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

July 20, 2012

Prepared for: Office of Policy and Planning
Office of the National Coordinator for Health Information Technology
US Department of Health and Human Services

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Center for the Advancement of Health Information Technology

ONC greatly appreciates the contributions of the Assistant Secretary for Planning and Evaluation (ASPE) throughout the roundtable

RTI INTERNATIONAL

Contents

Tables

Number **Page**

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1. INTRODUCTION

As the population of the United States ages, the number of people receiving Long-Term and Post-Acute Care (LTPAC) services is expected to grow rapidly. LTPAC is characterized by a variety of settings, from complex care in long-term acute-care hospitals to supportive services in community- and home-based settings. Compared to the general population, patients who receive LTPAC services 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 longer-term care settings. The range of LTPAC providers and care settings, and the frequent movement of patients among them, necessitates the exchange of relevant, timely care data. Coordination of care is essential, as is the need for systems to support information capture, use, and exchange.

Two important vehicles to manage the capture, summarization, and sharing of these data are electronic health records (EHRs) and health information exchange (HIE) technologies. Over that past decade, several public and private sector efforts have focused on developing and adopting health information technologies (IT) to support care delivery and administration within and across LTPAC settings. With the advent of the Medicare and Medicaid EHR Incentive Programs, EHR and HIE adoption by eligible professionals, eligible hospitals, and critical access hospitals ("eligible providers", or EPs) has increased. These important care partners must share patient information and coordinate care with LTPAC providers. In addition, emerging payment and delivery system changes driven by the Patient Protection and Affordable Care Act (ACA) will also reward providers for demonstrating improved care coordination, quality, and reduced costs. This interdependence heightens the need to examine and support EHR and HIE adoption across the LTPAC community.

The Office of the National Coordinator for Health Information Technology (ONC), Office of Policy and Planning (OPP) contracted with RTI International to host a roundtable discussion on the health IT needs of LTPAC providers, specifically related to EHRs and HIE to support quality and continuity of patient care.[1] The roundtable participants included representatives from LTPAC providers, professional associations, system vendors, consumer advocates, and representatives from related Federal programs and committees (**Appendix A**).

The roundtable discussions supported two main objectives. The first objective was to help ensure that LTPAC provider needs for EHRs and HIE services are well understood and to facilitate the availability of products in the marketplace that meet those needs. The second

[1] For a general overview of health IT issues in LTPAC, see: http://www.ltpachealthit.org. Additional information, including reference materials on the state of health IT in LTPAC, can be found on the Standards & Interoperability Web site: http://wiki.siframework.org/LCC+WG+Reference+Materials. A discussion of LTPAC and health information exchange can be found through the Assistant Secretary for Planning and Evaluation: http://aspe.hhs.gov/daltcp/reports/2011/StratEng.htm

objective was to help ensure that LTPAC providers know what EHR system features and functions to look for, and to adopt systems that support transitions of care (TOC), care coordination, and related HIE functions.

ONC focuses on coordinating adoption of health IT across all providers, and LTPAC is an important part of this spectrum. Moreover, ONC is aware of the uncertainties and questions regarding EHR certification confronting LTPAC and other providers that are ineligible for the Medicare and Medicaid EHR Incentive Programs. Thus, ONC is trying to coordinate adoption of health IT that supports LTPAC providers needs and is aligned with the Meaningful Use (MU) requirements that EPs must meet for the Medicare and Medicaid EHR Incentive Programs.

This report summarizes key findings from the roundtable discussion and outlines options based on the discussion for ONC's Federal Advisory Committees members—the HIT Policy and HIT Standards Committees—to consider when developing recommendations for additional EHR Certification Criteria (EHR CC) and additional Stage 3 MU requirements and measures. The recommendations in this report are based on the roundtable discussion. The roundtable discussion did not address operationalization of recommendations. Thus, implementation of recommendations is beyond the scope of this report.

