Subcommittee: HIE Operations, Compliance, and Efficiency

Chair: Ms. Lucinda Wade

Vice-Chair: Ms. Gayle Hurt

Date: July 23, 2020

Status: Final

District of Columbia Health Information Exchange Policy Board

Recommendation on Transition of Care Data Elements

I. SUMMARY

The recommendation on the *Transition of Care Data Elements* proposes a three phased approach (in **Table 1**) for CRISP DC to design, implement and evaluate the Transition of Care Data Elements enumerated in **Table 2**.

The recommendation incorporates feedback and guidance from the Technical Expert Panel on DC HIE Services on: 1) changes and amendments in the data element definitions, 2) prioritization of the data elements viewed as most important to exchange at the time of discharge in order to support an effective transition of care - and ultimately, improvement in care quality and health outcomes.

II. PROBLEM STATEMENT

In the subcommittee's findings, hospital discharge summaries may not always satisfy the documentation requirements needed by community-based providers to facilitate effective transitions of care. Additionally, based on an analysis conducted in October 2019 for the Hospital Discharge Innovations to Improve Care Transition grant, approximately half of discharge summaries for District patients are not exchanged within 48 hours, which can impede providers' ability to provide timely follow-up care.

In order to understand which data elements within the discharge summary are most relevant to exchange via HIE to facilitate a timely transition of care, the subcommittee reviewed nationally known definitions for data elements assessed from the Hospital Discharge Innovations to Improve Care Transition grant. This work informed a set of definitions that can be used to set out expectations for data elements exchanged in a consistent and timely manner.

III. SUBCOMMITTEE GOAL AND ACTIVITY

The HIE OCE subcommittee was tasked by the Board to work with the DC Hospital Association, CRISP DC, and other stakeholders to develop a recommendation on a set of data elements for the transition of care document.

IV. FINDINGS/ANALYSIS

In 2018, the Operations, Compliance, and Efficiency (OCE) subcommittee commenced its work on developing a recommendation that focused on setting benchmarks for accuracy, timeliness and

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completeness of health data. The OCE subcommittee has since modified the scope of its work to incorporate findings from several related initiatives in the District. The key initiatives that guided the work of the subcommittee are listed below:

- **Hospital Discharge Innovations to Improve Care Transition Grant (October 2019):** The Hospital Discharge Innovations to Improve Care Transition grant sought to assess and address the complex and challenging aspects of the discharge planning process in hospitals that provide acute care, emergency care, long-term acute care, and other core services in the District of Columbia. The goal was to improve the quality, timely availability of discharge data and completeness of discharge summary for care coordination. The grant work recommended several initial stakeholder element recommendations which helped to build a foundation for this recommendation.

- **The Mayor's Commission on Healthcare System Transformation (November 2019):** In June 2019, the Mayor established the Commission on Healthcare Systems Transformation to make recommendations to the Mayor on the strategies and investments necessary to transform health care delivery in the District of Columbia. One of the recommendations was made to the HIE Policy Board for the development of a recommendation on the prioritization of a minimum data set that should be transmitted upon discharge to improve transitions of care.

There were several additional factors and realizations that modified the scope of work. In December 2019, the subcommittee's focus was on the summary of care document (i.e. "discharge summary"). Upon further investigation by the subcommittee - and in response to the CMS Discharge Rule which requires that transition of care information be sent to a receiving facility[1] - members concluded that the summary of care document's data element definitions varied in meaning across facilities, resulting in differences in completeness across sites. Secondly, in anticipation of the Office of the National Coordinator's Interoperability Rule, the subcommittee concluded that it would be best to shift the focus to a more real-time exchange of data. As a result, the subcommittee decided to change its focus to the data elements identified through the Hospital Discharge Innovations to Improve Care Transition grant as a basis for the key transition of care concepts providers cared most about exchanging at the time of discharge.

The subcommittee refined the list of elements gathered through the Hospital Discharge Innovations to Improve Care Transition grant based on stakeholder input on the relevance and feasibility in light of the requirements of the CMS Discharge Rule to thirteen 'transition of care data elements'. Those data elements include:

- Medication allergies

[1] New requirement that sends necessary medical information to the receiving facility or appropriate PAC provider (including the practitioner responsible for the patient's follow-up care) after a patient is discharged from the hospital or transferred to another PAC provider or, for HHAs, another HHA. These requirements also apply in the event a patient is discharged to home.

