Commonwealth of Massachusetts
Executive Office of Health and Human Services

Transitions of Care & Mass HIway

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Today's Presenter

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Starting with Common Language

National Transitions Of Care Coalition (NTOCC) Defines a Transition of Care (TOC) as
Movement of patients between health care locations, providers, or different levels of care as their conditions & care needs change

- Within & Between Settings
- Across Providers & Communities
- Span Spectrum of Health & Health Status

Key Clinical Information Sharing at TOC

- Discharge Summary
- Consult & Progress Notes
- Referrals and Pending Labs/Orders
- Care Plan / Health Status Updates
- New Diagnosis / Condition
- Summary of Care Record, also referred to as the Continuity of Care Document (CCD)
- Minimum Criteria meets Meaningful Use Requirements for Summary of Care Core Measure

Why focus on TOC?

In Massachusetts alone there are literally millions of opportunities per year…

- **…For high quality handoffs from hospitals to the patient and next care team.** This includes reconciling patient medications, checking drug-to-drug interactions and allergies, avoiding adverse events, following through on hospital discharge instructions, and setting the patient and care team up to avoid hospital readmission.
- **…To avoid potentially expensive unnecessary or duplicate tests.** This includes review of prior test results, diagnoses, and past medical history prior to ordering new tests post discharge.
- **…To improve a patient's experience of care.** This includes getting information to the right place at the right time without the patient and her/his care team having to chase down information.
- **…To save administrative time and effort.** This includes significantly reduced processing time for transferred medical record summaries. For hospital discharges alone this means ~3.2 M avoided fax pages to process (800,000 discharges p/year * avg. 4 page discharge summary and ~213 trees in paper when printed).

Meaningful Use Stage 2

Provider Requirements

For Meaningful Use Stage 2*, EH's, EP's CAH's, the TOC objective includes 3 measures:

- **Measure #1:** Requires that a summary care record is provided for more than 50% of transitions of care and referrals
- **Measure #2:** Requires that a provider electronically transmit a summary care record for more than 10% of transitions of care and referrals using CEHRT
- **Measure #3:** Requires at least one summary care record electronically transmitted to recipient with different EHR vendor

* Sending via webmail does not satisfy MU requirements

Vendor Requirements

2014 Edition Certification Criteria – Vendor requirements:

- **70.314(b)(1) : Transitions of care -** receive, display, and incorporate transition of care/referral summaries.
- **170.314(b)(2)**: **Transitions of care-** create and transmit transition of care/referral summaries.

CEHRT enables a user to electronically create a transition of care/referral summary formatted according to the Consolidated CDA requirements and electronically transmit CCDA's in accordance with:

- Direct (required)
- Direct" + XDR/XDM (optional, not alternative)
- SOAP + XDR/XDM (optional, not alternative)

Patient-Centered Transitions of Care

PCMH 2014 Standards: Element 5B – Referral Tracking & Follow-up

- Provide consultant/specialist pertinent demographic and clinical data, including test results and current care plan

→ Mass HIway can operate as the vehicle to send Summary of Care records and TOC documents

→ Mass HIway can operate as the vehicle to send referrals and consult orders & notes

PCMH 2014 Standards: Element 5C – Coordinate Care Transitions

- Proactively identify patients with unplanned admissions and ED visits
- Shares clinical information with admitting hospitals/ED
- Consistently obtains patient discharge summaries

→ Mass HIway can operate as the vehicle to send Summary of Care records and TOC documents

→ Mass HIway can support workflow through exchange of encounter notifications and dispositions

Additional MU and PCMH resources

There are many nuances to the CMS Meaningful Use and NCQA PCMH programs – Here are some resources to address your questions:

Patient Centered Medical Home

- Important Deadlines for PCMH 2014 Information
- Behind the Enhancements of PCMH 2014
- PCMH 2014 - PCMH 2011 Crosswalk
- PCMH FAQ's

Meaningful Use/ CMS EHR Incentive Program

- Eligible Professionals Information
- Eligible Hospital Information
- Certified Health IT Product List (CHPL)
- MU FAQ's

TOC and the Mass HIway?

The Massachusetts Health Information Highway (Mass HIway) is the statewide Health Information Exchange (HIE) providing secure electronic transport of electronic health information among health care organizations*

The Mass HIway offers two services:

1. **Direct Messaging -** Secure "push" of messages from one healthcare organization to another
2. **Query and Retrieve –** Location and request of patient records

Note that the Mass HIway is <u>not</u> a clinical data repository HIE and holds no clinical information. The Mass HIway is also <u>not</u> the state health insurance exchange known as the Health Connector.

