Conditions of Participation (CoP) for Admissions Discharge and Transfer (ADT) Notifications Master Document

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A. Pointed Suggestions from Leadership for Review

What is the optimal functionality that we would desire for our system to work from the perspective of making it easiest on each of our hospitals and maximize their compliance?

The optimal functionality for maximized compliance would allow a hospital to send us an ADT message, and allow us to handle all routing to PACs and PCPs. While our current ADT Use Case accomplishes this at a high level, there are a few improvements, which could be made to support hospitals in sending ADT messages. They are outlined below.

Suggestion: Allow provider routing in addition to patient routing.

Currently, MiHIN Rhapsody extracts patient information from an ADT message and performs a search on ACRS to determine all providers who may have listed the individual as a patient. Providers and their delivery preferences are found using ACRS and the message is routed accordingly. While this functionality works well if providers have listed a patient, it does not account for a situation in which a hospital has listed a provider in the ADT message *but* the PAC or PCP has not provided us a list of patients for us to populate ACRS.

One way to resolve this would be to allow MiHIN to extract information from an ADT message to determine which PACs and PCPs should be receiving information (and which ones may not be already). We could find this by using the designated field in an ADT message in which PACS, PCPs, and other individuals pertinent to a patient's care are listed. We could extract out this information and allow provider- level routing to get the information to a PAC or PCP who has not provided us with an ACRS list.

Suggestion: Another solution to this would be to allow providers to supply us with a list of patients in a simplified manner—like Baby ACRS.

"Baby ACRS", a scaled down version of the Active Care Relationship Service®, this new tool reduces provider organization burden to communicate and register their selected types of endpoints, such as Direct Secure Messaging address, a FHIR URL 4.0.1, Connect URL, etc. with the NPPES. Baby ACRS also enables providers to attach a population, panel, or roster of their patients to submit to any hospital in the Unites States.

This secondary function helps address another aspect of the final rule that established a new condition of participation (CoP) for all Medicare and Medicaid participating hospitals, requiring them to send electronic event notifications regarding treatment status, care coordination, and quality improvement to another healthcare facility or community provider or practitioner when a patient is admitted, discharged, or transferred (ADT) to providers with whom patients' have established care relationship. Now with Baby ACRS practitioners can both comply with their additional digital contact registration requirements and request access to their patients' data from hospitals and emergency departments.

Suggestion: Compile a report of how many ADT messages are being received from a hospital and how many are not reaching its destination. An ADT may not reach the PAC or PCP because they are not connected to MiHIN, they have not provided a delivery preference, their delivery preference is inaccurate, or for some other reason.

When we determine that an ADT message was received from a hospital and does not reach the PAC or PCP, we could use the report to facilitate outreach. This could occur by doing individual outreach to PACs and PCPs to let them know they have an ADT message ready to be viewed and they can view by signing the following legal agreements if they have not done so:

- Simple Data Sharing Organization Agreement (SDSOA)
- Active Care Relationship Services (ACRS) Use Case
- Health Directory (HD)
- Common Key Service (CKS)
- Admissions, Discharge, and Transfer (ADT) Use Case)

We could provide these agreements via a Jira Link, where they can easily scroll through the agreements like a Terms of Service and click "I agree."

We could provide alternatives to PACs and PCPs through DSM if PCPs were able to provide us with an updated DSM address.

For providers who are legally connected to us, and are still not receiving messages, we could ask them to update their delivery preferences and/ or DSM accounts. We could then provide test messages to ensure messages would be routed moving forward.

Suggestion: Allow a method for hospitals to easily accommodate patient requests to share information. Patients are able to communicate who their PAC or PCP is in the hospital, at the point of care. Hospitals have fields to input this information into EPIC. We could allow PCPs and PACs to add providers for a patient through a provider portal and a manage ACRS page. The only problem here is that the provider would be updating the patients on behalf of another provider as opposed to for him/herself.

Are there manual work arounds we can do to help the most customers and what are they?

