



The Office of the National Coordinator for  
Health Information Technology



# Introduction to Transitions of Care & Care Plan Standards

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Putting the **I** in Health **IT**  
[www.HealthIT.gov](http://www.HealthIT.gov)



- Overview of ONC Standards & Interoperability Framework
- Introduction to Longitudinal Coordination of Care (LCC)
- Next Steps & Opportunities for Cross-Collaboration

# Overview of ONC Standards & Interoperability Framework (S&I)

**Enable stakeholders** to come up with simple, shared solutions to common information exchange challenges

**Collaborate** with federal agencies to coordinate federal health IT priorities as manager of Federal Health Architecture



**Curate a portfolio** of standards, services, and policies that accelerate information exchange

**Support Innovation** through SHARP program, Innovation/Challenge Grants, and interfacing with International Standards community

- Support the success of MU1 and MU2
- Continue to expand the value of the portfolio of standards to support ACOs, payment reform, DoD/VA systems acquisitions, and other admin priorities
- Modernize standards portfolio to include newer, simpler & more powerful standards



- Leverage *government as a platform* for innovation to create conditions of interoperability
- Health information exchange is *not one-size-fits-all*; create a portfolio of solutions that support all uses and users
- Build in *incremental steps* – “don’t let the perfect be the enemy of the good”

# Standard Interoperability

## “Building Blocks”

### Vocabulary & Code Sets

How should well-defined values be coded so that they are universally understood?

### Content Structure

How should the message be formatted so that it is computable?

### Transport

How does the message move from A to B?

### Security

How do we ensure that messages are secure and private?

### Services

How do health information exchange participants find each other?

Semantic Interoperability

Syntactic Interoperability

Building Blocks	Sample Standards	S&I Initiative(s)
<b>Vocabulary</b>	LOINC, SNOMED, RxNORM, ICD-10	Health eDecisions (HeD) Structured Data Capture (SDC) Clinical Quality Framework (CQF)
<b>Content</b>	CCDA, HQMF, QRDA, FHIR ISO/IEC 11179, ISO/IEC 19763	HeD, SDC, CQF Transitions of Care (ToC) Longitudinal Coordination of Care (LCC) BlueButton+ <a href="#">eLTSS (NEW*)</a>
<b>Transport</b>	DIRECT, SOAP, REST, OpenID, OAuth	DIRECT, ToC, SDC, BlueButton+, <a href="#">eLTSS (NEW*)</a>
<b>Security</b>	DIRECT, OpenID, OAuth, NSTIC	Data Segmentation for Privacy (DS4P) DIRECT
<b>Services</b>		Data Access Framework (DAF) BlueButton+ API



Phase	Planned Activities
<b>Pre-Discovery</b>	<ul style="list-style-type: none"><li>• Development of Initiative Synopsis</li><li>• Development of Initiative Charter</li><li>• Definition of Goals &amp; Initiative Outcomes</li></ul>
<b>Discovery</b>	<ul style="list-style-type: none"><li>• Creation/Validation of Use Cases, User Stories &amp; Functional Requirements</li><li>• Identification of interoperability gaps, barriers, obstacles and costs</li><li>• Review of Vocabulary</li></ul>
<b>Implementation</b>	<ul style="list-style-type: none"><li>• Creation of aligned specification</li><li>• Documentation of relevant specifications and reference implementations such as guides, design documents, etc.</li><li>• Validation of Vocabulary</li><li>• Development of testing tools and reference implementation tools</li></ul>
<b>Pilot</b>	<ul style="list-style-type: none"><li>• Validation of aligned specifications, testing tools, and reference implementation tools</li><li>• Revision of documentation and tools</li></ul>
<b>Evaluation</b>	<ul style="list-style-type: none"><li>• Measurement of initiative success against goals and outcomes</li><li>• Identification of best practices and lessons learned from pilots for wider scale deployment</li><li>• Identification of hard and soft policy tools that could be considered for wider scale deployments</li></ul>

## Timing

Framework Launch Date	Jan 7, 2011
First Initiative Launch Date	Jan 31, 2011
Elapsed Time since Initiative Launch (as-of today)	37 months