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- Immunizations
- Vital signs
- Discharge medications
- Plan of care
- Discharge appointments
- Points of contact for concerns
- Reason for visit
- Discharge diagnoses
- Laboratory results
- Procedure notes
- Consult notes
- Goals progress

By defining these data elements, the committee was able to turn to focusing on a strategy to assess 'how' they are being sent.

In developing a recommendation for transition of care, the committee first needed to clearly define the data quality assessment construct that objectively assesses the ability for the exchange of health information and the use of that data to affect the quality of care. Second, the committee developed a measure concept to assess the percentage of the required elements sent from the hospital EHR to CRISP DC. The measure concept includes a description of the measure, including a planned target and population. The following is the draft measure description for completeness and timeliness:

Completeness *assesses the percentage of required elements sent from the hospital EHR to CRISP for each patient. All data elements required for the measure should be transmitted for all patients, regardless of age, who are discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care.*

Timeliness *assesses the median turnaround time measured in days between the date the transmission is received at CRISP and the date of the discharge flag from the hospital. The exchange of information timing should be calculated for all patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care.*

In March 2020, the subcommittee established a technical expert panel (TEP) to guide its work on the following objectives:

1. Define the transitions of care data elements

2. Prioritize the transitions of care data elements

The *TEP on DC HIE Services* is a panel consisting of 15 members that represent providers from behavioral health, hospital systems, managed care organizations, primary care, skilled nursing facilities, and federally qualified health centers. The first meeting of the TEP was held on June 17th

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and the second on June 25th. Two surveys were distributed to the members to collect quantitative information on 1) preferences on the national recognized definitions for a sub-set of the data elements (13), 2) feedback on priority data elements that are needed at the time of discharge to support an effective transition of care.

Defining Data Elements: The 13 data elements presented were selected based on baseline availability of data elements that were identified through the Hospital Discharge Innovations to Improve Care Transition grant in November 2019. Per the subcommittee's research, there are variations in nationally recognized definitions for data elements. Through survey and structured focus group discussions, the subcommittee led the TEP in providing feedback on definition preferences. Additionally, the District Designated HIE Entity, CRISP, maintains its own definitions for the data elements, and as a result, the subcommittee found that there needed to be alignment between both the preferred national recognized definitions selected by the TEP along with those of the HIE. **Table 2** in the appendix section of this document identifies CRISP's definitions for the data elements and the consensus reached by the TEP on modifications/amendments to CRISP's definitions.

Prioritization of data elements for the transition of care: The prioritization of the data elements combined two methodologies 1) an assessment by CRISP DC on the feasibility of attaining each data element 2) a survey by the TEP to prioritize the data elements needed to support an effective transition of care at the time of discharge. The first set of data elements was chosen based on a combination of the highest votes received, as well as those viewed as almost feasible to exchange in the near term: discharge diagnosis, discharge medications, reason for visit, and medication allergies. As cited in **Table 1**, these data elements will be implemented and evaluated in phase 1 of CRISP's work.

The second set of data elements placed in phase 2 received fewer votes, were viewed as less feasible to exchange in the near term, or required further research by the TEP. The phase 2 elements include: laboratory results, discharge appointments, vital signs, consult notes, procedure notes, plan of care, immunizations, point of contact, and goal progress. While the data elements are split into two phases, the two phases will be implemented and evaluated simultaneously, with the primary difference being the longer timeframe to fully implement and evaluate the phase 2 data elements.

V. RECOMMENDATION FOR BOARD ACTION

The DC HIE Policy Board endorses this recommendation from the OCE subcommittee on the Transition of Care Data Elements. Furthermore, the Board advises that DHCF make this recommendation document available to the public on its website within a 72-hour timeframe from the day of this, July 23, 2020, HIE Policy Board meeting.