If we were able to determine which ADT messages were not routed, we could engage in a community outreach campaign targeted at those PAC, PCPs, and other small practices who may not participate in MiHIN.

Suggestion: We should develop an easy online onboarding process for small practices.

- Allow online legal onboarding
- Allow delivery method choice to be determined and confirmed during onboarding
- Allow them to sign up for a DSM account during onboarding (alternative?)
    - Allow us to accept credit card for a DSM account to expedite the process

a. DSM?

Everyone should have a Direct account if they have access to EPIC, but there are different tiers depending on their role within the hospital. The direct account may be build into their user ID; so when a doctor logs into Epic, they are able to see all their patients and receive notifications on them.

Suggestion: The PAC or PCP should be able to reach out to MiHIN directly and say I want to begin receiving ADT messages via DSM. If we had a process where we could receive those requests, go into HD to find them, insert their DSM, and save, it would make it

much easier for PAC and PCPs.

b. 1-800 number?

Suggestion: A 1-800 number is good idea, and it has been used in other states, but a better way to intake requests to connect or receive information would be through a ticketing process like Help Desk. This would allow us to track requests in a uniform, non-discriminatory manner. We could also point to this log during a CMS Surveyor Audit for the hospital or us as a HIN.

c. Direct Secure Messaging inbox to send an ACRS like list?

We do this now for Patient Ping. We could offer a service where a provider is given the opportunity to send us an ACRS like list via DSM. We could create a template for patient list submission and include a "checkbox" during onboarding, in which we would provide them that template for them to complete and send back to us.

d. Are other vendors doing something we should consider (example Patient Pings audit response team)?

While the focus really is on hospitals to send ADT messages, as opposed to PAC and PCPs receiving messages, other vendors are offering more functionality to PACs and PCPs to get more of them on their network. Being able to view ADT messages very easily on a webpage or phone would be a value-add.

Suggestion: Use Care Convene to allow providers to do everything from onboarding, to viewing the ADT messages, to follow up appointments. If a PAC or PCP downloads Care Convene from the App Store, we should provide a very easy legal onboarding to our use cases. Providers should be able to click a link or tab in the app itself that would allow them to scroll through the legal agreements and onboard in a matter of minutes. Once they have done this, they can begin receiving ADT messages to their phone or web page. They should also be afforded flexibility based on how often the receive alerts and what type of alerts they would like to receive.

Suggestions We should provide email notification for a PAC or PCP to log into TOC viewer because they have an ADT waiting to be viewed. We can find the email address by using HD, which has a field for an email address. To clarify, the provider would not get the full ADT message in the email, but just an alert that an ADT is available to view for a patient of theirs.

What are the technical approaches that offer the best solution and which ones are a priority?

e. Examples

i. Do we run a daily report from the ADT data lake and populate ACRS?

We could run a daily report and use it for provider routing.

Suggestion: With the goal of increasing participation of PACs and PCPs to participate with MiHIN, we can envision data options for identifying those physicians who ***would have been*** forwarded ADT notifications, but weren't

because they have not “subscribed”.

In reviewing what data is in place today, with the exception of HeathConnect, provider routing logs and additional development in capturing or comparing logic would be needed.

ii. **Do we modify real-time ACRs to pull the NPI numbers from the ADT message in addition to the sending facility?**
That is how real-time ACRS functions today. We pull the attending provider NPI from the ADT when creating the relationship.

Suggestion: Propose real-time ACRS for all out-of- state customers or customers who would like to maximize CoP compliance.

iii. **Do we pull direct addresses from NNPES and route ADTs**
We currently pull direct addresses from NPPES for the Med-Rec use case (Direct address from NPPES to HD).

Suggestion: Pull direct addresses from NPPES for ADT Use Case. But- as a disclaimer- NPPES DSM accounts not 100% accurate. When looking at the list, there are many gmail addresses and other inaccuracies. Having a self-updating HD would be another option.

What modifications do we propose to the ADT UCE that take the responsibility off hospitals once they get the ADTs to us?