*Initial participation is open to Massachusetts-licensed providers and entities, Massachusetts-licensed health plans, and Commonwealth agencies.

Example 1 – Specialist Referral

Example 1 - PCP refers patient to a Specialist

Patient Scenario:

1. Patient sees PCP
2. PCP refers patient to a Cardiac specialist
3. Patient sees specialist
4. Patient sees PCP for follow up care

Information Flows:

A. PCP sends Specialist a summary of care document via the Mass HIway

B. Specialist sends PCP a consult note via the Mass HIway

Example 2 – Hospital Encounter

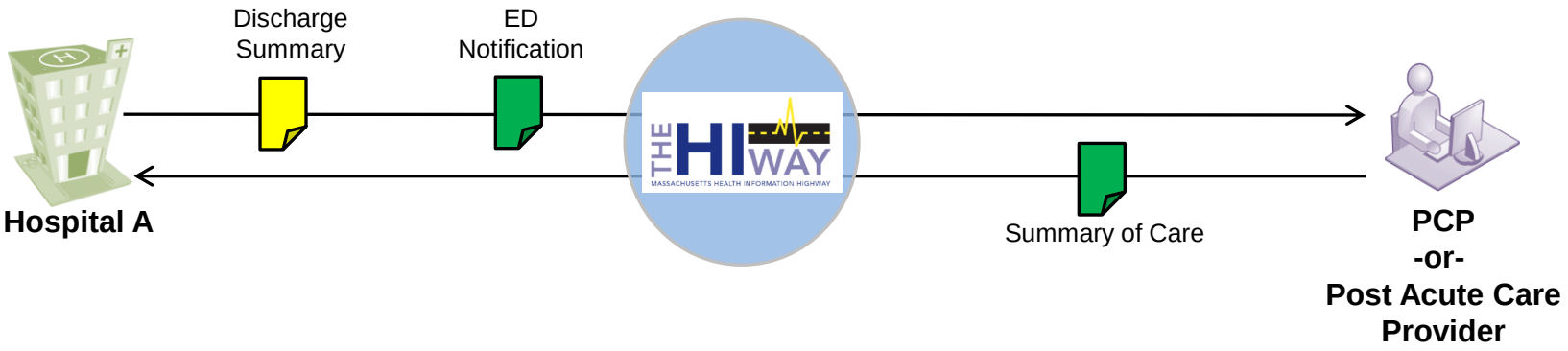
Example 2 – Patient admitted to Hospital – Patient discharged from Hospital

Patient Scenario:

1. Patient admitted to Emergency Department
2. Patient is treated
3. Patient is discharged
4. Patient sees PCP for follow up care

Information Flows:

A. Hospital sends PCP ED notification via the Mass HIway
B. PCP sends critical information to Hospital ED via the Mass HIway
C. Hospital sends PCP discharge summary via the Mass HIway



What can you send via Mass HIway?

Mass HIway is "content agnostic" so it all depends on your capabilities to send and your information trading partners' capabilities to receive

We recommend starting simple and building over time

Patient clinical information:

- Discharge Summaries
- Referral Summary Information
- Specialist Consult Notes
- Summary of Care / Transition of Care Record (TOC)
- Progress Notes
- Request for Patient Care Summaries

Patient clinical alerts:

- Emergency Department Notification
- Mortality Notification
- Transfer Notification
- Disposition Notification (admit/discharge)

Quality reporting:

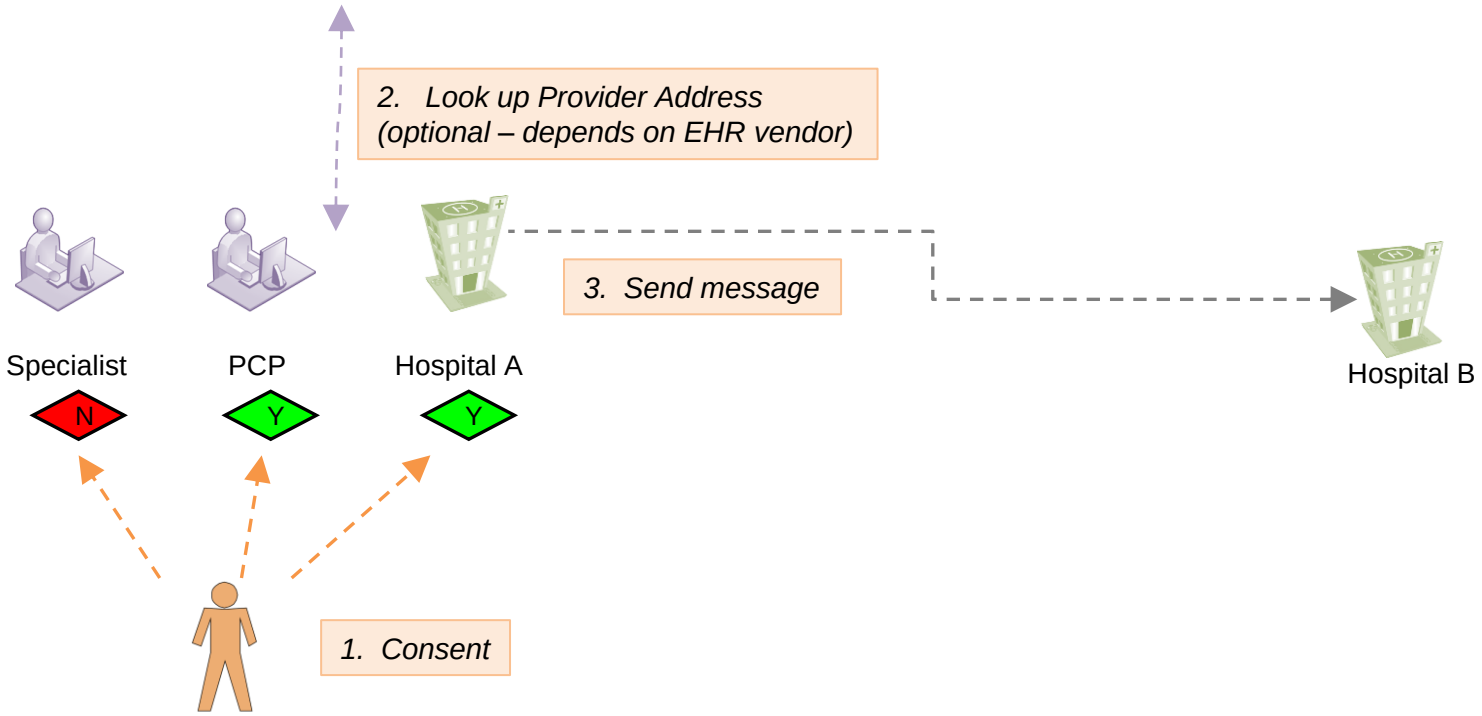
- Information for calculation and reporting of clinical quality measures

Simple workflow for Mass HIway

Data holder sends patient information to recipient

Provider Directory

Provider name	Local name	Institution	Direct address
Smith, Marilyn M	Smith, Marilyn	Hospital B	Marilyn.Smith@direct.HospitalB.masshighway.net
Smith, Marilyn M	Smith, Mary	Highland Primary Care	Marilyn.Smith@direct.HPC.masshighway.net



Mass HIway Provider Directory

The Mass HIway Provider Directory (PD) is a look up tool used to locate a known contact at another participating organization (i.e. locating Dr. X at facility Y)

- There are currently 400+ participant organizations signed up for the HIway. The full participant list is available at http://masshiway.net/HPP/Resources/ParticipantList/index.htm

- The Provider Directory contains over 6,000 addresses (department and individual level addresses included)

