HIM Best Practices for Records Management at Transitions of Care

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There is a significant amount of evidence that points to the existence of serious quality concerns for patients undergoing care transitions across multiple care settings. The 2001 Institute of Medicine (IOM) report "Crossing the Quality Chasm" famously described the US system as decentralized, complicated, and poorly organized, specifically noting the "layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful."[1] Unfortunately there hasn't been much improvement in this area in the 15 years since the IOM report was released, with issues related to transitions of care persisting.

Care transitions occur each time a patient goes from one healthcare provider or healthcare setting to another, including a patient's home. This Practice Brief will discuss best practices for health information management (HIM) professionals to ensure that health information needs are met at the time of discharge or transfer and to assess and improve transition of care practices. These best practices are designed to support and guide HIM professionals, providers, physician practice staff, clinicians, and other healthcare stakeholders through effective care transitions that can ultimately improve the quality of healthcare.

HIM professionals play a key role in making sure that patients receive quality, safe, cost-effective care by ensuring that care transitions for all patients are handled accurately and are well coordinated throughout the process. The healthcare industry has worked tirelessly to create the best care within each care setting. However, whenever patients transition between these care settings hazardous situations can occur, often as a result of the fact that the healthcare ecosystem is very complicated and there are oftentimes no clearly defined roles delineated for effective patient hand-offs.

A HIM professional's role in care transitions involves more than ensuring records are collected and disseminated as patients move from one care setting to another. This Practice Brief identifies best practices that ensure every patient gets the health information and services needed along the continuum of care and when transitioning care settings regardless of the final disposition of the patient.

Recommended Practices for HIM at Transition and Referral

Recommended practices for HIM at transition and referral points along the care continuum include the following:

- Develop policies for collaboration and integration with community partners.
- Update information governance plans to manage information/data governance across partner/community organizations and address timeliness.
- Spearhead and participate in one's local health information exchange by utilizing national standards. Health information exchanges (HIEs) often have a significant role in ensuring appropriate information is available for transitions of care.
- Ensure systems support tracking discharge planning/readiness, proactive medications management/reconciliation, and automated assessments. Work with internal departments to re-engineer the discharge process to have required documentation available prior to discharge.
- Review documentation processes to ensure all required components of discharge and/or care plans are captured as needed.
- Fully integrate referral and care transition processes within the electronic health record (EHR). Work with internal departments to ensure a fully integrated closed loop referral process.
- Workflow integration with EHR/tailoring information for transfer. Exchange tools must be integrated into clinical workflows. Physicians should have the ability to select documentation for transmission, such as push communication.
- Use automated alerts to update all care providers regarding patient status (admit/discharge to emergency department or hospital) to facilitate transitions.

- Ensure a process is in place for tracking tests pending at discharge and for sharing results with other providers and the patient once results are available post-discharge. Monitor the progress and follow up when goals are not met.
- Take ownership of the patient portal. Ensure patient data available on the portal are both accurate and timely.

Recommended Practices for HIM at Admission and Discharge

Ensuring best practices are followed at admission and discharge points is also important:

- Develop policies in coordination with nursing and the IT department to determine when/how information from outside facilities gets incorporated into the patient's medical record.
- Become involved with the IT department to see which facility systems do not interface with the main EHR to determine what information may need to be scanned into the facility's EHR. Evaluate the barriers to allowing an interface between these systems to ensure progress toward integration is a priority.
- Determine what information is provided to the patient upon discharge/transfer and whether this exact information can be recreated at a later time, or if a copy of the discharge instructions need to be scanned back into the EHR for potential use later. The information that is shared with the patient on discharge/transfer should be documented as part of the EHR.
- Develop internal HIM policies to document the location and storage of outside patient information within the patient's record, whether electronically or on paper.
- Develop a policy regarding whether the healthcare facility will release information received from another facility when transferring a patient.
- Develop a close working relationship with the IT department to stay abreast of changes or new functionality available within the facility EHR regarding patients' records.