Roundtable Format

ONC contracted with RTI International to hold the day-long LTPAC roundtable meeting on May 3, 2012, at its offices in the U.S. Department of Health and Human Services in Washington, DC. A background report that discussed roundtable motivations, objectives, discussion questions, and supporting materials was developed and shared with participants prior to the roundtable. The agenda (**Appendix B**) provided the following discussion points:

- LTPAC provider EHR and HIE needs, and ONC's role in meeting those needs;
- Identification of priority areas to align proposed Stage 2 MU and 2014 EHR CC with LTPAC provider needs; and,
- Approaches to addressing priority areas, in particular related to Stage 3 MU.

2. SUMMARY OF FINDINGS

Health IT Needs of LTPAC Providers and ONC's Role

Initial discussions among roundtable participants yielded the following general observations and guidance about how ONC should assess the health IT needs of LTPAC providers and how to support the LTPAC community.

ONC has a role in promoting LTPAC adoption of health IT, but needs to be cautious. Roundtable participants noted that the need to solve business problems, improve quality and continuity of care, and comply with reimbursement models has motivated LTPAC providers to adopt health IT. Generally, participants agreed that ONC has a role in helping LTPAC providers adopt EHRs and HIE more easily. They suggested that ONC consider other "policy levers" in addition to MU and EHR CC in helping LTPAC providers. A few participants noted that ONC support should include an understanding of LTPAC provider business needs, and should seek to ensure assistance to address these needs.

In providing any support to LTPAC providers, one participant advised that ONC guard against unfunded mandates for LTPAC EHR adoption. Many participants stressed relying on existing tools and infrastructure (where present) to promote data exchange and care coordination. Some participants also stressed that ONC initiatives in LTPAC EHR and HIE adoption remain "entrepreneurial friendly." For instance, ONC should recognize that innovations in HIE among LTPAC providers and EPs are occurring and will continue, and that any assistance from ONC should not hinder or constrain these innovations.

LTPAC provider health IT needs should be framed around care teams, including patients, families, and caregivers. When considering health IT for LTPAC care settings, roundtable participants advised ONC to move away from provider-centered models of EHR capabilities and needs assessments. One participant proposed adopting a patient-centered view of health IT: start with LTPAC patients and their goals, then consider the care team needed to support and achieve those goals (i.e., to provide optimal patient care), followed by the data and information needed to support service delivery to the individual by the care team, and finally determine which technologies best meet these information needs. Care teams would include families and other support systems. This approach, participants noted, is flexible and extendable, and helps identify gaps in information needs within and across care settings and providers.

Some participants cautioned against fixation on any previous structures of care when assessing LTPAC EHR needs, including episode-based treatment models, and to avoid viewing EHR needs according to traditional care silos (e.g., long-term acute care hospitals, skilled nursing facilities, home health, etc.). Taking this approach means that other technologies, such as case management systems, could be included in assessments of the health IT needs of LTPAC providers—not only EHR and HIE capabilities.

Other participants agreed with this approach, but emphasized that care delivery in LTPAC settings is heavily defined by reimbursement models, which helped to create siloed care and fragmentation in service delivery. They noted the importance of care coordination and of identifying the data elements needed to improve care coordination and care transitions across LTPAC settings. Moreover, participants stated that care transitions today are not cold handoffs; there is a process of assessing patient needs with multiple touchpoints that can get lost if it is perceived as simply sharing electronic care summaries. As ONC assesses LTPAC provider needs for health IT, ONC should consider multidisciplinary care teams and complexity of care within and between LTPAC settings and other providers (e.g., physicians). ONC also should factor in how health IT facilitates (or hinders) communication across team members, including patients, families, and caregivers.

Data collection and exchange strategies must consider both senders and receivers of health information, and be flexible enough to allow for innovation. Roundtable participants further noted that, as part of assessing ways to support LTPAC providers with health IT adoption, ONC should strive to understand what information health data senders and receivers truly need. One important effort in this area includes the work by the Standards & Interoperability Framework Longitudinal Coordination of Care Work Group (S&I LCC WG). The S&I LCC WG is defining functional requirements for care planning and coordination; assessing gaps in the care model as well as the steps needed to close these gaps; examining standards associated with data exchange, including the Consolidated CDA (CCDA) and how it could be used to move toward a vision of an integrated care plan exchanged across care settings.