Suggestion: Alter the ADT Use Case to allow for routing based on a PAC and PCP’s delivery preferences, regardless of what they may be. Right now the ADT Use Case may require all routing to only take place through ACRS and not necessarily directly to the provider through DSM or an alternative method.

Suggestion: We must think about national ADT routing and how that will come into play. Much of the documentation is or state-specific routing and we may want to examine how to address requests to send information out of state so we can respond in a uniform manner.

How is the best way to communicate that we are doing all this to our customers?
Suggestion: Use a three step approach of email, the Download content or targeted webinar, and a press release.

How would we accomplish all this and who would you expect to do which parts?
Dependent on which suggestions you believe are worth us examining, the following departments would need to support.

- Community engagement: Engage hospital and PAC/PCP community for awareness
- MarComm: Communication strategy
- Legal: Update UCEs, provide easy legal onboarding via webpage or Care Convene
- Rhapsody: Extracting PAC/PCP information out of ADT message

- Policy & Privacy: Department specific training

Other Suggestions

Suggestion: We should support hospitals by providing documentation—outlined below.

Hospitals can very easily meet compliance for the CoP. For example, if they are connected to a HIN/HIE, who is connected to a wide variety of participants, it points towards the reasonable effort that is necessary for compliance. Even more telling, however, would be documentation surrounding participation in MiHIN's ADT Use Case.

We should support hospitals with the following documentation:

- Letter confirming participation in MiHIN Network
- Letter confirming participation in our ADT Use Case
- Template response on how ADT Use Case complies with CoP
- Assurance we would assist with audit trail
    - We keep entire ADT message for 90 days, after which we store limited information in logs. While hospitals will maintain their own logs, we could provide ours as support in the event of a CMS surveyor audit. Our logs would match up to their information and would provide confirmation of all ADTs sent.
- Reports on ADT messages sent
    - We could offer them reports on ADT messages we received from them and which ones were routed to their end points. They could rely on statistics to show compliance. For example, they could state ADT messages were sent for 60% of patients or 90% of ADT messages reached their end points while 10% were undelivered.
    - We could also help them identify why ADTs are not being delivered
        - Providers not in our network
        - Did not provide delivery information
        - Inaccurate delivery information

B. General Questions for Hospital Compliance

What authority does Centers for Medicare & Medicaid Services (CMS) have for creating the new CoP requirements for ADT notifications?
The final CMS Interoperability Rule, which was released in 2020, included a requirement that all hospitals, critical access hospitals (CAHs), and psychiatric hospitals that participate in Medicare or Medicaid send ADT notifications to established providers of a patient.

Who is subject to the CoPs?
The new CoPs only apply to hospitals, psychiatric hospitals, and CAHs participating in Medicare or Medicaid and using an electronic medical or administrative (registration) system that generates HL7® version 2.5.1 (or newer) messages. A hospital is not required to purchase a new system if its existing system does not support HL7® version 2.5.1.

What are hospitals required to do?
Hospitals must demonstrate:

- ✓ Its ADT system is fully operational and operates in accordance with state and federal laws for health information;
- ✓ Its system sends the minimum patient information (that is, patient name, treating practitioner name, and sending institution name, and diagnosis if not prohibited by law);
- ✓ To the extent permissible under applicable federal and state law, its system sends ADT alerts either directly (or through an intermediary, like MIHIN) at the time of emergency department (ED) registration or inpatient admission, and either immediately prior to or at the time of discharge/transfer;
- ✓ It has made a reasonable effort to send the ADT alerts to the required Post Acute Care Providers (PACs) and Primary Care Providers (PCPs) specified in the CoPs, to the extent permissible under applicable law.

What is the standard of care that hospitals will be held to?
These hospitals must make a *reasonable effort* to send ADT notifications either directly or through an intermediary, such as MIHIN.

What does reasonable effort mean?
CMS said that it expect surveyors to "evaluate whether a hospital is making a reasonable effort to send patient event notifications while working within the constraints of its existing technology infrastructure."