Background, Considerations, and Context

Today's healthcare regulatory environment reflects the ever-growing importance of care coordination to promote quality, safe, and cost-effective care. This is evident through the work of The Joint Commission, the Hospital Readmission Program, the Improving Massachusetts Post Acute Care Transfers (IMPACT) Act, value-based healthcare programs, the Interact 2 project, and the proposed rule on discharge planning.[2-9]

Standards work is also stressing the importance of care coordination as is apparent in the Health Level Seven (HL7) Referral and Transition/Transfer of Care Workgroup, the FHIR Referral Request, the IMPACT program, and the concluded Longitudinal Coordination of Care Workgroup under the Standards & Interoperability Framework.[10-13]

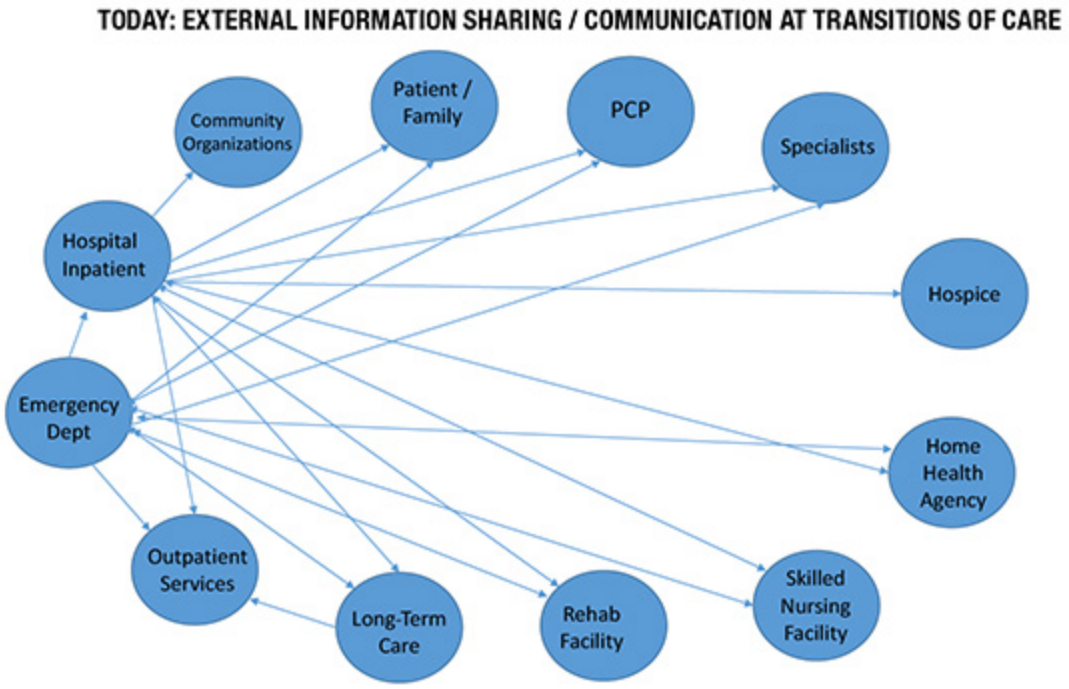
AHIMA's Information Governance Principles for Healthcare (IGPHC)TM and the recently published Integrating the Healthcare Enterprise (IHE) white paper entitled "HIT Standards for HIM Best Practices" both complement the aforementioned initiatives.[14-16] Additional resources are available in Appendix A, published in the online version of this Practice Brief in AHIMA's HIM Body of Knowledge.

The transition of care process includes patient admission and discharge, medical record documentation of care, and communication and exchange of information between providers, patients, and various care settings. It is important that care transitions and the coordination of care include the entire care team as well as the patient. The process today involves multiple parties as well as uni- or bi-directional information/communication flows—often via point solutions with many opportunities for incomplete or missing information. The future will consist of more integrated care teams across the continuum with shared care plans, real time communication, and real time information exchange. See the graphic on below for a visual interpretation of the transformation the healthcare industry is working towards.