Care plans must evolve to be more patient-centric. Roundtable participants also discussed how LTPAC processes of care must progress to include patient-defined goals, problems, and interventions. As a result, implications for EHR CC and MU requirements must be considered. If more complete, accurate information about LTPAC patients is the goal, ONC should examine data exchange standards for acute care relative to LTPAC provider needs. Unless data supporting TOC are collected accurately within acute and LTPAC provider EHRs, and include patients' views and goals, continuity of care may not be adequately supported.

Identify and Address Priorities

Following these initial conversations, roundtable participants reviewed an assessment of LTPAC provider health IT needs, and confirmed where these needs aligned with proposed 2014 EHR CC and Stage 2 MU criteria. Participants also identified additional areas not currently covered—or not adequately covered—by these proposed criteria. Finally, they discussed which of these areas should be priorities to address in subsequent EHR certification and Stage 3 MU measures. Roundtable participants identified three primary areas: care plans, transitions of care (TOC), and federally mandated patient assessments.

1. Care Plans

Participants suggested that developing a coordinated longitudinal care plan to be shared among patient's care team members, including LTPAC providers, patients, families, and caregivers should be an immediate priority. They noted that 2014 EHR CC and proposed Stage 2 MU begin to address care plans through incorporation in the proposed TOC criteria, but this information is not sufficient. Consensus around the definition of a "care plan", the components of a care plan and their definitions, and standards related to care planning are being addressed through the S&I LCC WG and will need to be more broadly assessed, piloted, and tested.

One participant noted that care plans incorporate information from many sources, including patient assessments, and expressed uncertainty about how to automate care planning in information systems. This participant suggested that work was needed to develop vocabularies and value sets for care plans, to determine ways to shorten the lag times between patient assessments and care planning, and to better understand how data collected outside of assessments could feed care planning and assessment processes.

Other roundtable members stated that development and maintenance of the care plan was a dynamic process, and that care plans should be reconciled and updated continually. Further, in line with prior comments, participants noted that these care plans should reflect patient status, goals, and care needs. The [electronic] exchange of care plans will necessitate the use of a time stamp to tell providers when these plans were last updated. Further, needed EHR functionality related to care plans (e.g., alerts, precautions, etc.) will require specification. Finally, one panelist stressed that providers who share care plans must be able to do so using a variety of modes—mail, fax, or electronic—to meet the needs of providers receiving these care plans.

2. Transitions of Care

Roundtable participants agreed that care transitions should be a central focus, as these are common activities across acute and LTPAC providers and are events in which LTPAC patients are most often harmed. Importantly, TOC care summaries are already part of proposed 2014 EHR CC and Stage 2 MU. Some participants stated that the TOC definitions and related standards as currently proposed for Stage 2 MU do not fully support the information exchange needs of LTPAC patients and their providers during care transitions. One panelist described work conducted as part of a Massachusetts Challenge Grant (IMPACT) that identified 169 possible types of care transitions and has constructed five different data sets to support key TOC use cases. Participants agreed that the TOC data elements proposed in Stage 2 MU could be augmented for Stage 3 to support interoperable health information exchange for a broader range of care transitions.

Some participants expressed concern that the CCDA as currently specified could not adequately link patient care goals to specific clinical interventions. The S&I LCC WG has identified CCDA specification as an issue requiring further review. In addition, participants suggested that bi-directional exchange of TOC core data sets is an important goal. As with care plans, one participant stressed that the sending provider (EP) must be able to send and receive TOC data using whatever mode the receiving provider (LTPAC) needed. Sharing data between EPs and LTPAC providers, even if not semantically interoperable, was a top priority. In short, "let's get started" with data sharing was a prevailing sentiment.