*In its role as the regulatory authority to maintain best practices and standards for the DC HIE, the Board recommends that DHCF works closely with its District Designated HIE Entity, CRISP, Inc., and for CRISP DC to implement the following phases of work outlined in **Table 1** to design, implement and evaluate the Transition of Care Data Elements enumerated in **Table 2**.*

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The DC HIE Policy Board advises its member, the DC Hospital Association, to continue efforts and ongoing conversations with its member hospitals to enhance their workflows and to efficiently document and share this information with DHCF, CRISP DC, and the OCE subcommittee. Additionally, the DC HIE Policy Board advises the OCE subcommittee to continue its work on the transition of care data elements and efforts in calculating measures for the TOC data elements.

Finally, the HIE Policy Board will request the progress and implementation of this recommendation, by mentioned parties in this recommendation, at the October 2020 HIE Policy Board meeting.

Table 1. Recommendation for Board Action: Phased Approach for Implementation, July 2020-January 2021

RECOMMENDATION FOR BOARD ACTION		
Phase #	**Task Description(s)**	**Timeframe for Implementation***
Phase 1	Incorporate modifications/amendments on data element definitions per consensus reached by the TEP and documented in **Table 1** of this document. The initial set of data elements are discharge diagnosis, discharge medications, reason for visit, and medication allergies. Further, ensuring that these initial four data elements can be obtained, counted and displayed in the District Designated HIE entity in a real-time basis.	July 2020 – December 2020
Phase 2	Continue collaborations with the OCE subcommittee and TEP on the remainder of the data element list (laboratory results, discharge appointments, vital signs, consult notes, procedure notes, plan of care, immunizations, point of contact, and goal progress) and assess, using a data quality methodology such as the *3x3 Data Quality Assessment* framework, which elements need further refinement, consensus, and resolutions to address technical challenges in operationalizing the element(s) and subsequently the elements (s) to be included in the measure.	July 2020 – December 2020
Phase 3	Evaluate outcomes of phase 1 and 2 and determine any modifications of elements in phase 1 strategy and to incorporate new elements identified in phase 2 into the measure and within the defined location in the District Designated HIE entity.	January 2021

**Timeline is subject to change*

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Committee Members: Mr. Ryan Bramble, Mr. Michael Fraser, Ms. Gayle Hurt, Ms. Nina Jolani, and Ms. Adaeze Okonkwo.

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Table 2.Transition of Care Dataset Elements

Data Element	TEP Prioritization of Data Elements	CRISP Definition	Recommended Amendment by TEP
Discharge Diagnosis	Phase 1	The discharge diagnosis is the final diagnosis reported to CRISP as any one of the following fields: • Problems/Diagnosis • Discharge Diagnosis Section • Continuing Care Plan • Principal Discharge Diagnosis	The discharge diagnosis is the final diagnosis reported to CRISP as any one of the following fields: • Problems/Diagnosis, • Discharge Diagnosis Section, • Continuing Care Plan, • Principal Discharge Diagnosis, *and* • *Secondary Discharge Diagnosis.*
Reason for Visit	Phase 1	The reason for visit is the initial presentation on hospital admission and reported to CRISP as any one of the following fields: • Encounter reason • Encounter diagnosis • Encounter condition • Chief complaint	The reason for visit is the initial presentation on hospital admission and reported to CRISP as any one of the following fields: • Encounter reason, • Encounter diagnosis (also refers to admitting diagnosis), • Encounter condition, • Chief complaint.
Medication Allergies	Phase 1	Allergies includes any adverse reaction to medications previously experienced by the patient and reported to CRISP as any one of the following fields: • Allergic drug reaction • Antibiotic allergy • Allergy intolerance	Allergies includes adverse reaction to *substances* including medications previously experienced by the patient and reported to CRISP as any one of the following fields: • Allergic drug reaction, • Antibiotic allergy, • Allergy intolerance.

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Data Element	TEP Prioritization of Data Elements	CRISP Definition	Recommended Amendment by TEP
Discharge Appointment	Phase 2	Discharge appointments that follow-up appointments have been scheduled and reported to CRISP as any one of the following fields: • Discharge planning • Post-discharge appointment scheduled within 7 days	Discharge appointments for follow-up appointments that have been scheduled or should be scheduled including specialty/provider, timeframe, contact information.
Plan of Care	Phase 2	Plan of care is the detailed approach based on the hospitalized patients future needs and is reported to CRISP as any one of the following fields: • Assessment and Plan of Treatment • Plan for follow-up care • Continuing Care Plan in the Principle • Discharge Diagnosis' section • Continuing Care Plan in the Discharge • Medications' section	***Further research needed with the TEP to define and amend the definition.***
Point of Contact	Phase 2	POC for concerns are those providers who treated patient during their visit/hospitalization, or are part of the patients regular care team and reported to CRISP as any one of the following fields: • Contact info for responsible provider • Primary physician • Other health care professional designated for • follow-up care	***Further research needed with the TEP to define and amend the definition.***
Vital Signs	Phase 2	Measurements of basic body functions that can	The most recent measurements of basic