## Participation & Process

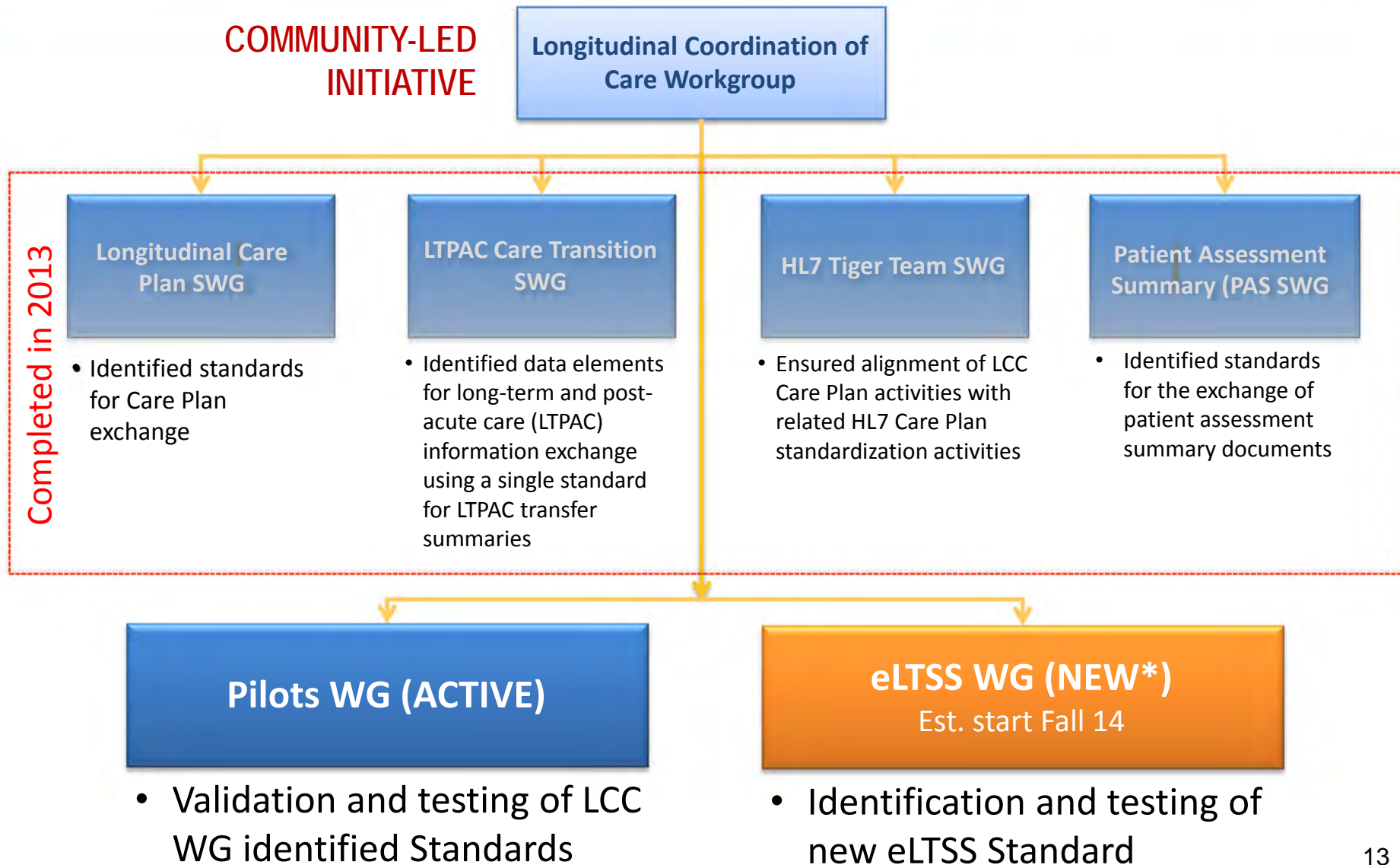
# Wiki Registrants	3,007
# Committed Members	757
# Committed Organizations	580
# Working Sessions Held	2,171
S&I Face to Face meetings	3
Standards Organizations engaged	35
S&I Monthly Newsletter Editions	24
SDS Newsletter Subscribers	1,927

## Outputs

# Consensus Approved Use Cases	22
# Pilots Committed	39
# Pilot Vendors	42
Total Ballots	28
# Total HL7 Ballot Comments Received	5,638
# HL7 Ballot Comments Resolved	5,385