3. Federally Mandated Patient Assessments

Roundtable members stated that federally mandated patient assessments, and data elements used in populating them, were very important to LTPAC providers and should therefore be a priority for ONC. LTPAC providers assess patients in a range of areas, including skin integrity, gait, fall risk, ambulation, cognitive function, mood, and nutritional status. The ability to continually assess and track the progress of clinically significant events, such as the skin breakdown and care of pressure ulcers, is vital both within and across LTPAC and other care providers. The proposed rule for Stage 2 MU requires EPs to transmit demographic, problem, diagnosis, and other information during TOC. These data may help receiving LTPAC providers populate federally mandated patient assessments. Thus, alignment between acute and LTPAC settings will be beneficial to support care continuity.

Roundtable members noted that many data elements used in patient assessments were already being collected routinely as part of care delivery, and suggested that work is needed to find ways for data captured in the course of routine documentation to be used to populate patient assessments. Further, LTPAC providers are already required to send patient assessment data to Centers for Medicare and Medicaid Services (CMS) electronically. Participants suggested that LTPAC providers could use existing electronic infrastructure and capabilities to share assessment data—containing valuable baseline information about a patient—with EPs and other providers. Some participants cautioned that patient assessment data provide a snapshot of a patient's health status that may be days or weeks old and may not reflect real-time information of importance during transitions. One example of missing information could include the reason for transferring a patient from a LTPAC setting to another care setting such as the emergency department, a common occurrence.

Finally, one participant encouraged the roundtable to view patient assessments relative to quality measurement. This participant noted some assessment data are collected as part of quality measure reporting. The focus, then, could be on identifying which care processes need improvement, and use these to determine assessment data needs and, in turn, what kinds of systems and capabilities vendors need to develop to capture and share these data.

Additional Recommendations in Support of Priorities

The participants had several additional discussions and suggestions in support of the above priorities: a review of current ONC efforts in these areas; discussion of health IT pilot projects and initiatives in LTPAC provider organizations; and recommendations for development and exchange of care summaries, patient assessments, and advanced directives. Each of these is reviewed in detail in the following section.

ONC workgroups are identifying and developing standards related to LTPAC roundtable priority areas. The S&I LCC WG, and three of its associated sub-workgroups (SWGs), are working to address many priorities identified by roundtable participants.

- The Patient Assessment Summary (PAS) SWG, for instance, has identified a subset of the Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS) data elements to be included in patient assessment summary documents. The PAS SWG is examining additional data elements, including those in other assessment instruments, to support TOC. The PAS SWG anticipates identifying the domains of data (e.g., diagnoses, functional status, cognitive status, etc.) that are comparable across instruments and needed for TOC, and will collaborate with HL7 to identify standards to support the interoperable exchange of document containing these data.

- The Longitudinal Care Planning SWG is defining use cases, functional requirements, and content needs for shared care plans. They are also assessing how these requirements may align with the proposed Stage 2 EHR CC and MU requirements, and how any gaps could be addressed.

- Finally, the TOC SWG is examining data exchange for care transitions and, using the experience of the Massachusetts Challenge Grant, assessing what receiving care providers need to know to care for the transferring patient, and whether or not transfer documents can be sufficiently populated to meet these needs.

As Federal Advisory Committees consider Stage 3 MU and EHR CC criteria, the S&I Framework LCC WGs will be a key source of information on what standards exist, where gaps remain, and the feasibility and challenges with adopting new LTPAC-related standards and criteria in subsequent stages of Meaningful Use.

Current pilots and initiatives should inform development of EHR CC and Stage 3 MU measures. Roundtable participants provided examples of data exchange projects and initiatives at LTPAC provider organizations present at the roundtable. ONC also reviewed a variety of current LTPAC initiatives, including ONC's four Challenge Grants focused on LTPAC TOC and a few Beacon Community Programs. Example initiatives include pilot projects to exchange transfer data sets, emergency department admission and discharge data (Massachusetts Challenge Grant); the exchange of patient assessments and their transformation into interoperable CCD patient assessment summary documents (KeyHIE Beacon Community); data from INTERACT assessments (Oklahoma Challenge Grant); and the exchange of the home care plan of care between the home health agency and the

ordering physician (Visiting Nurse Services of New York). For these data exchanges, participants thought that including care team member information was critical—i.e., care team member's name, role, and contact information. The results of all these pilots can be used to develop and test programs on a broader scale to support LTPAC providers.