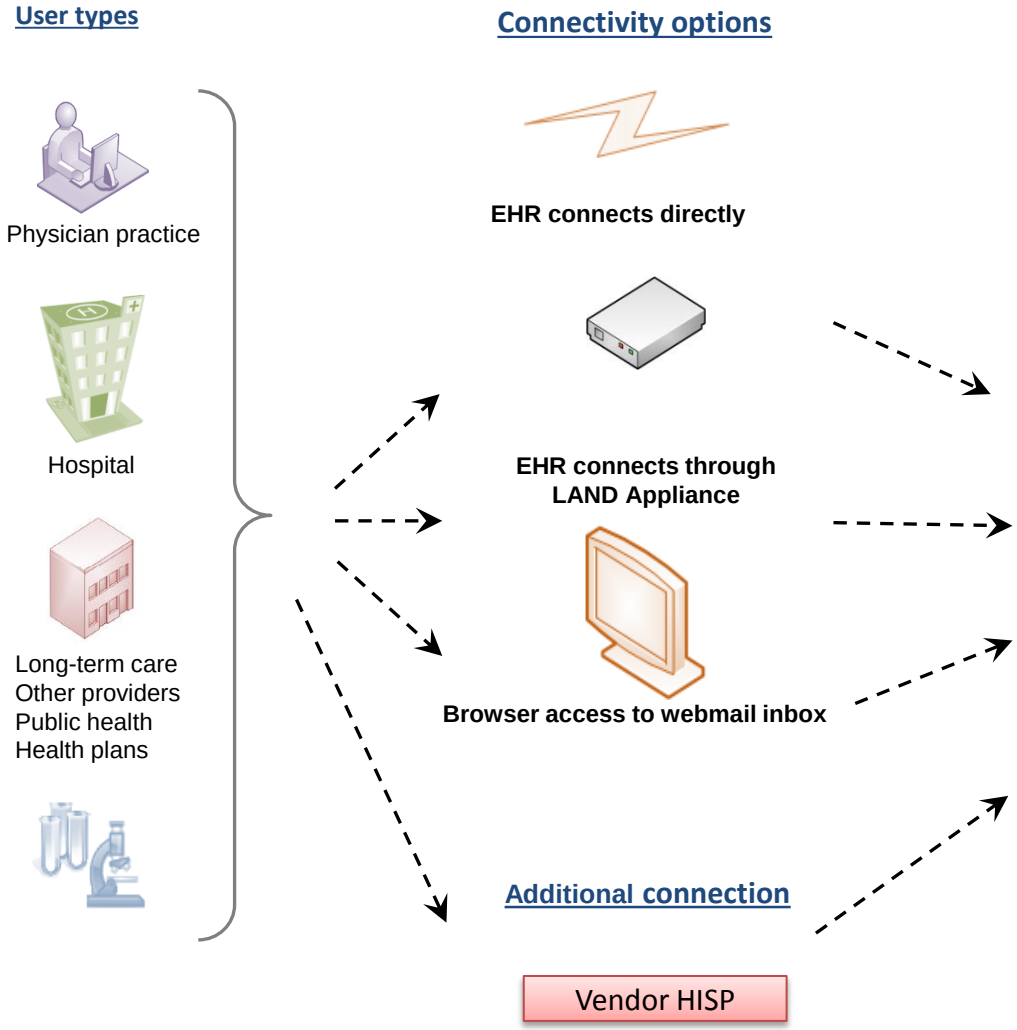
  - Organizational Direct Address
  Participant.A@direct.ParticipantA.masshiway.net

  - **Department Direct Address**
  Medical.records@direct.ParticipantA.masshiway.net

  - Individual Provider Direct Address
  Firstname.lastname.npi1234@direct.ParticipantB.masshiway.net

- The latest Provider Directory extracts are available at the Mass HIway website http://masshiway.net/HPP/Services/ProviderDirectory/index.htm. You will need to sign up to receive monthly notifications of PD extract updates