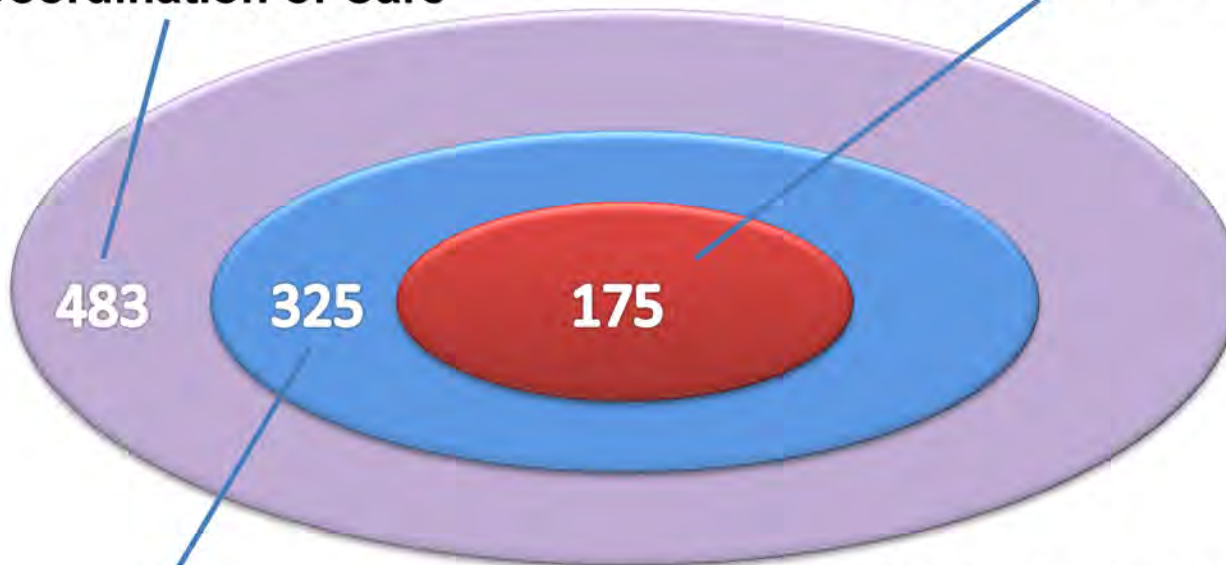
# Overview of ONC Longitudinal Coordination of Care (LCC) Initiative

- 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
- Supports and advances 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)**



