enabled for inclusion, likely the product/solution would not be generalizable for a vendor's entire client base as each organization has found specific documentation practices that meet their workflow and patient care needs. Elements that are particularly difficult are the care plan with goals and instructions and discharge instructions. This information traditionally resides in the provider's note. Changing that documentation so the data is*

more discrete (making the TOC smaller because we would not have to pull in the entire note) would cause a step backward with our provider adoption of CEHRT tools. We have found formatting to be very challenging. If not, when do you anticipate receiving the Stage 2 certified product?

- *Have you tested your ability to use these tools to send and receive information with other healthcare organizations you frequently refer patients too? If so, what has your experience been? Yes. We have received feedback from the centers to whom we refer and they find that the document is not useful. It is too long and is often missing information that they require e.g. orders. Our social workers and case managers pick very specific information to send that is documented in forms specific to our organization. The TOC would have to be structured to allow a clinician to choose what they wish to include while ensuring that required data elements are included to meet the meaningful use objective. While this might work when our social workers and case managers are involved in a patient transfer of care, this would not be ideal in the case of a patient being discharged home with OP follow up. Sending the TOC would not fit in the clinical staff (providers/nurses) workflow for a discharge home. It would be a clerical function. Timing of receipt of the data is also an issue. The TOC summary is a summary of the encounter. If a patient is being discharged and will receive follow up care as an OP generating and sending the TOC post discharge works. However if a patient is being transferred to a skilled facility, acute care hospital, SNF, LTACH, home health, hospice etc., much of the data that is in the TOC has already been sent to the facility during the referral process. This causes our referral centers to receive the same data multiple times instead of just updates and new information. We have not been able to eliminate the documents that we already send to the organizations to which we refer. The TOC is an additional document we send. Our list of Direct partners that are capable of receiving an electronic TOC is very short-3 thus far. All of our partners are using stand-alone inboxes. They are not receiving the TOC into their EMR so no electronic data is being consumed at this time. The lack of partners able to receive electronic transmissions kept us from meeting the measure in Q1 FFY 2014. I have concerns that it will continue to be an issue.*
- How are providers/vendors collecting the numerator and denominator data for ToC measure? *Reporting has always been one of the biggest hurdles in meaningful use. We have orders that fire based on discharge disposition and follow up orders placed prior to discharge. These orders signal the report to increment the denominator. It has been very difficult to tease out follow up with internal vs. external providers. There is no need to send a TOC to our internal providers because they can access any data related to the IP/ED encounter in our EMR. It would cause additional work. That is why we use a combination of discharge dispositions and follow up orders to qualify discharges in the denominator. We*

have had many difficulties getting patients/TOC to qualify for the numerator due to the complexity of the measure. The report must ensure that the medication list, allergy list and problem list are not blank. Additionally, the report must ensure that all problems that are included are coded in SNOMED CT. The requirement of SNOMED coding has also caused us to restrict what problems we include in our TOC and has changed the way our some of our providers use the problem list. We have had our EMR since 1998 and the problem list has been used in the past to capture data that was not able to be captured as structured data--procedures, medication lists etc. As our EMR evolved, we have transitioned most of that data to other discrete fields in the EMR. We feel that a complete "clean-up" would alter the record in such a way that is undesirable. We are not going to completely rid the problem list of items that are non-SNOMED. The majority of this historic data is in a resolved or inactive status, but some persists in an active state because and it is unmappable. In order to meet the measure, we can only include active problems in the TOC. The SNOMED requirement was one factor that caused us not to meet this measure for attestation in Q1 FFY 2014.

- What if any fees is your vendor charging you for sending and/or receiving ToC transactions? *There are no fees outside of the fees for use of the record to my knowledge.*
- How much staff training/workflow redesign has been required to implement and effectively use the exchange tools that support ToC*? Because of the difficulty in incorporating the TOC in a clinical workflow, the burden to train a large clinical staff and concerns about sending PHI, our HIM department has been tasked with sending the TOC for our hospitals. We continue to have to alter workflows and make changes to documentation. It is a work in progress and will be for quite some time.*
- Any particular challenges or best practices from you're experience? *It has been challenging to ensure that the HIM staff know where to send the TOC. They spend a great deal of time ensuring the correct data is sent to the correct facility/provider. There are separate solutions used to create/send the TOC depending on the method of transmission-fax/print/mail or secure electronic transmission. We found it helpful to limit the staff that are responsible for sending the TOC because the technology, workflows and reporting continue to change. This limits the burden of re-training a large group.*
- When your organization receives a transfer summary how are you: *We have not begun to receive any TOC summaries. We have had contact with a few groups that refer to us, but they are not ready to send.*
  - Matching the summary to the correct patient?
  - Routing the transfer summary to the appropriate location (primary care provider, specialists, medical records department etc.)?

- Are you aware of unique issues that small or rural provider are facing meeting the ToC requirements? *We have been working with getting Direct partners and secure exchange for quite some time and to date we only have 3 facilities that are able to accept and no individual providers.*
- With regard to exchange across vendor platforms:
  - Is it happening? What is working? *We have been able to send to stand-alone inboxes that are using a different HISP, but they are not receiving into their EMR at this time.*
  - What challenges are slowing or inhibiting it?
- With regard to exchange across unaffiliated providers:
  - Is it happening? What is working?
  - What challenges are slowing or inhibiting it?