CMS allows hospitals to demonstrate that its system meets this requirement in a variety of different ways. They have provided a few illustrative examples for hospitals (below):

- Having processes and policies in place to identify patients' PCP;
- Working with an intermediary that maintains information about a patient's care relationship;
- Analyzing care patterns or other attribution methods that seek to determine the provider most likely to be able to effectively coordinate care post-discharge for a specific patient; or
- Allowing a provider to specifically request notifications for a given patient for whom they are responsible for care coordination as confirmed through conversations with the patient.

What information are hospitals required to send?
The minimum ADT alert content requirements include:

1. Patient name;
2. Treating practitioner (*e.g.*, the attending physician); and
3. Sending institution (*e.g.*, hospital)

However, hospitals are not required to send this content if doing so would not be permissible under other applicable law.

May hospitals send more than the minimum ADT notifications required by the CoPs?
Yes, so long as additional sharing is permissible under other applicable law. CMS guidance encourages hospitals to send more information if it would facilitate better patient treatment and care coordination. CMS expressly mentions sending the following additional data elements:

- Diagnosis;
- Chief complaint;
- Discharge disposition;
- Medication list;
- Insurance policy coverage;
- Other data that can be used for patient matching;
- Hospital address and tax ID; and
- Patient contact information.

When should hospitals send ADT Notifications?
The following events trigger the ADT alert requirement:

- ED registration (including for observation);
- Hospital inpatient admission;
- Discharge from the hospital's ED;
- Transfer from the hospital's ED (*i.e.*, to the hospital's inpatient services); and
- Discharge or transfer from the hospital's inpatient services.

*Please note: notifications are required for all patients who have ADT events, not only Medicare and Medicaid patients.

What is the timeframe for sending ADT notifications?
The CoPs require real time alerting. For inpatient admission or ED registration, ADT alerts must be sent at the time of such admission or registration. For discharge or transfer, ADT alerts must be sent immediately prior to, or at the time of, such discharge or transfer.

Is there a specific format for sending ADT notifications?
CMS does not require a particular format or transport protocol for making ADT alerts available.

CMS provides, as examples, Direct messaging, FHIR-based API, and even C-CDA. But, hospitals may choose the electronic delivery method (or mix of methods) that works best for them.

Who should hospitals send ADT messages to?
Hospitals must make reasonable efforts to send ADT alerts to the following providers which need to

receive notification of the patient's status for treatment, care coordination or quality improvement purposes:

- All ***applicable*** post-acute care service providers and suppliers (collectively, "PACs")
- A patient's ***established*** PCP practitioner or group, or other practitioner/group identified by the patient as primarily responsible for the patient's care (collectively, "PCPs")

Please note that CoPs place a floor (not a ceiling) on who may receive ADT alerts. Therefore hospitals are able to send to individuals beyond the PAC and PCP.

Can hospitals send ADT notifications if it contradicts a patient's expressed preferences?
No. CMS explains that: "[W]e do not intend to prevent a hospital from recording a patient's request to not share their information with another provider [as permitted by the] HIPAA Privacy Rule. Similarly, if a hospital is working with an intermediary to deliver patient event notifications, the intermediary may record information about a patient's preferences for how their information is shared, and, where consistent with other law, restrict the delivery of notifications accordingly." 85 Fed. Reg. 25510, at 25602.

May hospitals use an intermediary organization to meet their ADT alert obligations?
Yes. Hospitals may use an intermediary organization(s) to meet their obligations under the new CoPs. Health Information Networks (HINs) and Health Information Exchanges (HIEs) are examples of intermediaries. A hospital may use intermediary organizations to do some or all of the following:

- Send ADT alerts;
- Determine which receiving providers will receive ADT alerts;
- Record patient privacy preferences and honor them; and/or
- Curate ADT alerts to meet recipient delivery and content preferences.

CMS expressly permits hospitals to make exclusive use of a single intermediary organization to satisfy the ADT alert requirements. However, this intermediary organization must connect to wide range of recipients, and not impose restrictions on which recipients are able to receive notifications through the intermediary organization.

