New Standards to Support Coordinated Care Planning

Overview for NY Department of Health

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Agenda

- Current National Efforts to Stimulate electronic Coordination of Care
- Overview of MA IMPACT Project
- Understanding Care Planning
- Turning Datasets into National Standards
- Q & A
- Appendix A: Introduction to Interoperability & Standards
- Appendix B: National Policies & Standards to support Coordination of Care
- Appendix C: Overview of S&I Longitudinal Coordination of Care Initiative
Current National Efforts to Stimulate electronic Coordination of Care
What is Meaningful Use (MU)?

- Introduced in American Recovery and Reinvestment Act of 2009 (ARRA)
- Intent was to stimulate and increase adoption of HIT by specific provider groups
- ‘Meaningful use’ is defined as using certified electronic health record (EHR) technology to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family
  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information
- Eligible providers/ hospitals that attest to MU can earn EHR Incentive Payments
Meaningful Use Stage 2 & 2014 EHR Certification Criteria

• Sept 2012: ONC published final rule for 2014 EHR Certification Criteria to support MU Stage 2

• MU Stage 2 introduces three objectives which require the HL7 “Consolidated Clinical Document Architecture (C-CDA) R1.1” standard to communicate clinical information between healthcare providers and patients
  – D2 Engage Patients & Families: View, download and transmit; and Clinical Summaries
  – D3: Improve Care Coordination: Summary of Care
So does the Consolidated CDA meet the needs of its users?
IMPACT Grant

February 2011 – HHS/ONC awarded $1.7M HIE Challenge Grant to state of Massachusetts (MTC/MeHI):

Improving Massachusetts Post-Acute Care Transfers (IMPACT)
Datasets for Care Transitions

• **Traditionally** – What the **sender** thinks is important to the receiver

• **Future** – Also take into account what the **receiver** says they need
“Receiver” Data Needs Survey

- 46 Organizations completing evaluation
- 11 Types of organizations
- 12 User roles
- 1135 Transition surveys completed
- Largest survey of Receivers’ needs

<table>
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<th>6</th>
<th>From Acute Care Hospital</th>
<th>From Emergency Department</th>
<th>From Skilled Nursing Facility</th>
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<td>Chief Complaint</td>
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<td>73</td>
<td>Reason Patient is being referred</td>
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<td>74</td>
<td>Reason for Transfer</td>
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<td>75</td>
<td>Sequence of events proceeding patient's disease/condition</td>
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<td>76</td>
<td>History of Present Illness</td>
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Findings from Survey

• Identified for each transition which data elements are required, optional, or not needed
• Each of the data elements is valuable to at least one type of Receiver
• Many data elements are not valuable in certain care transitions
Five Transition Datasets

1. **Report from Outpatient testing**, treatment, or procedure
2. **Referral to Outpatient testing**, treatment, or procedure (including for transport)
3. **Consultation Note** (Office Visit, Consultation Summary, Return from the ED to the referring facility)
4. **Referral Note** Clinical Summary (Referral to a consultant or the ED)
5. Permanent or long-term **Transfer Summary** to a different facility or care team or Home Health Agency
Five Transition Datasets

Consultation Note:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc…

Referral Note:
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP
Additional Contributor Input

State (Massachusetts)

• MA Universal Transfer Form workgroup
• Boston’s Hebrew Senior Life eTransfer Form
• IMPACT learning collaborative participants
• MA Coalition for Prevention of Medical Errors
• MA Wound Care Committee
• Home Care Alliance of MA (HCA)
Additional Contributor Input

National

- American College of Physicians
- NY’s eMOLST
- Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
- Substance Abuse, Mental Health Services Agency (SAMHSA)
- Administration for Community Living (ACL)
- Aging Disability Resource Centers (ADRC)
- National Council for Community Behavioral Healthcare
- National Association for Homecare and Hospice (NAHC)
- Longitudinal Coordination of Care Work Group (ONC S&I Framework)
- Transfer of Care & CCD/CDA Consolidation Initiatives (ONC’s S&I)
- Electronic Submission of Medical Documentation (esMD) (ONC S&I)
- ONC Beacon Communities and LTPAC Workgroups
- Assistant Secretary for Planning and Evaluation (ASPE): Standardizing MDS and OASIS, LTPAC Assessment Summary, and Care Plans, including home health plan of care
- Geisinger: LTPAC Assessment Summary Documents and CCD
- Centers for Medicare & Medicaid Services (CMS)(MDS/OASIS/CARE)
- DoD and VA: working to specify Home Health Plan of Care dataset
- AHIMA LTPAC HIT Collaborative
- HIMSS: Continuity of Care Model
- INTERACT (Interventions to Reduce Acute Care Transfers)
- Transfer Forms from Ohio, Rhode Island, New York, and New Jersey
International

