NY–RAH

CASE STUDY

Using the C-CDA, Electronic *Summary of Care* Document, for Medication Reconciliation and Hospital Description of Visit

Since 2014, the NY–RAH project has worked to improve electronic communication between its participating skilled nursing facilities and their hospital partners during transitions of care. NY–RAH project managers have worked one-on-one with participating nursing facilities to install a Direct Messaging mailbox, coordinate receipt of summary of care documents from partner hospitals, and to incorporate the document into their residents' health record for use in developing a care plan and reconciling medications.

USE OF THE C-CDA

Nursing facilities rely on clinical and administrative data to assess whether a potential resident can be appropriately cared for in the facility. Facility staff will review the Patient Review Instrument (PRI) to assess the resident and later reconcile this information with the paper discharge packet that is physically sent to the nursing facility with the resident upon discharge from the hospital. Due to the inaccuracy and inefficiency of these forms, combined with the Centers for Medicare & Medicaid Services (CMS) goals to promote health information exchange (HIE) between care settings, an alternate tool was created, known as the Consolidated Clinical Document Architecture (C-CDA). The C-CDA is also known as the electronic *Summary of Care* document.

Hospitals nationwide are working to meet CMS Stage 2 meaningful use (MU) requirements to transfer a summary of care record for a certain percentage of their patients who are transferred or referred to community providers, including nursing facilities.

NY–RAH Electronic Solutions Intervention

The NY–RAH electronic solutions intervention is focused on enabling nursing facilities to receive summary of care documents directly from their hospital transfer partners at the time of discharge through Direct Messaging. Direct Messaging is a technology used to transmit the C-CDA, similar to secure email, which allows for the transmission of protected health information to specified recipients over a secure network.

NY–RAH contracted with health information service provider MedAllies Mail to install Direct Messaging mailboxes at facilities without an electronic health record (EHR) or Regional Health Information Organization (RHIO) membership that could support this functionality. Nursing facilities received secure Direct Messaging mailboxes from MedAllies Mail, their partner hospital, or their RHIO. NY–RAH is working with nursing facilities to develop custom workflows that facilitate the effective use of transferred information to ensure that it can be used to improve communication during transitions of care, complete medication reconciliation, and support care plan development. NY–RAH is also working with EHR vendors and the RHIOs to develop a work plan for bidirectional communication from nursing facilities to hospitals using Direct Messaging technology. The following case study evaluates the successes and challenges of implementing Direct Messaging and describes the use of an actual C-CDA electronic Summary of Care document during the admission of a resident at a NY–RAH nursing facility.

C-CDA USE CASE: MEDICATION RECONCILIATION AND HOSPITAL COURSE DESCRIPTION OF VISIT

A hospital patient completed the discharge process with the intention of being transitioned to a nursing facility. Prior to discharge, a C-CDA was sent to the nursing facility. Staff in the facility's Admissions Department received the C-CDA in the Direct Messaging shared inbox approximately two and a half hours before the patient was transferred from the hospital. The Admissions Department was prompted to download and print the C-CDA, which was sent to the unit for review by the nurse manager and physician. The nursing facility admitted the patient from the hospital with the C-CDA in hand.

The nurse manager and physician reviewed the C-CDA and reconciled the medication list with the PRI and the paper discharge summary. Using the C-CDA to reconcile the medication list is vital to resident care as the C-CDA is pulled directly from the EHR at the time of discharge, making it the most accurate source of medication information for the resident, which may differ from the PRI and paper discharge summary.

The nurse manager and physician were also able to utilize the *Hospital Course* section (Appendix A) of the C-CDA, which details the hospital visit in the treating physician's own words as transcribed in the hospital EHR. The hospital's treating physician dictated the determining factors for discharge and his recommended plan of care, which assisted the nursing facility in developing its own care plan for the patient. Clinical data, including past medical history, vital signs, and administered medications, are also found in the *Hospital Course* section, providing an invaluable narrative and recount of the hospital stay. This information is not typically found in the PRI or paper discharge summary.

CHALLENGES

Hospital Delay in Sending the C-CDA

The NY–RAH 2017 Nursing Facility Electronic Solutions Report found that 45% of nursing facilities are unsure of how to best use the C-CDA. Technical and operational barriers related to the hospital transmission time continue to slow adoption. Current CMS regulations incentivize hospitals to transmit the C-CDA for only a subset of their discharges in order to avoid payment penalties. Therefore, nursing facilities typically do not receive C-CDAs for all admissions.

Most hospitals utilize manual processes for transmitting the C-CDA. The transmission is often overseen by the information technology (IT) department, resulting in delays in transmission times. These issues pose challenges to the nursing facility's ability to standardize workflow processes. To address these barriers, the NY–RAH project management team is meeting with nursing facilities and their hospital partners to provide recommendations for improving electronic workflow processes during transitions of care.

NURSING FACILITY BEST PRACTICES

Interdisciplinary team

The nursing facility's Admissions Department should champion the C-CDA workflow process with interdisciplinary support. Ideally, the interdisciplinary team should be comprised of staff from Admissions, Health Informatics and Information Technology, Quality and Process Improvement, Nursing, and Administration. Within the NY–RAH project, nursing facilities have typically been assigned three individual Direct Messaging mailboxes for users in the Admissions Department, Nursing/Medicine, and IT. All users also have access to a common, shared inbox, which is associated with the Direct Messaging address that the hospitals use to send the C-CDA. The NY–RAH project trained users on accessing the C-CDAs through the Direct Messaging mailboxes and assisted in establishing a workflow driven by the Admissions Department (Appendix B).

Downloading and Disseminating the C-CDA

Compared to the PRI and paper discharge summary, the clinical data included in the C-CDA is the most accurate and useful data. It is generated directly from the hospital EHR at the time of discharge. When the document is received prior to the resident's admission to the facility, it can be used for the admissions process, medication reconciliation, and as a detailed progress note summarizing the hospital stay. The C-CDA should be downloaded from the Direct Messaging mailbox and incorporated into the paper chart or EHR, making it available to the entire facility.

APPENDIX A:
Sample C-CDA Hospital Course Section

HOSPITAL COURSE

Patient with the past medical history of dementia, hypothyrodism, osteoporosis, bronchial asthma (never intubated, non-steroid dependent), pre-diabetes (last Hba1c is 6.3 as of March 2014), stasis dermatitis over right leg was brought to the ED with the chief complaint of dizziness for two days at home. Patient states a feeling of lightheadedness and kind of dizzy. Patient examined this morning at bedside and refers to feeling well and wanting to go home, currently denies dizziness, chest pain, SOB, and palpitation. No numbness/weakness noted at time.

APPENDIX B:
Workflow Processes

DIRECT MESSAGING WORKFLOW PROCESS