Data Elements for Longitudinal  
Coordination of Care

CCD Data Elements



IMPACT Data Elements  
for basic Transition of  
Care needs

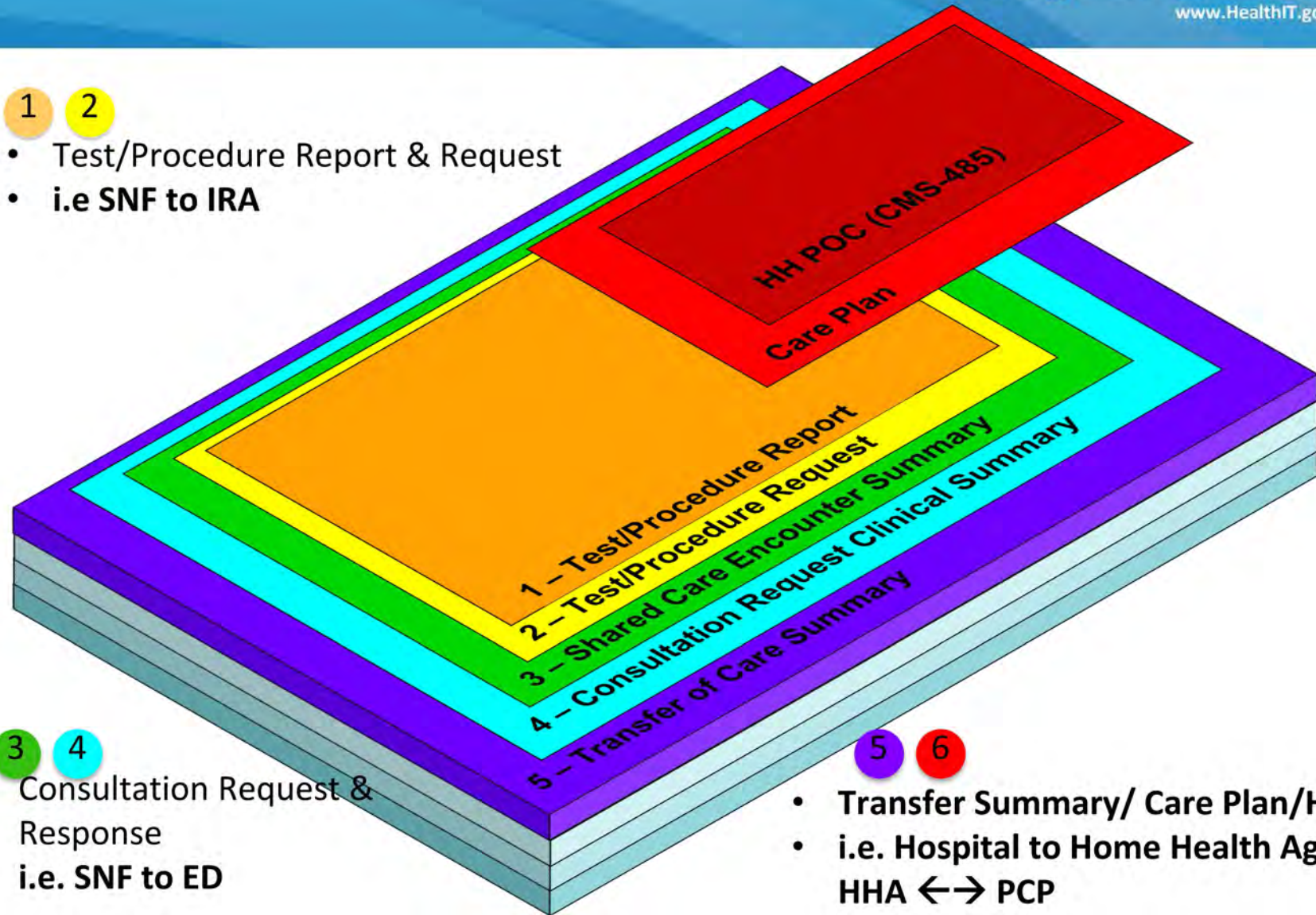
- Many “missing” data elements were mapped to CDA templates with applied constraints
- **New templates were created to meet 20% gap**

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

# Transition Datasets

1 2

- Test/Procedure Report & Request
- i.e SNF to IRA



3 4

- Consultation Request & Response
- i.e. SNF to ED

5 6

- Transfer Summary/ Care Plan/HHPoC
- i.e. Hospital to Home Health Agency;  
HHA ↔ PCP





- LCC Community sponsored updates to C-CDA 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 Consultation Request
  - 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 May 2014

# Discuss Opportunities for Cross-Collaboration

# Back-Up

# LCC WG Impact on EHR Certification Criteria & Meaningful Use Programs

# 2015 EHR Certification Criteria Proposed Rule

- Released for public comment on Feb. 21 2014:  
<http://www.gpo.gov/fdsys/pkg/FR-2014-02-26/pdf/2014-03959.pdf>
- Voluntary certification program; not tied to MU3
- Proposed new capabilities, standards-based requirements and public comment solicitations on potential future certification criteria included in this proposed rule will help inform ONC on what to consider for inclusion for the 2017 Edition in support of MU3 (to be published by Fall 2014)
- **Public Comments due April 28, 2014 via [www.regulations.gov](http://www.regulations.gov)**
  - 2015 Final rule to be published by Summer 2014
  - 2017 NPRM to be published by Fall 2014

# 2015 Proposed Rule: Updated C-CDA Standard

- Proposes the adoption of the **updated CCDA standard** (current in ballot) in 170.205(a): Patient Summary Record to include the new sections & templates:
  - New document templates: Care Plan; Referral Note; Transfer Summary
  - New sections for: Goals; Health Concerns; Health Status Evaluation/ Outcomes; Mental Status; Nutrition; Physical Findings of Skin
- Proposes reference use of new standard in proposed 2015 Edition ToC Certification criterion as well as three other certification criteria: VDT, Clinical Summary and Data Portability
- Proposes EHR technology must be capable of including the UDI for patient's implantable device(s) as data within a CCDA formatted document