- **HL7** Structured Document, Patient Care, Care Coordination Services, Child Health, and Security Workgroups
- **IHE** Patient Care Coordination Technical Committee
Datasets include Care Plan

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- Office Visit to PHR
- Consultant to PCP
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Home Health
Plan of Care

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP
Understanding Care Planning

Home Health Plan of Care

Care Plan

HH POC (CMS-485)
Patients are evaluated with assessments (history, symptoms, physical exam, testing, etc...) to determine their status.
Health Conditions/Concerns

Risk Factors
- Age, gender
- Significant Past Medical/Surgical Hx
- Family Hx, Race/Ethnicity, Genetics
- Historical exposures/lifestyle (e.g. alcohol, smoke, radiation, diet, exercise, workplace, sexual...)

Risk/Concerns:
- Wellness
- Barriers
- Injury (e.g. falls)
- Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Patient Status
- Functional
- Cognitive
- Physical
- Environmental

Treatment Side effects

Patient Status helps define the patient’s current conditions, concerns, and risks for conditions
Risks/concerns come from many sources
Goals for treatment of health conditions and prevention of concerns are created collaboratively with patient taking into account their statuses and Care Plan Decision Modifiers.
Decision making is enhanced with evidence based medicine, clinical practice guidelines, and other medical knowledge.
Interventions and actions to achieve goals are identified collaboratively with patient taking into account their values, situation, statuses, risks & benefits, etc...
The Care Plan is comprised of Modifiers, Conditions/Concerns, their Goals, Interventions/Actions/Instructions, Assessments and the Care Team members that actualize it.
Interventions and actions achieve outcomes that make progress towards goals, cause interventions to be modified, and change health conditions.
The Care Plan (Concerns, Goals, Interventions, and Care Team), along with Risk Factors and Decision Modifiers, iteratively evolve over time.
A many-to-many-to-many relationship exists between Health Conditions/Concerns, Goals and Interventions/Actions
Care Plan Decision Modifiers

- Patient/family preferences (values, priorities, wishes, adv directives, expectations, etc...)
- Patient situation (access to care, support, resources, setting, transportation, etc...)
- Patient allergies/intolerances

Care Team Members each have their own responsibilities

Health Conditions/Concerns
- Active Problems
- Risks/Concerns:
  - Wellness
  - Barriers
  - Injury (e.g. falls)
  - Illness (e.g. ulcers, cancer, stroke, hypoglycemia, hepatitis, diarrhea, depression, etc...)

Goals
- Desired outcomes and milestones
- Readiness
- Prognosis
- Related Conditions
- Related Interventions
- Progress

Patient Status
- Functional
- Cognitive
- Physical
- Environmental

Interventions/Actions
(e.g. medications, wound care, procedures, tests, diet, behavior changes, exercise, consults, rehab, calling MD for symptoms, education, anticipatory guidance, services, support, etc...)
- Start/stop date, interval
- Authorizing/responsible parties/roles/contact info
- Setting of care
- Instructions/parameters
- Supplies/Vendors
- Planned assessments
- Expected outcomes
- Related Conditions
- Status of intervention
Care Team Members each need different views of care plan

Care Plan Decision Modifiers
- Patient/family preferences (values, priorities, wishes, adv directives, expectations, etc…)
- Patient situation (access to care, support, resources, setting, transportation, etc…)
- Patient allergies/intolerances

Health Conditions/Concerns
- Active Problems
- Risks/Concerns:
  - Wellness
  - Barriers
  - Injury (e.g. falls)
  - Illness (e.g. ulcers, stroke, heart disease, diabetes, etc.)