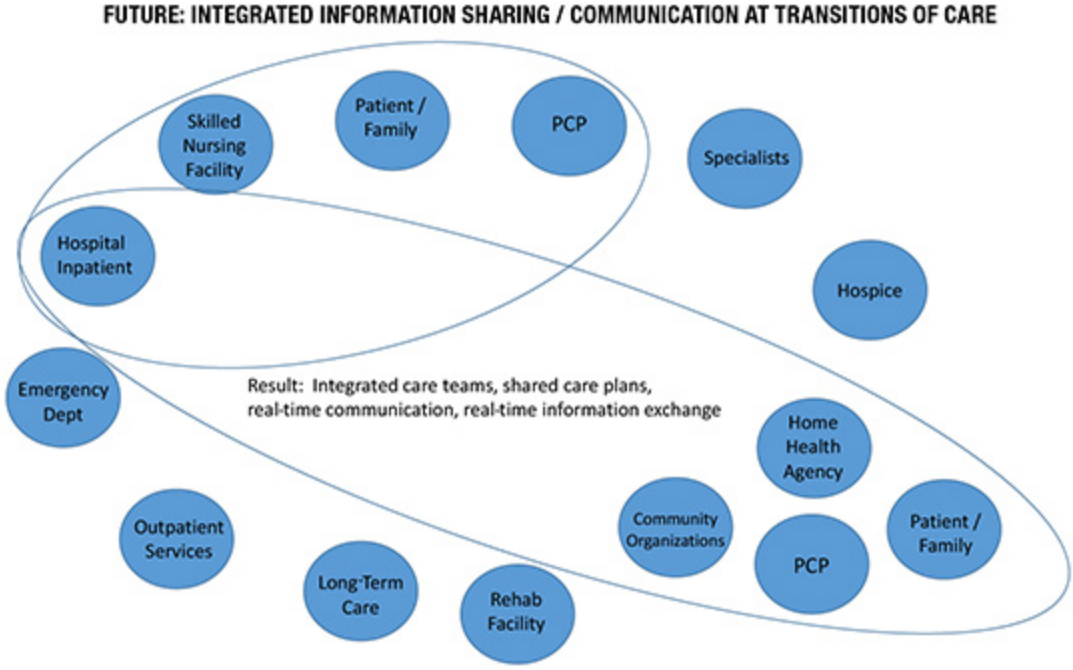
Technological challenges such as interfacing with multiple systems, managing modifications to reports by staff, identifying who is making the changes in the system, and knowing where documentation originated can be mitigated by following best practices at admission, discharge, transfer, and referral.

Moving Toward Effective Information Sharing and Communications for Transitions of Care

The future will consist of more integrated care teams across the continuum with shared care plans, real-time communication, and real-time information exchange.



Result: Multiple parties, uni- or bi-directional flow, often via point solutions, with many opportunities for incomplete or missing information



Recommended Practices at Patient Admission

Admissions occur in a healthcare facility from a variety of locations. While the majority of admissions may come through the emergency department, there can also be direct admissions from a referring facility, a nursing home, or private physician's office. In each of these instances, there is the potential for outside agency information that must be incorporated into the patient's current medical record to provide the best treatment possible for the patient.

Depending upon the EHR system at the hospital, and whether the facility is 100 percent electronic, using a hybrid system, or still entirely on paper, the HIM department will have various levels of involvement at the admission stage. Even when the patient's admission begins in the emergency department, there are facilities with multiple EHRs that do not always communicate with each other. In those situations, the HIM department would be required to obtain a copy of the emergency department documentation and either incorporate that into the patient's paper record or scan it into the hospital's EHR.

To provide optimal treatment to the patient, it is imperative that all available information regarding the patient's current condition, as well as past medical/surgical history, medications, allergies, dietary requirements/restrictions, and other health information be available to the current treating team. The HIM department should work closely with the nursing department to determine the best practice for the facility to make sure this information is available in a timely fashion. If this information is being scanned into the EHR, it is vital that nursing staff and treating practitioners know where to quickly find the information in the EHR when needed. This would involve working closely with the IT department, as well as nursing and medical staff, to provide the appropriate location within the EHR and educate staff to locate these documents.

Recommended Practices that Support the Transitions of Care Process at Admission and Discharge

- Develop policies in coordination with nursing and IT to determine when/how information from outside facilities gets incorporated into the patient's medical record.
- Become involved with the IT department to see what facility systems do not interface with the main EHR to determine what information may need to be scanned into the facility's EHR.
- Determine what information is provided to the patient upon discharge/transfer and whether this exact information can be recreated at a later time or if a copy of the discharge instructions need to be scanned back into the EHR for potential use later. Establish a practice to document that the patient or responsible party fully comprehends the instructions.
- Develop internal HIM policies to document where outside patient information is stored within the patient's record (whether electronically or on paper).
- Develop a policy regarding whether the healthcare facility will release information received from another facility when transferring a patient.
- Develop a close working relationship with IT to stay abreast of changes or new functionality available within the facility EHR regarding patient records.
- Develop a mechanism to ensure the policies and data meet the various regulatory and/or standard requirements.