Additionally, some participants made a plea to vendors to help start and support data exchange efforts, and to work with stakeholders to figure out low-burden ways to participate. Others noted that many other approaches to data exchange were being tried in the private sector and in public-private collaborations. Specifically, activities in CMS's Program of All-Inclusive Care for the Elderly (PACE) could be a relevant source of experience in LTPAC data exchange.

In total, discussions involving current pilots in LTPAC-related data exchange suggest that ONC should identify, assess, and consult with a range of the projects to determine lessons learned and to inform development of EHR CC and Stage 3 MU measures in this area. One participant also recommended developing and administering a survey to more fully understand LTPAC HIT adoption.

New LTPAC data exchange criteria and measures are needed in Stage 3 MU. One participant recommended that a new data exchange criteria be included in Stage 3 MU related to TOC and care plans. EPs would be required to transmit a core TOC data set and a separate care plan (i.e., care summary data) to all other members of the care team at the time of the transfer. As part of these new criteria, EPs would have to document that the data and plan were received by the care team members assuming care of the transferred patient, and that these data were actionable (i.e., what the provider needed to care for the transferred patient). In addition, the transmission would include a time stamp for both sending and receiving the TOC data and care plan. Conversely, LTPAC providers would send updated care summary data back to the EP should the patient be transferred back to their care, as in the case of a rehospitalization. Here again, the providers would receive these data and plans in their preferred transmission method; otherwise, an unfunded mandate would result.

Regarding the timing of this exchange, one participant suggested that EPs be required to send TOC data and care plan at the time of patient transfer or within 1 hour of transfer. Other participants took a more incremental approach to this aspect, and suggested that EPs and LTPAC providers could first ensure timestamps for sending and receiving of data and care plan, and then work on an acceptable time interval for this transmission. One roundtable participant suggested that Stage 3 MU include a measure of readiness of LTPAC providers to receive these data, and a way to share preferences for data transmission.

Certified EHR technologies must be able to capture and share patient assessment data, especially for cognitive status, functional status, and pressure ulcers. Roundtable members expressed clear support for a new MU quality measure related to skin

integrity and pressure ulcers. Skin integrity is a key area in patient assessments currently performed in LTPAC settings, and new pressure ulcers are a "never event" for acute-care hospitals. Stage 3 MU should require the capture and exchange of skin integrity data among EPs and LTPAC providers. Functional status and cognitive status are also central to these assessments, and many members of the patient care team (e.g., EPs and LTPAC) need this information. Standards for the exchange of this content were included in the spring 2012 HL7 ballot refining the CCDA. Exchange of this information could be included as a requirement as part of Stage MU.

Participants discussed some of the assessment tools and data sets LTPAC providers use today, and noted how the Continuity Assessment & Record Evaluation (CARE) tool is an amalgam of some of the data elements in these instruments.[2] Some participants asserted that CARE is currently the best available patient assessment tool and data set that spans LTPAC care settings; others stressed that CARE would not be appropriate as it is not presently in use by LTPAC providers (although long-term care hospitals will be required to use some CARE data elements beginning October 2012) and its validation is not yet public. The balloted HL7 CCDA will support the exchange and communication of information about functional and cognitive status and pressure ulcers.

Roundtable members also discussed the complexity and length of certain patient assessments, and the need to represent results data clearly and concisely through patient summaries. One roundtable participant stressed that the providers receiving LTPAC patients must have a quick and easy way of understanding the incoming patient's state—including his/her preferences and goals—and of determining whether or not their facility was the most appropriate care setting for this patient. This abbreviated summary would precede a more detailed patient assessment summary document, composed of data subsets of the complete patient assessment. Participants indicated that this abbreviated summary would facilitate usability of information.