# LCC Datasets proposed for MU3 for Summary of care requirement

## A Summary of Care is Provided at Transitions to Improve Care Coordination

- **EPs/EHs/CAHs** provide a summary of care record during transitions of care
- Threshold: No Change
- **Types of transitions:**
  - Transfers of care from one site of care to another (e.g.. Hospital to: PCP, hospital, SNF, HHA, home, etc)
  - Consult (referral) request (e.g., PCP to Specialist; PCP, SNF to ED) [**pertains to EPs only**]
  - Consult result note (e.g. consult note, ER note)
- **Summary of care may (at the discretion of the provider organization) include, as relevant:**
  - A narrative (synopsis, expectations, results of a consult) [**required for all transitions**]
  - Overarching patient goals and/or problem-specific goals
  - Patient instructions (interventions for care)
  - Information about known care team members

**Discussion:** Although structured data is helpful, use of free text in the summary of care document is acceptable. When structured fields are used, they should be based on standards (not all fields need to be completed for each purpose). Summary of care documents contain data relevant to the purpose of the transition (i.e. not all fields need to be completed for each purpose)

Focus Area	Type	Provider use effort	Standards Maturity	Development
• Care Coordination	Primary Care Specialty	<b>High</b>	Adopted	<b>High</b>



# LCC Pilot Program

- Launched in September 2013 for the purpose of creating a forum to share lessons learned and best practices from committed LCC Pilot Projects:
  - MA IMPACT Project
  - NY Downstate Care Coordination Project
- WG also aims to identify additional organizations to test and validate the LCC identified datasets and standards within the C-CDA R2.0:
  - *Is this implementable? Usable?*
- Other aims include:
  - To provide awareness on available national standards for HIE and care coordination
  - Provide tools and guidance for managing and evaluating LCC Pilot Projects

- **MA IMPACT**
  - Go-live scheduled for May 2014 (initially Sept 13)
  - Implement 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'
- **GSI Health 'Brooklyn Health Home Consortium'**
  - Go-live scheduled for March 2014
  - Implement C-CDA R2.0 'Care Plan'
- **Other Vendor Demonstrations**
  - CCITI-NY: Transfer Summary
  - Datuit: Care Plan
  - Healthwise: Care Plan
  - Lantana 'SEE' tool: Care Plan

# How to Join: LCC WG & Complete Pilot Survey

- <http://wiki.siframework.org/Longitudinal+CC+WG+Committed+Member+Guidance>
- <http://wiki.siframework.org/LCC+Pilots+WG>

## ☆ LCC Pilot Plan

Initiative Home

Join the Initiative

Charter & Members

S&I Phases

Materials

Edit PageTabs

[About LCC Pilots](#) | [Pilot Materials](#) | [Pilot Timeline](#) | [Pilot Purpose](#) | [Pilot Contacts](#)

### About LCC Pilots

The Longitudinal Coordination of Care (LCC) Initiative is approaching the Pilot phase for the LCC Transfer of Care and Care Plan/Home Health Plan of Care (HHPoC). **We are seeking organizations who may be interested in participating as a Pilot Site.** Please fill out the form found on the [LCC Pilot Interest Survey](#) page if your organization is interested in becoming a Pilot Site for LCC. The LCC Pilots SWG will officially launch September 16th.

### Pilot Materials

Document Name	Description
<a href="#">Pilot Overview Document</a>	An overview of the LCC Pilots Workgroup including a Value Statement for Participating Entities, Benefits of Participation as an LCC Pilot Site and steps for How to Get Started.
<a href="#">Work Group Planning Presentation</a>	A presentation for potential pilots that provides an overview of the Transition of Care and Longitudinal Coordination of Care Problems, the Role of Standards for Problem Resolution, and Overviews of the IMPACT and Downstate New York Care Coordination Projects.
<a href="#">Pilot Documentation Template</a>	A PowerPoint template for potential pilots to use to present their Pilot Team; Goal of the Pilot; C-CDA of Interest; Use Case Scenario and Actors/Systems; Minimum Configuration; Timeline; Success Criteria; In Scope/Out of Scope; and Risks & Challenges details of their pilot.
<a href="#">Pilot Plan Template</a>	A word template for potential pilots to use to present their Pilot Team; Goal of the Pilot; C-CDA of Interest; Use Case Scenario and Actors/Systems; Minimum Configuration; Timeline; Success Criteria; In Scope/Out of Scope; and Risks & Challenges details of their pilot.

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**LCC Wiki Site:** <http://wiki.siframework.org/Longitudinal+Coordination+of+Care>