Key Questions to Ask

- What EHR systems are being used within the facility? Do these systems interface with the primary system?
- When the patient is in-house, who is responsible for releasing information when the patient transitions to another level of care? Consider auditing the records to ensure appropriate information is being sent.
- Are records released during transitions of care added to the accounting of disclosures for the patient? This is vital for HIPAA documentation if the patient requests an accounting of disclosures.
- How is the organization preparing for new models of care, extended care plans, and extended care teams?

- What health information applications being used at your facilities are integrated into the EHR or transmitted to other health systems?

Recommended Practices at Patient Discharge

Regardless of where the patient is going post discharge, information needs to go with patients to assist in their post hospital care, follow-up care, and any additional treatment required for their condition. This would be equally true if the patient is being discharged to their home or being transferred to another level of care, including home health or a long-term care facility. Discharge instructions are vital for educating the patient on disease processes, medication usage, and necessary follow-up. The HIM department needs to work in tandem with the IT department to ensure a version of the discharge instructions provided to the patient is maintained within the patient's record. If the discharge instructions are automatically populated from various documentation sources in the EHR, such as dictated physician reports and available lab tests, it is imperative that the exact instructions be maintained in the record.

A legal issue could ensue in the event of a discrepancy between the discharge instructions provided to the patient and the final instructions in the patient record. This situation may occur if the discharge summary has not been dictated or transcribed at the time the instructions are prepared. The HIM department must be able to recreate the exact discharge instructions provided to the patient when requested. This may require scanning them back into the EHR.

Collaboration between the nursing department, case management, social services, and the HIM department is required to determine what information is being sent to an outside facility upon transfer or return to a long-term care facility, as well as who is responsible for sending that information. While it may be best practice for this information to be sent by case management or social services when the patient is being transferred elsewhere, it is imperative this information be documented within the health record in the event a question arises later. The HIM department should work with the IT department to determine whether this information is being sent in an electronic format or faxed. In the event it is being faxed, a copy of the faxed information, including verification it was received, should be maintained in the EHR for future reference.

Information regarding the patient's living situation and needs must also be addressed at the time of transition in order to ensure the necessary services and equipment are in place. A method to ensure patient understanding of the instructions should also be integrated into the transfer data. For example, if the patient has limited vision or is illiterate, the likelihood of them taking their medications appropriately may be in question and may lead to readmissions. Having a method to ensure the patient's understanding of their discharge instructions could help to avoid such a readmission.

The HIM department must work closely with the medical staff to provide timely dictation and transcription of dictated reports if the patient is going to another level of care or to another facility—especially the discharge summary. This will require an awareness of the requirements from regulatory agencies as well as medical staff rules and regulations to make sure documentation is timely and appropriate. If the medical staff has the option of documenting within the EHR directly instead of dictation/transcription, the HIM department must be able to monitor that activity for both appropriateness and timeliness to make sure all required elements are met and the information is available as needed for follow-up care. This requires a close working relationship between the IT department, HIM department, and members of the medical staff.

Patient portals provide an excellent way for the patient and their care teams to be able to review patient information after discharge. However, this requires HIM department involvement to review what is available for the patient, and when it is available, in order to make sure timely and accurate information is available while also making sure the medical staff is aware of what the patient can see. Depending on the EHR, the system will allow the facility to determine what is posted in the patient portal, as well as provide a time delay for this information to post. This provides the attending physician an opportunity to review the results prior to the patient seeing them in the event additional issues may arise, such as additional testing, medication, or discussion with the patient. In addition, education must be provided to the patient prior to discharge on how to access the portal and how to navigate through the available information. Each facility needs to determine whether these education processes falls within the HIM department or the IT department.

Recommended Practices for Referrals

Referrals are included as part of the transition of care processes and involve multiple steps. Referrals can be made to the emergency department, for hospitalization, for rehabilitation, for diagnostic testing, to community agencies, or for specialized therapies or equipment. A closed loop referral process occurs when the originating provider gives a reason for a referral and associated documentation to a receiving provider, and is then sent back documentation from the receiving provider that illustrates any action taken during the referral visit. This closed loop process is required for accreditation such as the National Committee for Quality Assurance's Patient-Centered Medical Home program. The goal is to have the closed loop referral process completely integrated within the EHR so tracking can occur as to what tasks have been completed, whether follow-up is required and as to when a referral is complete and can be closed.

The process can be facilitated via health information exchange or Direct protocols. A number of identification and matching processes are required—both for patients and providers as well as patient records. Consideration must also be given as to what format and record types can be exchanged.