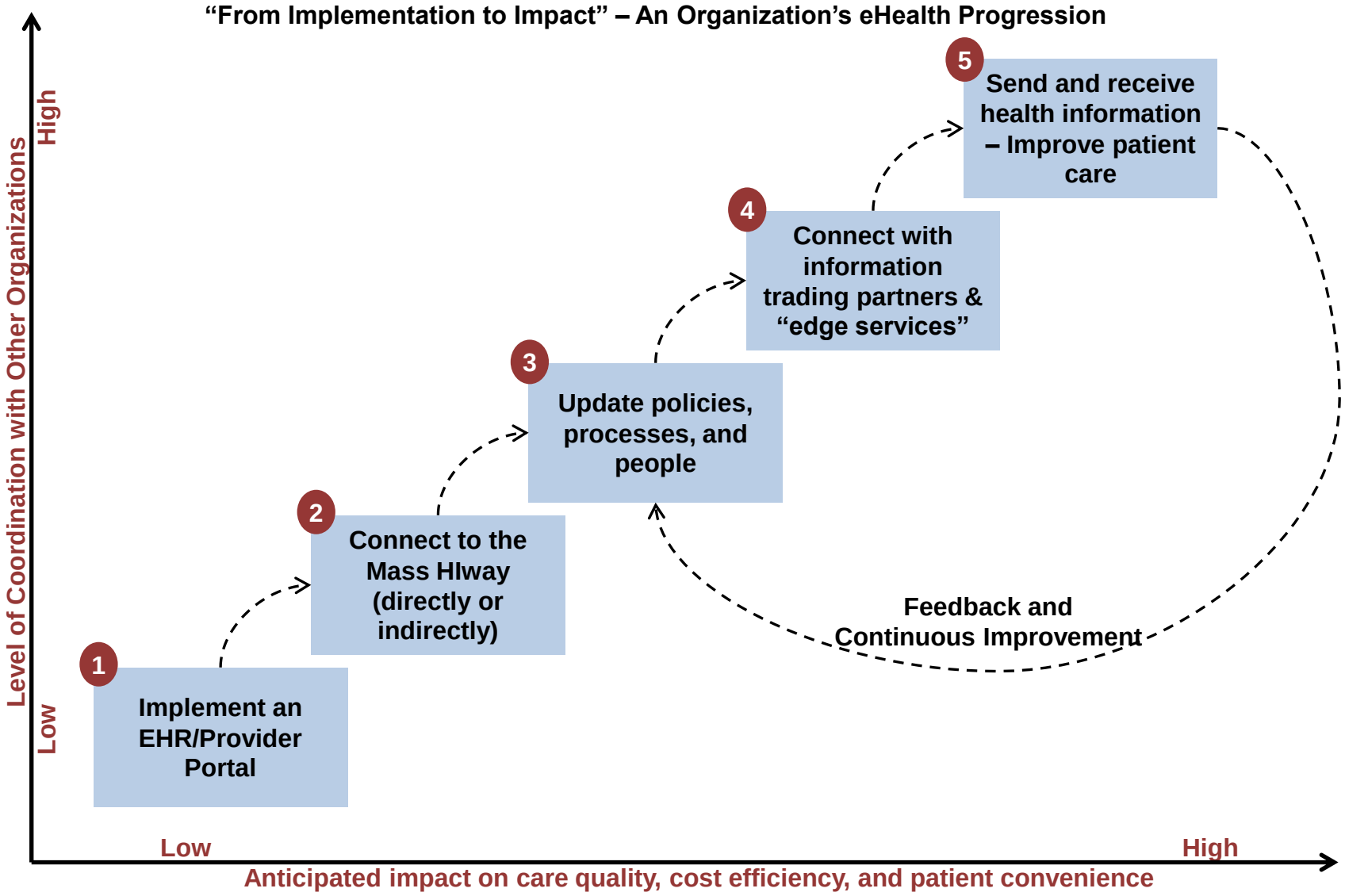
Mass HIway Connectivity Options



HISP to HISP Connectivity

#	HISP Vendor	Kickoff	Onboarding	Testing	HIway Prod Readiness	Live/Target Date
1	eLINC					✓ 2014-May
2	ADS/DataMotion					✓ 2014-Jun
3	Alere					✓ 2014-Jul
4	Inpriva					✓ 2014-Aug
5	Surescripts					✓ 2014-Oct
6	eClinicalWorks					✓ 2014-Oct
7	McKesson(RelayHealth)					✓ 2014-Dec
8	Allscripts(MedAllies)					✓ 2014-Jan
9	EMR Direct					✓ 2015-Mar
10	SES					✓ 2015-Mar
11	Medicity					✓ 2015-Apr
12	NHHIO					✓ 2015-May
13	MyHealthProvider(Mercy Hospital)					✓ 2015-May
14	NextGen Share					2015-Jun
15	athenahealth					2015-Jun
16	Aprima					2015-Jun
17	Cerner					TBD
18	UpDoxx					TBD
19	MaxMD					TBD
20	VA					TBD

TOC and Change Management



More information

For the latest information, updates and to signup for the HIway Newsletter, please visit http://masshiway.net

If you are not already a Mass HIway participant, please reach out to one of our Account Managers. Participation Agreements are also available for self-service at: http://masshiway.net/HPP/HowtoJoin/StepstoEnroll/index.htm

Account Manager	Email	Phone
Murali Athuluri	mathuluri@maehc.org	781-296-3857
Jim Bush	jbush@maehc.org	339-222-6124
Len Levine	llevine@maehc.org	339-223-3498

The Massachusetts Health Information Highway
1.855.MAHIWAY (1.855.624.4929) Option 1
General Support: masshiway@state.ma.us
Production Support: masshiwaysupport@state.ma.us