Participants also noted that patient assessment tools and related data cover a range of important domains, including skin integrity, functional status, memory and cognition, mood, and nutrition. Some suggested using ongoing research using structured vocabularies and value sets to identify one or two of the most sensitive data elements that show a patient's status and risk for each of these domains. These values could be combined to create an abbreviated standardized screening functional status data set: a simple, one-page document that contains patient goals, current active health concerns (not just problems and diagnoses), and summary patient assessment results. This document could help providers more quickly understand an incoming patient's functional and health status and align core assessment elements across the care continuum. Participants noted that nothing like this

[2] For an overview of the CARE tool developed as part of the CMS Post-Acute Care Payment Reform Demonstration (PAC-PRD) project, see: http://www.pacdemo.rti.org/meetingInfo.cfm?cid=caretool

exists today in MU, but could be a useful addition to subsequent MU stages. The Certification Commission for Health Information Technology includes a clinical summary as part of their LTPAC certification standards, which could be used as a point of reference for ONC in developing a usable, high-level patient assessment summary for Stage 3 MU. Data elements such as these and those required for TOCs and longitudinal coordination could be used as quality metrics, which would facilitate adoption of data exchange.

Finally, a few participants cautioned against over-defining care processes in the context of patient assessments and data exchange. They urged ONC and other participants to consider ensuring flexible means of assessing functional status by focusing on outcomes and patient goals as one way of preserving providers' ability to innovate in this area.

Advance directives also need separate consideration in Stage 3 MU. Documenting advance directives—do patients have one, do they or members of their care team know where it is and what it contains?—is important for all members of the care team. Participants discussed enhancing the MU requirements to include patient preferences related to quality of care and quality of life and goals, and noted the need for a document schema for advanced directives that could be exchanged in a computable form. Existing work in Medical Orders for Life-Sustaining Treatments could serve as the basis for this schema. One participant noted that the Health IT Policy Committee was scheduling an upcoming hearing focusing on advance directives, and will discuss current state of documentation and provider's ability to access these directives—including policies needed to enable this access.

3. CONCLUSION AND NEXT STEPS

The roundtable participants identified person-centric longitudinal care plans, transitions of care, and patient assessments as three priority areas for ONC to examine relative to EHR CC and MU requirements. They recommended development of new measures, criteria, and resources in these areas that help improve LTPAC care coordination and outcomes. Throughout the roundtable, certain themes pervaded discussions, including the role for ONC to provide "balanced" support to LTPAC providers: get started now with assisting LTPAC providers; work with existing infrastructure and resources whenever possible; ensure that clear, useful information is shared; preserve (even enhance) LTPAC provider's ability to innovate with new approaches; and incorporate lessons learned. This report will be shared with the Health IT Policy Committee's Meaningful Use Work Group, Subgroup #3 that is focused on improving care coordination.[3] Roundtable participants hope the priorities, recommendations, and themes from the roundtable as described in this report will guide ONC's efforts to better support LTPAC providers with adopting and using health IT/EHRs. A summary table of participant recommendations, and current activities around them, is provided in Table 1.

[3] 7/16/2012 HITPC MU WG, Subgroup #3 presentation of the ONC LTPAC Roundtable Recommendations http://healthit.hhs.gov/portal/server.pt?open=512&objID=1472&&PageID=17094&mode=2&in_hi_userid=11673&cached=true#071612