Goals
- Desired outcomes and milestones
- Readiness
- Prognosis
- Related Conditions
- Related Interventions
- Progress

Interventions/Actions
(e.g. medications, wound care, procedures, tests, diet, behavior changes, exercise, consults, rehab, calling MD for symptoms, education, anticipatory guidance, services, support, etc…)
- Start/stop date, interval
- Authorizing/responsible parties/roles/contact info
- Timing of care
- Interventions/parameters

Who on my Care Team is taking care of my wound?

Which problems am I responsible for?

What problems are treated by this intervention and what are the goals of treatment?

What interventions are in place for this health concern?
IMPACT Learning Collaborative: Testing Transfer Summary on Paper

2 hospitals, 2 large group practices, 8 nursing facilities, 1 IRF, 1 LTACH, 2 home health agencies and several hundred patient transfers...
Senders found the data

I was able to send all of the requested IMPACT data elements

- Yes: 93%
- No: 7%
Receivers’ needs met

Fewer than 5 data elements were missing

- No: 8%
- Yes: 92%
How do datasets compare to CCD?

Data Elements for Longitudinal Coordination of Care with Care Planning

483

325

175

CCD Data Elements

IMPACT Data Elements for basic Transition of Care needs

• Many “missing” data elements can be mapped to CDA templates with applied constraints
• 20% have no appropriate templates
Turning Datasets into National Standards
C-CDA Revisions Project: C-CDAR2.0

- S&I Longitudinal Coordination of Care (LCC) Community sponsored updates to C-CDAR1.1 and balloting of this new version through HL7
- One ballot package to address 4 revisions based on IMPACT Dataset:
  - Update to C-CDA Consult Note
  - NEW Referral Note
  - NEW Transfer Summary
  - NEW Care Plan document type (includes HHPoC signature requirements and aligns with HL7 Patient Care WG's Care Plan Domain Analysis Model- DAM)
- Ballot Package received 1013 comments
  - All 1013 ballot comments were reconciled from Oct 2013 until March 2014
  - Final C-CDA R2.0 scheduled to be published in August 2014
3 NEW Documents

- Transfer Summary
- Care Plan
- Referral Note

(Also enhanced Header to enable Patient Generated Documents)

6 NEW Sections

- Nutrition Section
- Physical Findings of Skin Section
- Mental Status Section
- Health Concerns Section
- Health Status Evaluations/Outcomes Section
- Goals Section

30 NEW Entries

- Advance Directive Organizer
- Cognitive Abilities Observation
- Drug Monitoring Act
- Handoff Communication
- Goal Observation
- Medical Device Applied
- Nutrition Assessment
- Nutrition Recommendations
- Characteristics of Home Environment
- Cultural and Religious Observation
- Patient Priority Preference
- Provider Priority Preference
- and lots more.....
C-CDAR2.0 Implementations

• MA IMPACT
  – Go-live scheduled for Aug 2014
  – Implement pre-ballot C-CDA R2.0 ‘Transfer Summary’ and C-CDA R1.1 ‘Continuity of Care Document (CCD)’

• NY Downstate Coordination Project
  – Go-live was Nov 2013
  – Implemented C-CDA R2.0 ‘Care Plan’ (pre-ballot)

• GSI Health ‘Brooklyn Health Home Consortium’
  – Go-live was March 2014
  – Implemented C-CDA based ‘Care Plan’ (not final standard)

• Veterans Health Administration
  – Demonstration of C-CDAR2.0 Care Plan Aug 2014

• Other Vendor Demonstrations (pre-ballot C-CDAR2.0)
  – CCITI-NY: Transfer Summary
  – Datuit: Care Plan
  – Healthwise: Care Plan
  – Lantana ‘SEE’ tool: Care Plan
  – Care at Hand: Care Plan
Adoption Challenges & Barriers

- Heterogeneous implementation of C-CDA R1.1 documents and templates
  - Impacts exchange of data at the ‘date element’ level due to diversity in codes and terminologies adopted by vendors
  - Challenge not resolved with C-CDA R2.0

- Interchangeable use of terms for ‘care plan’ and ‘plan of care’ and ability to translate electronically and into clinical practice

- Limitations in ‘spreading’ IMPACT SEE tool to other organizations
  - Different cost model proposed by SEE vendor

- C-CDA datasets do not currently meet information needs of all providers across continuum of care: dentists, pharmacists, long-term service and supports (LTSS) providers and other non-eligible provider groups
  - This will be addressed in future initiatives (e.g. S&I eLTSS Initiative)
Questions???
Appendix A: Introduction to Interoperability & Standards
Defining Interoperable HIE

Interoperable health information exchange (HIE) refers to the ability of two or more systems or components to:

(i) exchange information, and
(ii) use the information that has been exchanged.