Transfers to Other Facilities

Transitions of care to other facilities such as skilled nursing facilities or inpatient rehabilitation need special attention in terms of information transfer and communication. Consideration should also be given to the informational requirements under which the receiving facility must operate in order to initiate the assessment and care of the resident. For example, the data requirements for the home care assessment instrument, OASIS-C, include conditions prior to medical or treatment regimen change or inpatient stay within the past 14 days including prior ADL status, immunizations, living situation, cognition, behavior, and psychiatric symptoms.

A long-term care facility's resident assessment instrument, MDS 3.0, requires diagnosis within the last 60 days, weight changes in the last one to six months, chemotherapy, radiation therapy, oxygen therapy, secretions, tracheostomy, ventilator/respirator, IV medications, transfusions, dialysis, hospice, respite care, and isolation while not a resident. Patients in these transition situations may be more at risk for readmissions if the transition is not done successfully. In addition to the summary of care record items, documentation of advance directives and any orders for end-of-life care or life-sustaining treatment must be included. Information transfer should occur prior to the patient's move to the new facility to allow time for the receiving facility to ensure any special requirements or equipment needs are in place. Having a complete discharge summary is very important to the success of the care transition process. It can also be very helpful for the receiving facility to have electronic access to the patient's records during a transition period so any pending test results and final reports can be reviewed. The receiving facility needs to agree to notify the granting facility if the employee given electronic access to the EHR leaves the organization.

Technology Considerations

Technology is increasingly being used to facilitate the care transition process. Key technologies used include patient portals, mobile apps, EHR modules, and third-party care coordination applications. Most major EHR vendors have modules that allow for functionality for automated referrals and/or access to health information exchange. Third-party applications are being used to enable patient self-management and engagement. These applications can offer extended care coordination via online shared care plans between caregivers, providers, and patients as well as team discharge planning. Notifications and alerts can be used to remind patients to take action—particularly in high-risk situations.[17]

Some new software applications provide automated post-discharge assessments, alerts, notifications, and reports or a combination of online options, multimedia programs, and automated phone calls that interact with patients during the care transition process to help drive patient engagement. Other interactive programs guide patients through the care plan process including the discharge planning process for patients and their families. There are also discharge readiness tools for clinicians and case managers to monitor discharge readiness in real time. The items found in the sidebar on below do not represent an exhaustive list, and examples are only provided for illustration purposes.

Recommended Practices for HIM to Support the Transitions of Care Process During Transitions or Referrals

- Develop policies for collaboration and integration with community partners.
- Update the organization's information governance plan to manage information/data governance across partner/community organizations and address timeliness.
- Ensure systems support tracking discharge planning/readiness, proactive medications management/reconciliation, automated assessments. Work with internal departments to re-engineer the discharge process to have required documentation available prior to discharge.
- Fully integrate referral and care transition processes within the EHR. Work with internal departments to ensure a fully integrated closed loop referral process.
- Spearhead/participate with health information exchange; use national standards.
- Workflow integration with EHR/tailoring infomation for transfer. Health information exchange tools must be integrated into clinical workflows to be used. Physicians should be allowed to select documentation for transmission, such as push communication.
- Use automated alerts to update all care providers regarding patient status (admit/discharge to emergency department or hospital) to facilitate transitions.
- Review documentation processes to ensure all required components of discharge and/or care plans are captured as needed.
- Ensure process is in place for tracking tests pending at discharge and for sharing results with other providers, and potentially the patient, once results are available post-discharge.

Key Questions to Ask

- Do policies address shared care plans and the longitudinal care plan?
- Does the EHR support closed loop referral? What is the workflow and/or use case?
- Does the EHR allow the physician to select what patient information to transmit to other care providers?
- How will shared care plans be handled with regard to the health record?
- Can your organization provide EHR access to patient records for extended care teams (care teams outside the organization)?

HIM Plays a Vital Role in Transitions of Care

HIM professionals play a key role in helping to ensure information about a patient is shared with the right care providers at the right time during care transitions. Regardless if the patient is being discharged from a facility or admitted, or being referred from one provider to another, the quality and ease of exchange of information is paramount. The best practices outlined in this Practice Brief are intended to help HIM professionals ensure a sound and quality process which supports providers and patients during these transitions. Through effective information sharing, HIM professionals are integral to achieving quality care by ensuring information is complete, timely, and shared appropriately. The net result is that care transitions are safe and cost-effective.