What can hospitals expect from CMS Surveyors?
CMS expects surveyors will use their existing survey procedures and methods to evaluate compliance with the new CoPs, including:

- Reviewing the organizational structure and policy statements and conducting an interview with the person responsible for the medical records service to ascertain whether the hospital is subject to or exempt from the patient event notification requirements (i.e., whether the hospital has an ADT system that uses HL7® version 2.5.1 (or newer version) messaging standard);
- Reviewing a sample of active and closed medical records for completeness and accuracy, including any patient event notifications, in accordance with hospital policy and federal and state laws and regulations;
- Interviewing medical records staff and other hospital staff, such as physicians and other practitioners, to determine the staff's understanding of the patient events notification function of the system; and

- Conducting observations and interviews with medical records staff and leadership to determine if requirements for patient event notifications are being met.

Thus, hospitals (and their intermediaries) should be ready to show documented policies, procedures, processes, and audit logs that support compliance with the ADT alert requirements, including compliance with applicable state and federal health information laws.

C. General Questions for Providers

As a point of clarification, there are no obligations imposed on providers for this compliance period

How can a PAC or PCP that is not already receiving ADT messages begin to do so?
Providers are able to begin receiving ADT messages through an easy two-step process.

First they must legally connect to the MiHIN network by signing our legal stack, including:

- The Simple Data Sharing Organization Agreement- our standard data sharing agreement
- Active Care Relationship Service (ACRS)- to establish relationships with your patients
- Health Directory (HD)- for provider information
- Common Key Service- for accurate patient matching
- ADT Use Case- for receiving ADT messages

Second, you must technically onboard to begin receiving ADT messages.

Are there any alternative methods for me to receive ADT notifications on my patients?
Yes. If you provide us with your Direct Secure Messaging (DSM) address, and communicate that this is your preferred delivery method, we will route to your DSM inbox.

Providers are also able to sign up for the mobile application Care Convene, in which they are able to legally onboard and begin receiving ADT messages to their phone. They are also able to tailor their preferences in the Care Convene application to view ADT messages for specific patients only or for only certain types of messages (e.g. only admissions). The value of the Care Convene app is also that providers may utilize it to schedule follow up appointments with their patients in real-time.

What if I am not receiving my ADT messages?
Please contact help@mihin.org for support.

D. Template for Hospital Response to CMS Audit

MiHIN is able to provide assurance to hospitals that its ADT Use Case meets the requirements in the CoP. Please see the document below on how MiHIN ADT Use Case meets CoP requirements.

[Date]

[Name]
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services (HHS)
[Attention:]
[Address]
[E-mail address]

Re: Compliance with Centers for Medicare and Medicaid (CMS) Conditions of Participation (CoP)—Admissions, Discharge, and Transfer (ADT) Notifications

Dear [Name],

[Hospital Name] provides this letter to confirm participation in the MIHIN Admissions, Discharge, and Transfer (ADT) Use Case, which is fully compliant with the CMS CoPs.

As is referenced throughout CMS responses to the public comment period, intermediaries, such as a Health Information Networks (HIN) like MIHIN, were explicitly suggested as a resource to assist with both ADT routing and compliance efforts. CMS stated:

"In the CMS Interoperability and Patient Access proposed rule, we stated that, if finalized, hospitals would be required to send notifications 'directly or through an intermediary that facilitates exchange of health information.' We believe this would allow exclusive use of either method, or a combination of these methods, provided other requirements of the CoP are met.

For instance, if a hospital makes exclusive use of an intermediary to satisfy the CoP, the hospital would still be subject to the requirement that notifications must be sent to the set of recipients we are finalizing in this rule, specifically all applicable post-acute care services providers and suppliers as well as a patients' primary care practitioners or practice groups and entities primarily responsible for a patient's care, as well as practitioners identified by the patient.