- Interoperable HIE needs to be supported across a myriad of information systems (i.e., used by patients, providers, and payers)
- Real-time interoperable HIE is critical for health care system transformation
- Interoperable HIE facilitates better communication and enables more coordinated and connected care across the full continuum of health delivery and payment settings
- Effective communication and information sharing is essential to improving the quality of care, bettering health of communities, and lowering per capita costs
HHS Principles and Strategy for Accelerating HIE

• August 2013: HHS/ONC and CMS published “Principles and Strategy for Accelerating HIE”

• HHS philosophy regarding interoperable HIE:
  – All patients, their families, and providers should expect to have consistent and timely access to standardized health information that can be securely shared between primary care providers, specialists, hospitals, mental health and substance abuse services, LTPAC, home and community-based services, other support and enabling services providers, care and case managers and coordinators, and other authorized individuals and institutions.
  – It will take time to build a fully electronic interoperable system of coordinated care and communication across health care providers.
  – HHS is fully committed to ensuring ubiquitous, standards-based electronic exchange of health information across all care settings through a multi-year approach that is consistent, incremental, yet comprehensive.

HHS Principles and Strategy for Accelerating HIE:
Some Key Principles

Principles are organized into three categories:

1. Accelerating HIE
   • New regulations and guidance
   • Policies that encourage HIE incrementally
   • Federal and state partnerships
   • Encourage interoperable state infrastructure (e.g., Medicaid)
   • Facilitate adoption of HHS HIT standards across Federal Government
   • Educate consumers
   • Privacy, security, and integrity of patient health information

2. Advancing Standards and Interoperability
   • Multi-stakeholder development of standards
   • Align HIT standards with quality measurement and improvement
   • Align electronic clinical quality measures, electronic decision support interventions and electronic reporting mechanisms.
   • Electronic management of consent of sensitive health data

3. Consumer/Patient Engagement
   • Patient access to their health information
   • Access to a patient’s health information by family caregivers
   • Make HHS standardized data available to patients wherever possible
ONC Interoperability Vision

- June 2014: ONC published *Connecting Health and Care for the Nation: A 10-year Vision to Achieve an Interoperable Health IT Infrastructure*
- Describes ONC’s broad vision and framework for interoperability
- Call for all health IT stakeholders to join in developing a defined, shared roadmap to help achieve interoperability as a core foundational element of better care at a lower cost
- Paper ascertains **Interoperability is a national priority**
- ONC will be offering several opportunities in the coming months for the public to provide their feedback

Nationwide Health IT Infrastructure: 5 Critical Building Blocks

1. Core technical standards and functions
2. Certification to support adoption and optimization of health IT products and services
3. Privacy and security protections for health information
4. Supportive business, clinical, and regulatory environments
5. Rules of engagement and governance

Building blocks are interdependent and progress must be incremental across all so that the Interoperability vision can be achieved over the next decade.
Putting It All Together: The Learning Health System

- **Personal Health Record**
  - Quality Measures

- **Electronic Health Record**
  - Public Health

- **Health Information Exchange**
  - Clinical Research

- **Natl & Intl Health Analytics**
  - Interoperability standards and services
    - Certification of HIT to accelerate interoperability
    - Privacy and Security Protections
    - Supportive business, clinical, and regulatory environments
    - Rules of Engagement and Governance

- **Patient**
  - Clinical Decision Support

- **Practice**
  - Public Health Policy

- **Population**
  - Clinical Guidelines
What is the S&I Framework?

• The Standards and Interoperability (S&I) Framework represents one investment and approach adopted by ONC to fulfill its charge of prescribing health IT standards and specifications to support national health outcomes and healthcare priorities.

• Consists of a collaborative community of participants from the public and private sectors who are focused on providing the tools, services and guidance to facilitate the functional exchange of health information.