Data Element	TEP Prioritization of Data Elements	CRISP Definition	Recommended Amendment by TEP
		include: • Heart rate rhythm • Respiratory rate and respiratory effort • Blood pressure • Temperature • Oxygen saturation	body functions that can include: • *Weight* • *Height* • *Heart rate,* • *Heart rhythm,* • Respiratory rate and respiratory effort, • Blood pressure, • Temperature, • Oxygen saturation.
Immunizations	Phase 2	Not currently exchanged through the District designated HIE.	Describes the event of a patient being administered a vaccine or a record of an immunization including the source. We support the DC Health Immunization Registry as the District's system of record for immunizations. ***Further research needed to explore API integration of the registry with the District designated HIE.***
Discharge Medications	Phase 1	Discharge medications are the medications prescribed to the patient post discharge and at times include current medications. They are reported to CRISP as any one of the following fields: • Medications • Current Medication list	Routinely scheduled and PRN (new and continued) medications that include the • *name,* • *dosage,* • *indication,* • *length of the therapy, and* • *the quantity prescribed for use or*

Data Element	TEP Prioritization of Data Elements	CRISP Definition	Recommended Amendment by TEP
		• Continuing Care Plan- Discharge Medications • Medication	*that no medications were ordered at discharge.*
Laboratory Results	Phase 2	Lab results that were completed on the patient during visit and reported to CRISP as the following field: • Lab Values and Results	The most recent lab results that were completed on the patient during visit reported to CRISP as the following field: • Lab Values and Results. ***For further research: need to look into designating and transmitting the relevant and pending labs.***
Procedure Notes	Phase 2	Procedure notes are those documented procedures that occurred during the hospitalization and are reported to CRISP as any one of the following fields: • Procedure • Summary of major procedures • Tests performed during visit • Procedure notes	Procedure notes are those documented procedures that occurred during the hospitalization and are reported to CRISP as any one of the following fields: • Procedure, • Summary of major procedures, • Tests performed during visit, • Procedure notes. *These procedure notes should include major surgical procedures and secondary procedures.*
Consult Notes	Phase 2	Consult notes include evaluation and management information during the hospitalization that are reported to CRISP as any one of the following fields:	No amendment.

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Data Element	TEP Prioritization of Data Elements	CRISP Definition	Recommended Amendment by TEP
		• Consultation Note	
Goals Progress	Phase 2	No definition available.	Further research is needed. The Technical Expert Panel identified the key element as the *summary of care* and not the *goals progress*.

***** VOTING *****

FIRST MOVEMENT: Dr. Yavar Moghimi

SECONDED BY: Dr. Eric Marshall

Attendance: 10

Quorum: 8

TIME: 4:26 PM

Public Members	Ayes	Nays	Abstain	Not Present
Osinupebi-Alao, Olubukunola				x
Herstek, Jessica	✔			
Hettinger, Zach (Aaron)			✔	
Ramos-Johnson, Donna	✔			
Leiter, Alice	✔			
Lewis, Barry				x
Marshall, Eric	✔			
Moghimi, Yavar	✔			
Orlowski, Janis	✔			
Palmer, Justin J. (Vice-Chair)	✔			
Rein, Alison	✔			
Turner, James				x
Wade, Lucinda	✔			
VACANT				

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Public Members	Ayes	Nays	Abstain	Not Present
VACANT				
Ex-Officio Members				
Bazron, Barbara				x
Byrd, Melisa (Designee: Pamela Riley)	✔			
Hasan, Dena	✔			
Holve, Erin (Chair)	✔			
Krucoff, Barney	✔			
Nesbitt, LaQuandra (Designee: Lauren Ratner)			✔	
Ex-Officio (Non-Voting) Member				
Leak, Chikarlo				