Given this requirement, exclusive use of an intermediary with a limited ability to deliver notifications to the specified set of recipients, for instance an intermediary which restricts its delivery to only those providers within a specific integrated health care system, would not satisfy the CoP.

Alternatively, if a hospital demonstrates that an intermediary connects to a wide range of recipients and does not impose restrictions on which recipients are able to receive notifications through the intermediary, exclusive use of such an intermediary would satisfy the CoP."

From this guidance, if a hospital system is connected to an intermediary, who is connected to a wide range of recipients, as is the case with MIHIN, then use of the MIHIN's ADT Use Case would satisfy CoP compliance.

Given this information, we respectfully request CMS to acknowledge CoP compliance. This would not only reduce the administrative burden involved CMS surveyor assessments, but it would also serve to encourage greater participation in health information exchange.

MiHIN meets all requirements and CMS guidance, as outlined in the table below.

☑ This symbol signals compliance

✓ This symbol signals alignment with guidance

CoP Requirement	CMS Guidance	Compliant
Hospital ADT Requirement Only hospitals that possess EHR system with capacity to generate the basic patient personal or demographic information for information for electronic patient event notifications 1. Fully operational + compliant with federal statutes for health information 2. Utilizes content exchange standard 3. Sends notifications that would have to include minimum patient information (below) 4. Sends notifications directly to through an intermediary that facilitates exchange of health information at the time of admission or immediately prior to or at time of discharge Minimum patient information 1. Patient's basic personal or demographic information 2. Name of the sending institution 3. the patient's diagnosis (if not prohibited by law)	Must have technical capacity or not subject to requirement Anybody who supports immunization registry exchange or laboratory exchange will have technical capabilities Adopting certified health IT that meets this criteria is already required for Promoting Interoperability May provide advanced content but not required to	☑✓
Hospital must demonstrate that the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's hospital ADT to licensed and qualified practitioners, other patient care team members, and PAC services providers and suppliers that: 1. Receive the notification for treatment, care coordination, or quality improvement purposes; 2. Have an established care relationship with the patient relevant to his or her care 3. The hospital has reasonable certainty that such notifications are received.	Diverse set of strategies that hospitals might use when implementing patient event notifications Send notifications to those practitioners or providers that had an established care relationship with the patient relevant to his or her care Recognized that hospitals and their partners may identify appropriate recipients through various methods (provider, patient, caregiver, record)	☑✓
Hospitals, psychiatric hospitals, and CAHs comply with HIPAA Privacy and Security Rules	Permits event notification for treatment Also ADTs could be considered requirement by law once finalized	☑✓
Hospital only send ADT if reasonable certainty of receipt	Reasonable certainty means hospital made a reasonable effort to ensure that" the system sends the notifications to any of the following that need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes to all applicable post-acute care services providers and suppliers and: (1) The patient's established primary care practitioner;	☑✓

	(2) the patient's established primary care practice group or entity; or (3) or other practice group or entity, identified by the patient as the practitioner, or practice group or entity, primarily responsible for his or her care.	
Hospitals to transfer or refer patients, medical information to appropriate facilities, agencies or outpatient services	Existing duty under CoP, but think about ways to reduce redundancy under this and new CMS CoPs	☑✓
Psychiatric Hospital ADT Requirement Only hospitals that possess EHR system with capacity to generate the basic patient personal or demographic information for information for electronic patient event notifications 1. Fully operational + compliant with federal statutes for health information 2. Utilizes content exchange standard 3. Sends notifications that would have to include minimum patient information (below) 4. Sends notifications directly to through an intermediary that facilitates exchange of health information at the time of admission or immediately prior to or at time of discharge Minimum patient information 1. Patient's basic personal or demographic information 2. Name of the sending institution 3. the patient's diagnosis (if not prohibited by law)	Only if have technical capacity	☑✓
Psychiatric hospitals: Must demonstrate that the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's hospital ADT to licensed and qualified practitioners, other patient care team members, and PAC services providers and suppliers that: (1) Receive the notification for treatment, care coordination, or quality improvement purposes; (2) Have an established care relationship with the patient relevant to his or her care (3) The hospital has reasonable certainty that such notifications are received.		☑
Critical Access Hospitals: Only hospitals that possess EHR system with capacity to generate the basic patient personal or demographic information for information for electronic patient event notifications 1. Fully operational + compliant with federal statutes for health information 2. Utilizes content exchange standard 3. Sends notifications that would have to include minimum patient information (below) 4. Sends notifications directly to through an intermediary that facilitates exchange of health information at the time of admission or immediately prior to or at time of discharge Minimum patient information 1. Patient's basic personal or demographic information 2. Name of the sending institution 3. the patient's diagnosis (if not prohibited by law)		☑
Critical Access Hospitals: Must demonstrate that the system sends notifications directly, or through an intermediary that facilitates		☑