• Uses a set of integrated functions, processes, and tools that enable execution of specific value-creating initiatives.
S&I Framework: The Value of Community Participation

FACAs
- HIT Standards Committee
- HIT Policy Committee
- Tiger Team

Community
- Technology Vendors
- System Integrators
- Government Agencies (National & International)
- Industry Associations
- Other Experts

S&I Framework
- State HIE Program & CoPs
- REC Program & CoPs
- Beacon Program

SDOs
- HL7
- IHE
- CDISC
- Other SDOs

ONC Programs & Grantees
What is a Standard?

- Standards provide a common language and set of expectations that enable interoperability between systems and/or devices.
- Health IT standards permit data (or electronic information) to be shared between clinician, lab, hospital, pharmacy, and patient regardless of application.
- Standards are typically developed, adopted and/or maintained by Standard Development Organizations (SDOs).
  - S&I Framework serves as a community forum to identify or create standards which are then presented to an SDO for accreditation and publication.

ONC Privacy & Security Framework: Shared Responsibility

Health Care Providers
- Understand Rules
- Protect and Secure Information
- Educate Staff and Patients

Government
- Promotes Trust
- Develops Policies
- Fairly Enforces Rules

Patients
- Understand Rights
- Protect Personal Information
- Be Engaged

Technology Vendors
- Embrace Privacy by Design
- Provide Convenient Technology
- Implement Standards
ONC Goal: Inspire Confidence & Trust

Promote the Secure Use of Health IT
- Information Assurance

Coordinate Development of Privacy and Security Policy
- Patient Direct Access to Lab Report (CLIA)
- Meaningful Use

Educate and Empower Patients and Providers
- Improved Access to Health Information
- View and Download Health Records
- Patient Education
- Enhanced Understanding of Patients

Provide Technical Assistance
- Interactive Security Training
- Data Segmentation for Privacy
- Notice of Privacy Practices
- eConsent Trial

Conclusion
Putting the I in HealthIT
www.HealthIT.gov
The Office for Civil Rights (OCR) and Office of the National Coordinator for Health Information Technology (ONC) collaborated to develop model NPPs for covered entities to use:

- One set for health plans
- One set for health care providers

http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html
Appendix B:
National Policies & Standards to Support Coordination of Care
Meaningful Use & EHR Certification Process

• **CMS** administers the Meaningful Use EHR Incentive Programs
  – 2 Separate Programs: Medicare & Medicaid
  – Pays and/or penalizes eligible professionals/hospitals/CAHs for demonstrating MU

• **ONC** administers the EHR Certification Process
  – Provides a defined process to ensure EHR technologies meet adopted standards and certification criteria to help eligible professionals/hospitals achieve CMS MU objectives and measures
  – Certified EHR Technology (CEHRT) gives assurance to purchasers and other users that an EHR system or module offers necessary technological capability, functionality and security
CMS & ONC Programs: Complimentary but Different Scope

• CMS Meaningful Use Program is ‘Procedural’
  – Specifies how eligible providers need to use Certified EHR Technology in order to receive incentives

• ONC Certification Program is ‘Technical’
  – Specifies the capabilities EHR technology must include and how they need to be certified
  – It does NOT specify how the EHR technology needs to be used
  – It is not directly tied to MU
    • 2014 Edition EHRs can be used to meet Stage 1 and Stage 2
    • CERHT does not only need to be used to meet MU
C-CDA Release 1.1 Documents: 8 standard document templates


Document Templates: 9
- Continuity of Care Document (CCD)
- Consultation Note
- Diagnostic Imaging Report (DIR)
- Discharge Summary
- History and Physical (H&P)
- Operative Note
- Procedure Note
- Progress Note
- Unstructured Document

Section Templates: 60
Entry Templates: 82

### Document Template
- Continuity of Care Document (CCD)
  - Allergies
  - Medications
  - Problem List
  - Procedures
  - Results
  - Advance
  - Directives
  - Encounters

### Section Template(s)
- Family History
- Functional Status
- Immunizations
- Medical Equipment
- Payers
- Plan of Care

### History & Physical (H&P)
- Allergies
- Medications
- Problem List
- Procedures
- Results
- Family History
- Immunizations
- Assessments

### Section Template(s)
- Assessment and Plan
- Plan of Care
- Social History
- Vital Signs
- History of Present Illness
- History of Present Illness

Section templates in GREEN demonstrate CDA’s interoperability and reusability.