Table 1. Roundtable Participant Recommendations

Topic	General Recommendations	Current Activities
Advancing LTPAC adoption of Health IT	▪ Consider policy levers for driving change in addition to Meaningful Use and EHR Certification Criteria. ▪ Develop and administer a survey to more fully understand LTPAC HIT adoption.	—
Topic	**Stage 3 MU Recommendations**	**Current Activities**
Transitions of Care: Patient-centered view of care	▪ Frame HIT needs around care teams, including patients, families, and caregivers, and have a patient-centered view versus a provider-centric one. ▪ Consider HIT impact on communication among specific team members across the continuum.	LCC Work Group is addressing
Transitions of Care: Standards to support HIE	▪ Consider a broader range of TOC data elements and use cases in Stage 3 MU to support LTPAC. ▪ Support care coordination among the care team and across care settings. At transition, transmit a core set of data and a care plan to all members of the care team in the receiver's preferred transmission method (even if not electronic). ▪ Acknowledge data received in a reasonable time frame and actionable. Recommend a time stamp to automate acknowledgement of receipt.	LCC Transitions of Care SWG is identifying standards
Care Plans: Integrated Care Plans Across Settings	▪ Move toward vision of a dynamic, longitudinal care plan that can be shared among care team members, including providers, patients, families, and caregivers and exchanged across care settings. ▪ Come to consensus around the definition of a care plan, the components of a care plan and their definitions, and standards related to care planning needed across the spectrum of care, including inpatient, outpatient, and LTPAC settings. ▪ Include patient-defined goals, problems, and interventions to support patient-centered care plans. ▪ Include a time stamp with care plans to inform providers about when the plans were last updated. ▪ Identify care team members and related information such as name, role and contact information. ▪ Reconcile care plan and patient goals at each care transition.	LCC Care Planning SWG is addressing
Patient Assessments	▪ Support the capture and exchange of patient assessment content, including cognitive status, functional status, and pressure ulcer content, to support care coordination, delivery, and planning.	LCC Patient Assessment SWG is identifying standards and considering
Quality Measures	▪ Support a new MU quality measure related to skin integrity and pressure ulcers.	—
Advance Directives	▪ Consider inclusion of advance directive content including patient preferences and goals. ▪ Consider adoption of a document schema to support exchange.	—

Appendix A:
LTPAC Roundtable Participants

Name	Provider
Peter Kress *Chief Information Officer*	ACTS Retirement—Life Communities
Rosemarie Namisato, RN, MS *Manager, Systems Analysis and Design*	Visiting Nurse Services of New York
Rusty Williams *Chief Information Officer*	Good Samaritan Society
Jim Walker, MD *Chief Health Information Officer*	Geisinger Health System FACA Member—HIT Standards Committee Chair, Clinical Quality Workgroup
Larry Wolf *Health IT Strategist*	Kindred Health Care FACA Member—HIT Policy Committee Co-Chair, Certification/Adoption Workgroup
Roberta Steinhauser *Assistant Director Hospital Applications*	Madonna Rehabilitation Hospital
John Derr *Strategic Clinical Technology*	Golden Living FACA Member—HIT Standards Committee Member, Clinical Quality Workgroup, Implementation Workgroup and Consumer Engagement Workgroup
Bill Russell, MD *Geriatrician, Clinical Informaticist*	Seasons Hospice S&I Framework—Co-Leads LCC Longitudinal Care Plan SWG; Working on key functional requirements and use cases that would be supported by a longitudinal care plan
Barbara Manard *Vice President, Long-Term Care Health Strategies*	Leading Age
Majd Alwan, PhD *SVP of Technology and Executive Director*	Center for Aging Services Technologies (CAST)
Peter Gruhn *Director of Research*	American Health Care Association (ACHA)
Richard D. Brennan, Jr., MA *Executive Director*	Home Care Technology Association of America (HCTAA)
Dan Cobb *Chief Technology Officer*	HealthMEDX, LLC President of the National Association for the Support of Long-Term Care (NASL)
Doc Devore *Director of Clinical Informatics and Industry Relations*	Answers on Demand (AOD)

Name	Vendor
Dave Wessinger *Chief Technology Officer*	PointClickCare
Karen Utterback *Vice President, Clinical Strategy & Marketing*	McKesson
Larry Triplett *Vice President, Product Development*	Cerner Corporation

Name	Other FACA Member (HITPC—MU Coordination of Care SWG)
Charlene Underwood *Senior Director, Government & Industry Affairs*	Siemens Healthcare Health Services FACA Member—HIT Policy Committee Meaningful Use Work Group Chair, Care Coordination SWG

Name	HIE Expertise
Terry O'Malley, MD *Medical Director for Partners HealthCare At Home and Spaulding Rehabilitation Network*	Partners HealthCare; IMPACT HIE Challenge Grant (MA) S&I Framework—Co-Leads LCC Care Coordination SWG; Working on standards development and piloting related to discharge summary document

Name	Consumer Representative
Donald Redfoot, PhD *Strategic Policy Advisor*	American Association of Retired Persons (AARP)

