Committee Approval Date:

Publishing Lead:
Dave Hill, MITRE

Contributing or Reviewing Work Groups:
Patient Care Work Group (sponsor)
Community-Based Care and Privacy Work Group (sponsor)
Patient Administration Work Group (interested party)

FHIR Development Project Insight ID:
1572

Scope of coverage:
This guide leverages the eLTSS work to provide the profiles and necessary extensions required to specify how to syntactically and semantically exchange cognitive status post-acute care assessment data between care settings.

Content location:
https://paciowg.github.io/cognitive-status-ig/

Proposed IG realm and code:
US/pacio-cs

Maintenance Plan:
The PACIO Project intends to provide ongoing support of this implementation guide.

Short Description:
Develop a FHIR R4 IG that leverages eLTSS and utilizes the Confusion Assessment Method (CAM) assessment to enable the sharing of cognitive status information when a patient moves from one clinical care setting to another.

Long Description:
Poor quality discharge information is a major barrier to safe and effective transitions. With 45% of Medicare beneficiaries requiring post-acute care (PAC) services after hospitalization, the need for a seamless exchange of health information is great.
In 2014, the Social Security Act was amended to include the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, which required the standardization and interoperability of patient assessment in specific categories for post-acute care (PAC) settings, including long-term care hospitals (LTCHs), home health agencies (HHAs), skilled nursing facilities (SNFs), and inpatient rehabilitation facilities (IRFs). It focuses on standardizing data elements in specified quality measure domains and patient assessment domains for cross-setting comparison and clinical information exchange, respectively. The Act requires:

- Reporting of standardized patient assessment data through commonly used PAC assessment instruments for LTCHs, SNFs, HHAs, and IRFs
- Minimum Data Set (MDS) for SNFs
- Inpatient Rehabilitation Facility – Patient Assessment Information (IRF – PAI) for IRFs
- LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) for LTCHs
- Outcome and Assessment Information Set (OASIS) for HHAs
- Implementation of data elements specified in each assessment domain using standardized data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers
- Data to be standardized and interoperable to allow exchange of data between PAC providers, among others, using common standards and definitions to provide access to longitudinal information and facilitate coordinated care.

Required assessment content includes standardized questions and response options (aka “data elements”) for assessing a patient’s cognitive status.

This FHIR R4 IG leverages the eLTSS work to provide the profiles and necessary extensions required to specify how to syntactically and semantically exchange that cognitive status post-acute care assessment data between care settings.

**Involved parties:**

This implementation guide is being developed by the clinical, EHR, and client app organizations as part of the PACIO Project.

**Expected implementations:**

MITRE, Patient Centric Solutions

**Content sources:**

Requirements are drawn from the IMPACT Act and clinical, EHR, and client app organizations as part of the PACIO Project.

**Example Scenarios:**

A patient is discharged from an acute care facility and admitted into a post-acute care facility. The post-acute care facility can retrieve the results of cognitive status assessments from the acute care facility’s FHIR API.

**IG Relationships:**

This guide will reference, where possible, the “standards” defined by Argonaut, US Core efforts for FHIR R4, and eLTSS.

**Timelines:**

STU Ballot in May 2020

**FMG Notes**