exchange of health information, at the time of the patient's hospital ADT to licensed and qualified practitioners, other patient care team members, and PAC services providers and suppliers that: 1. Receive the notification for treatment, care coordination, or quality improvement purposes; 2. Have an established care relationship with the patient relevant to his or her care 3. The hospital has reasonable certainty that such notifications are received.		
	Only minimum floor for information sharing Minimum floor- allows for greater information sharing if possible CMS not concerned with excessive information being sent at this time	✓
	Compliance on case by case basis Surveyors will be trained accordingly Accreditation organizations responsible for own training	✓
	Rules are not duplicating other final rules and TEFCA draft, instead they complement one another Ensure compliance with all rules	✓
	Health Information Exchanges (HIEs) are well positioned to alleviate costs for small providers and entities, however, if they do not have the technical capabilities, they are not subject to the CoP Is not requiring hospitals to go out and buy new EHR system	✓
	Can use hospital registration systems to send clinical information with ADT	✓
	ED patients should be included in patient notification system (direct or observational stays)	✓
	Hospitals can dictate whether to send internal and external notifications differently for patients transferred to different areas within same health system	✓
	Who is considered an established care relationship (broadened): -PCP or primary care practice group or entity - other groups identified by the patient as the practitioner -practice group responsible for patient's care -relationship documented in patient record -Readmissions rates dropped and significant factor was identifying PCP at discharge	✓
	If a hospital is not able to identify a PCP, or has not been identified by a provider, and no PAC identified, no event notification is required	✓
	CMS recognizes importance of patient matching, but these CoPs not meant to address that. For patient matching guidance, turn to National Association of Healthcare Access Management and American Health Information Management Association, the Agency for Healthcare Research and Quality, and the ONC	✓
	This cannot be used as a basis for a measure under the Promoting Interoperability program – because it does not require the use of Certified Health IT	✓
	No certification standards for event notification in ONC Health IT Certification program; open to any method of sharing information; does not need to be HL7 standard Want to emphasize flexibility in standards to get everyone on board	✓
	Do not want to emphasize a standard ADT method right now	✓
	C-CDAs are typically for clinical information and may not be the best method for event notifications, but is technically allowed and can supplement ADTs with more information than required	✓
	Diagnosis is not required an may already be sent through summary of care record under Promoting Interoperability	✓

	Even limited information with ADTs can have a positive effect if delivered in timely manner- try to get as close to real time as possible	✓
	Try to accommodate providers preferences for receiving information- it is not a requirement but it is encouraged HIEs and HINs are good intermediaries for tracking these preferences	✓
	Hospitals do not need to send to entities that have declined because it does not support care coordination Intermediaries like HINs or HIEs can help with communication between these two	✓
	Can use an intermediary to comply with all CoP requirements, but best to find an intermediary that is connects to a wide range of recipients and does not impose restrictions on which recipients are able to receive notifications through intermediary	✓
	Can delegate CoP requirements to intermediary- more to reduce burden but could have a situation where it does everything	✓
	Does not create a situation where ACOs or any entities need to receive, but just hospitals need to send	✓
	May include a regulatory mechanism later on to track if organizations are not receiving notifications from certain hospitals	✓
	Widespread adoption of technology systems can be used to send these notifications (E.g. intermediaries)	✓
	Do not need to wait for TEFCA- current infrastructure is sufficient to facilitate ADT exchange	✓
	May be able to demonstrate compliance through single patient- but keep in mind reasonable effort standard outlined	✓
	Do not need to demonstrate you can deliver a message to every provider or entity, just need to show reasonable effort	✓
	One year compliance period from date of release	✓
	Follow all applicable consent laws and regulations (federal, state, local level) -Not required to share without consent if consent is required	✓
	If a patient opts out of exchange, find a way to honor those preferences	✓
	Hospitals must attest to 3 information blocking provisions under promoting interoperability	✓