Name	Certification Organization
Naomi Levinthal *Certification Manager*	Certification Commission for Health Information Technology (CCHIT)

Name	Federal Partners
Jennie Harvell *Senior Policy Analyst*	Assistant Secretary for Planning and Evaluation (ASPE) Leads HHS efforts to integrate health IT standards into Medicare / Medicaid post-acute care and long-term care programs. S&I Framework LCC WG—Leader across all three sub workgroups
Susan Joslin, PhD *Nurse Researcher and Informatics Specialist*	CMS, Office of Clinical Standards and Quality (OCSQ) Survey and Certification, Division of Nursing Homes
Judy Tobin, PT, MBA *CARE Project Officer*	CMS, OCSQ Quality Measurement and Health Assessment Group

Name	**ONC Representatives**
Judy Murphy	Deputy National Coordinator for Programs & Policy
Jodi Daniel	Director, Office of Policy and Planning
Seth Pazinski	Division Director for Planning and Operations, Office of Policy and Planning
Liz Palena Hall	ONC Policy Analyst / Nurse Advisor, Office of Policy and Planning
Steve Posnack	Director of Federal Policy Division, Office of Policy and Planning
Claudia Williams	Director, State HIE Program
Victor Palli (Contractor)	Initiative Coordinator, S&I Framework
Jamie Skipper	Coordinator, S&I Framework
Kory Mertz	Challenge Grant Director, State HIE Program

Name	**RTI International**
Linda Dimitropoulos, PhD	Director, Center for the Advancement for Health IT (CAHIT)
Don Mon, PhD	Senior Director and Director of Standards and Interoperability, CAHIT
Barbara Gage, PhD	Deputy Director, Aging, Disability, and Long-Term Care RTI International
Chuck Thompson, PhD, MS	Senior Research Health Policy Analyst, CAHIT
Stephen Brown, MS	Research Analyst, CAHIT
Doug Johnston, MTS	Director, Health IT Policy, CAHIT

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Appendix B:
LTPAC Roundtable Agenda

Long Term Post-Acute Care Roundtable
May 3, 2012
AGENDA

1. Welcome & Opening Remarks **Jodi Daniel** **8:30 – 9:00**

a. Housekeeping & Introductions
b. Project overview
c. Roundtable objectives and agenda

2. Framing the Discussion **Liz Palena Hall** **9:00 – 9:30**

a. EHR needs of LTPAC providers
b. *Proposed* 2014 Edition EHR Certification Criteria (CC) and Stage 2 Meaningful Use (MU)

3. Identifying Priorities **Liz Palena Hall** **9:30 – 10:15**

a. Gap analysis tables
b. Suggested priorities

- ***What EHR functionality do LTPAC providers need?***
  - ***What EHR functions are critical to supporting delivery, coordination, and administration of care?***
  - ***What EHR functions are central to enabling HIE?***

- ***How do these needs align with proposed CC and Stage 2 MU criteria?***
  - ***Which proposed criteria are relevant to LTPAC providers, and which are not?***

- ***Which of these EHR needs and criteria are priorities to address in Stage 3 MU?***

BREAK		**10:15 – 10:30**
Identifying Priorities (cont.)	**Liz Palena Hall**	**10:30 – 12:00**

a. Continue discussion
b. Summarize priority areas

LUNCH		**12:00 – 12:45**
2. Comments	**Judy Murphy**	**12:45 – 1:00**
3. Addressing Priorities	**Jodi Daniel**	**1:00 – 2:45**

- ***How might proposed CC and MU criteria be modified to support LTPAC provider EHR needs, including data exchange between eligible providers and LTPAC?***
- ***What new criteria might be needed to support LTPAC provider EHR needs, including HIE? What might these criteria include?***
- ***What current initiatives/work would help answer these questions?***
- ***What other types of analyses would be needed to answer these questions?***

BREAK		**2:45 – 3:00**
Addressing Priorities (cont.)	**Jodi Daniel**	**3:00 – 4:00**
4. Summary and Next Steps	**Jodi Daniel**	**4:00 – 4:30**

a. Summarize options
b. Follow up
c. Timeline

THANK YOU!