Chief Complaint
Reason for Visit
Review of Systems
Physical Exam
General Status
2014 Edition:
Transition of Care Criterion

Common MU Data Set
- Patient name
- Sex
- Date of birth
- Race**
- Ethnicity **
- Preferred language**
- Care team member(s)
- Medications **
- Medication allergies **
- Care plan
- Problems **
- Laboratory test(s) **
- Laboratory value(s)/result(s)
- Procedures **
- Smoking status **
- Vital signs

Criterion-Specific Data Requirements
- Criterion-Specific Data Requirements
- Provider Name & Office Contact Information (Ambulatory Only)
- Reason for Referral (Ambulatory Only)
- Encounter Diagnoses **
- Cognitive Status
- Functional Status
- Discharge Instructions (Inpatient Only)
- Immunizations**

NOTE: Data requirements marked with a double asterisk (**) also have a defined vocabulary which must be used.
MU Requirements Achieved via C-CDA

CDA standardizes the expression of clinical concepts which can be used/re-used

Templates are used to specify the ‘packaging’ for those clinical concepts

Sets of CDA templates are arranged to create a purpose-specific clinical document

MU adds data requirements, which can be layered on top of C-CDA document templates by the EP or EH/CAH to achieve MU compliance

NOTE: No single C-CDA document template contains all of the data requirements to sufficiently meet MU2 compliance – C-CDA & MU2 guidelines must be implemented together.

Office of the National Coordinator for Health Information Technology
Appendix C:
Overview of ONC Longitudinal Coordination of Care (LCC) Initiative
Background of LCC Initiative

- Initiated in October 2011 as a **community-led** initiative with multiple public and private sector partners, each committed to overcoming interoperability challenges in long-term, post-acute care (LTPAC) transitions
- Focused on advancing interoperable health information exchange (HIE) on behalf of LTPAC stakeholders and promotes LCC on behalf of medically-complex and/or functionally impaired persons
- **Goal is to** identify standards that support LCC of medically-complex and/or functionally impaired persons that are aligned with and could be included in the EHR Meaningful Use Programs (focus on MU3)
- Activities supported via 5 sub-workgroups (SWGs):
  - *Longitudinal Care Plan (LCP)*
  - *LTPAC Care Transition (LTPAC)*
  - *HL7 Tiger Team*
  - *Patient Assessment Summary (PAS)*
  - *Pilots (ONLY ACTIVE)*

* The work of the LCP and LTPAC completed in SEP2013, HL7 Tiger Team completed in AUG13 and PAS SWG completed in JAN13
LCC Workgroups Structure

COMMUNITY-LED INITIATIVE

Longitudinal Coordination of Care Workgroup

Longitudinal Care Plan SWG
- Identified standards for Care Plan exchange

LTPAC Care Transition SWG
- Identified data elements for long-term and post-acute care (LTPAC) information exchange using a single standard for LTPAC transfer summaries

HL7 Tiger Team SWG
- Ensured alignment of LCC Care Plan activities with related HL7 Care Plan standardization activities

Patient Assessment Summary (PAS SWG)
- Identified standards for the exchange of patient assessment summary documents

Pilots WG (ACTIVE)
- Validation and testing of LCC WG identified Standards

eLTSS WG (NEW*)
Est. start Fall 14
- Identification and testing of new eLTSS Standard
LCC Initiative: Contact Information

- **LCC Leads**
  - Dr. Larry Garber (Lawrence.Garber@reliantmedicalgroup.org)
  - Dr. Terry O’ Malley (tomalley@partners.org)
  - Dr. Bill Russell (drbruss@gmail.com)
  - Sue Mitchell (suemitchell@hotmail.com)
- **LCC/HL7 Coordination Lead**
  - Dr. Russ Leftwich (Russell.Leftwich@tn.gov)
- **Federal Partner Lead**
  - Jennie Harvell (jennie.harvell@hhs.gov)
- **Initiative Coordinator**
  - Evelyn Gallego (evelyn.gallego@siframework.org)
- **Project Management**
  - Pilots Lead: Lynette Elliott (lynette.elliott@esacinc.com)
  - Use Case Lead: Becky Angeles (becky.angeles@esacinc.com)

**LCC Wiki Site:** [http://wiki.siframework.org/Longitudinal+Coordination+of+Care](http://wiki.siframework.org/Longitudinal+Coordination+of+Care)