Acknowledgement

AHIMA thanks ARMA International for use of the following in adapting and creating materials for healthcare industry use in IG adoption: Generally Accepted Recordkeeping Principles® and the IG Maturity Model. www.arma.org/principles. ARMA International 2013. Find the IGPHC here.

Notes

[1] "Health Policy Brief: Care Transitions." *Health Affairs*. September 13, 2012.

[2] The Joint Commission. "Hot Topics in Health Care: Transitions of Care: The need for a more effective approach to continuing patient care." June 2012.

[3] Centers for Medicare and Medicaid Services. "Stage 2 Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures; Measure 12 of 16." Updated August 2015.

[4] Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017." *Federal Register*. October 16, 2015.

[5] Centers for Medicare and Medicaid Services. "Readmissions Reduction Program." Updated January 15, 2016.

[6] National Priorities Partnership. "Preventing Hospital Readmissions: A $25 Billion Opportunity." November 2010.

[7] Centers for Medicare and Medicaid Services. "IMPACT Act of 2014 & Cross Setting Measures." Updated October 28, 2015.

[8] Burwell, Sylvia. "Progress Towards Achieving Better Care, Smarter Spending, Healthier People." HHS.gov. January 26, 2015.

[9] Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (Proposed rule)." *Federal Register*. November 3, 2015.

[10] INTERACT. Home page.

[11] Health Level Seven International. "Referral and Transition/Transfer of Care."

[12] Health Level Seven International. "FHIR Resource Referral Request."

[13] Massachusetts eHealth Institute. "IMPACT – Improving Massachusetts Post Acute Care Transfers."

[14] S&I Framework. "Longitudinal Coordination of Care WG Charter."

[15] AHIMA. Information Governance web page.

[16] Integrating the Healthcare Enterprise ITI Planning Committee. "Health IT Standards for Health Information Management Practices." September 18, 2015.

[17] Hoffman, Jock. "Managing Risk in the Referral Lifecycle." CRICO. December 20, 2012.

Appendix A: Additional Suggested Resources

1. AHIMA Information Governance principles ensure that information is trustworthy and actionable through alignment with organizational strategy and engagement of senior leaders and important stakeholders across the enterprise.

2. AHIMA partnered with Integrating the Healthcare Enterprise (IHE) to develop a white paper entitled *HIT Standards for HIM Best Practice* as part of AHIMA's Information Governance initiative which offers an organization-wide framework for managing information throughout its lifecycle and supporting the organization's strategy, operations, regulatory, legal risk, and environmental requirements.

3. The Joint Commission *Hot Topics in Health Care, Transitions of Care: The Need for a more effective approach to continuing patient care* describes the movement of patients between health care practitioners, settings, and home as their condition and care needs change. Identifies the root causes of ineffective transition of care as:

    a. Communication breakdowns.
    b. Patient education breakdowns.
    c. Accountability breakdowns.

    Several evidence-based transitions of care models have been developed to improve patient outcomes. These models include the Care Transitions Intervention (CTI), Transitional Care Model (TCM), Better Outcomes for Older Adults

through Safe Transitions (BOOST), The Bridge Model, Guided Care, Geriatric Resources for Assessment and Care of Elders (GRACE), and Project RED (Re-Engineered Discharge).

4. In Meaningful Use Stage 2 for eligible hospitals transition of care is defined as "The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all discharges from the inpatient department and after admissions to the emergency department when follow-up care is ordered by an authorized provider of the hospital." Transitions include referrals. Referrals are defined as a closed loop referral.

    a. Summary of Care Record must include:

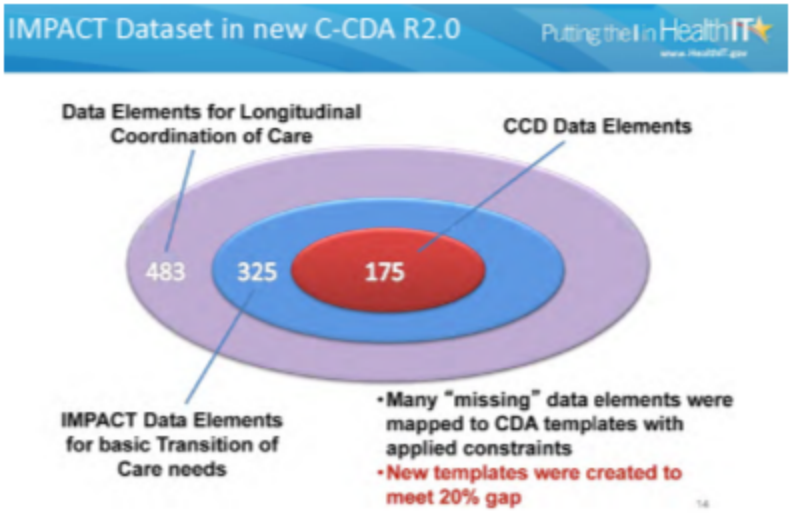
        i. Patient name

        ii. Referring or transitioning provider's name and office contact information (Eligible Providers only)
        iii. Reason for referral (Ambulatory only)
        iv. Procedures
        v. Encounter diagnosis
        vi. Immunizations
        vii. Laboratory test results
        viii. Vital signs (height, weight, blood pressure, BMI)
        ix. Smoking status
        x. Functional status, including activities of daily living, cognitive and disability status
        xi. Demographic information (preferred language, sex, race, ethnicity, date of birth)
        xii. Care plan field, including goals and instructions
        xiii. Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
        xiv. Discharge instructions (IP only)
        xv. Current problem list (Hospitals may also include historical problems at their discretion)
        xvi. Current medication list, and
        xvii. Current medication allergy list

5. In the Federal Hospital Readmissions Reduction Program readmission is defined as an admission to a subsection (d) hospital within 30 days of a discharge from the same or another subsection (d) hospital. Readmission measures are available here.
6. National Priorities Partnership report on Preventing Hospital Readmissions: A $25 Billion Opportunity, Nov. 2010, stated that within the first three weeks of a care transition, 20% of patients experience an adverse event.
7. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) includes five transition datasets and 196 possible transition types. This includes:

    a. Report from OP testing, treatment or procedure
    b. Referral to OP testing, treatment or procedure (including transport)
    c. Shared care encounter summary (office visit, consultations summary, return from the ED to the referring facility)
    d. Consultation Request clinical summary (referral to a consultant or the ED)

e. Permanent or long-term Transfer of Care to a different facility or care team or home health agency



8. The Health and Human Services (HHS) Value Based Healthcare Programs have two key goals to achieve by 2016. They are aiming for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients (e.g. value), instead of how much care they provide; by 2018, the goal is 50%. The second is to tie virtually all Medicare FFS payments to quality and value by 2016 and 90% by 2018. Delivering value requires integration across the continuum of care including care transitions. These programs include:

    a. Hospital Value-Based Purchasing (Hospitals)

    b. Bundled Payments for Care Improvement programs
    c. New care models such as Accountable Care Organization (ACOs)

9. The Centers for Medicare & Medicaid Services (CMS) released a proposed rule in October 2015 on Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies. Under the proposed rule hospitals and critical access hospitals would be required to develop a discharge plan within 24 hours of admission or registration and complete a discharge plan before the patient is discharged home or transferred to another facility. This would apply to all inpatients and certain types of outpatients, including patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, and emergency department patients who have been identified by a practitioner as needing a discharge plan. In addition, hospitals, critical access hospitals, and home health agencies would have to:

    a. Provide discharge instructions to patients who are discharged home (proposed for hospitals and critical access hospitals only);

    b. Have a medication reconciliation process with the goal of improving patient safety by enhancing medication management (proposed for hospitals and critical access hospitals only);
    c. For patients who are transferred to another facility, send specific medical information to the receiving facility; and
    d. Establish a post-discharge follow-up process (proposed for hospitals and critical access hospitals only)

10. INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities
11. The HL-7 Referral and Transition/Transfer of Care project identifies and defines additional FHIR resources related to the domain of Patient Care and includes support for referral and transition of care of patient from one provider to another/an organization. It defines Referral as:

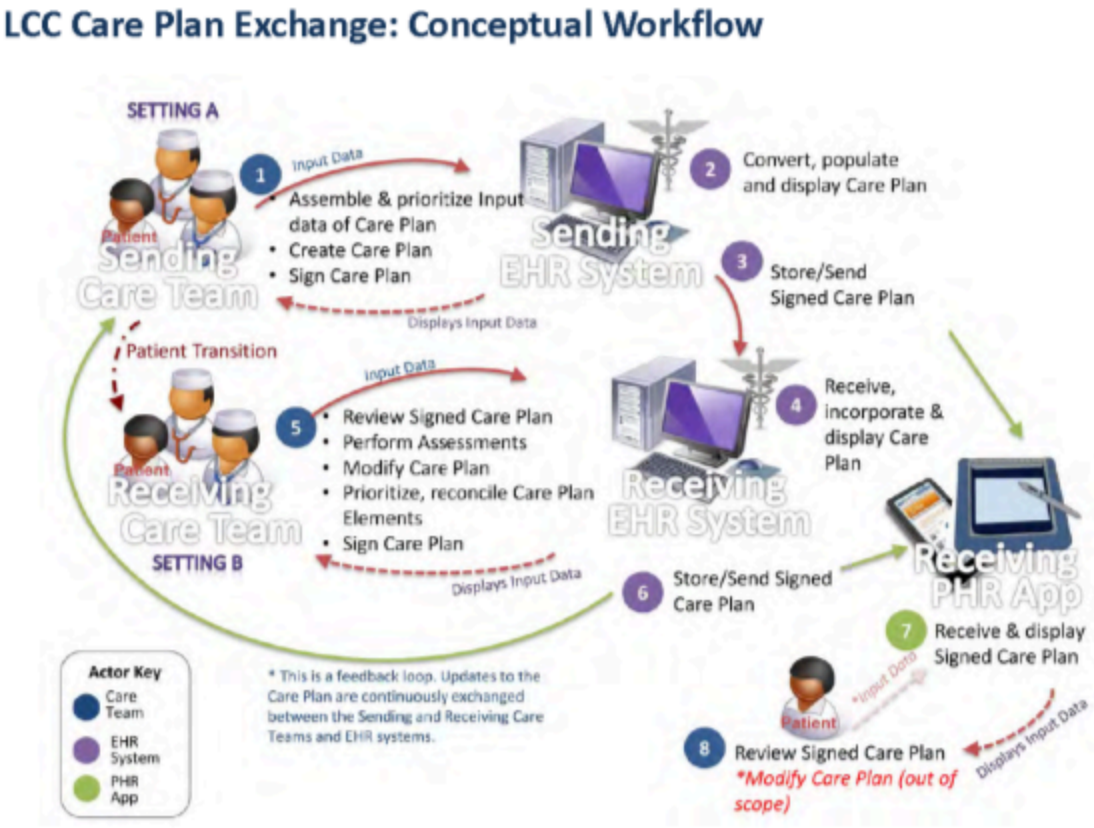
    a. Referral is the process, with the intention of initiating care transfer, from the provider making the referral to the receiver.

b. NOTE: The essential components of referral are the intent and facilitation of transferring patient care in whole or in part from one health care provider or organization to another provider or organization. Self referral is also possible: a person, the subject of care, may be the referrer or the referee. Referral is normally accompanied by clinical information to responsibly enable takeover of such care by the referee.
c. Referral can take several forms most notably:
(a) Request for management of a problem or provision of a service e.g. a request for an investigation, intervention, or treatment. (b) Notification of a problem with hope, expectation, or imposition of its management e.g. a Discharge Summary in a setting which imposes care responsibility on the recipient.
d. The common factors in all of these are a communication whose intent is the transfer of care.

It defines transition of care as:

a. The term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.
b. For example, in the course of an acute exacerbation of an illness, a patient might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she would receive care from a visiting nurse. Each of these shifts from care providers and settings is defined as a care transition (Source: http://www.caretransitions.org/definitions.asp)

12. The Improving Massachusetts Post-Acute Care Transfers (IMPACT) program was an Office of the National Coordinator (ONC) grant-funded project designed to improve care transitions using an enhanced electronic Universal Transfer Form (UTF) and Electronic Health Information (HIE) exchange. http://mehi.masstech.org/programs/past-programs/impact#sthash.4kld5DsL.dpuf
13. The now closed Longitudinal Coordination of Care (LCC) workgroup under the Standards & Interoperability (S&I) Framework completed its task of defining the necessary requirements to drive the identification and harmonization of standards supporting and advancing patient-centric interoperable health information exchange, including care plan exchange, for medically complex and/or functionally impaired individuals across multiple settings. The workgroup focused on the needs and experience of the patient respective to the Patient Assessment Summary (PAS) or LTPAC Summary document leveraging the Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS) and Care Tool datasets; a more robust Transition of Care (ToC) dataset required by Care Team ‘receivers’ building off the S&I ToC dataset; and the Care Plan/Plan of Care documents used to coordinate patient care across multiple settings and disciplines.



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