As illustrated above, the MIHIN Use Case is not only compliant with the CMS CoPs, but it also meets all relevant CMS guidance, as outlined in the final rule.

If we can provide any additional information or clarification, please do not hesitate to contact me at [insert email].

E. Overview of MiHIN's ADT Use Case, titled ADT Hub

MiHIN: Michigan's Statewide Health Information Network

Michigan Health Information Network Shared Services (MiHIN) is a non-profit organization, created to facilitate the exchange of electronic health information and build technical and collaborative partnerships between healthcare providers throughout the state of Michigan. From hospitals and providers, to pharmacies and payers, MiHIN creates the technology needed to ensure the electronic health records of Michigan citizens are available to all that deliver care services. MiHIN has been at the forefront of statewide interoperability efforts for almost a decade and is devoted to completing the natural progression toward nationwide interoperability.

ADT Hub in Michigan

Background

ADT messages are automated, electronic communications sent from a provider or entity—who is admitting, discharging, or transferring a patient—to others who have a relationship with the patient. Notifications can also be sent for changes to demographic data (e.g name, insurance, next of kin) or changes to visit information (e.g. patient location, attending doctor). These communications allow members of a patient's active care team to stay informed of important health events and conduct appropriate follow-up measures as necessary.

ADT notifications are widely regarded as a low-cost, highly- scalable service, which serves as the keystone to coordinated health information exchange. Additionally, studies have increasingly shown efficient exchange of ADT information has led to better care coordination and reductions in hospital readmission.

What is MiHIN's ADT Hub?

MiHIN has successfully led the charge for ADT exchange through its robust ADT Use Case also known as MiHIN's ADT Hub. MiHIN's ADT Hub allows for a single on ramp, where once an organization is connected to MiHIN, it can exchange ADT messages with all other organizations connected to MiHIN. This eliminates any inefficiency from point-to-point interfaces and further fosters greater coordination.

Diagram 1. General Hub Model for Health Information Network

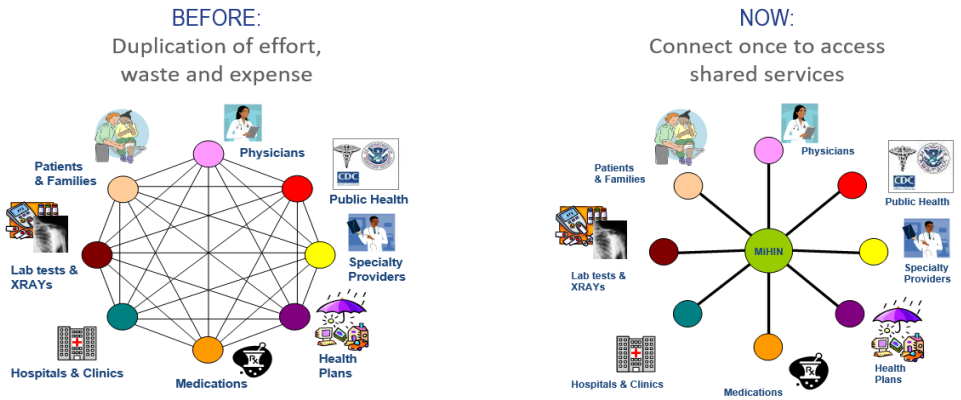
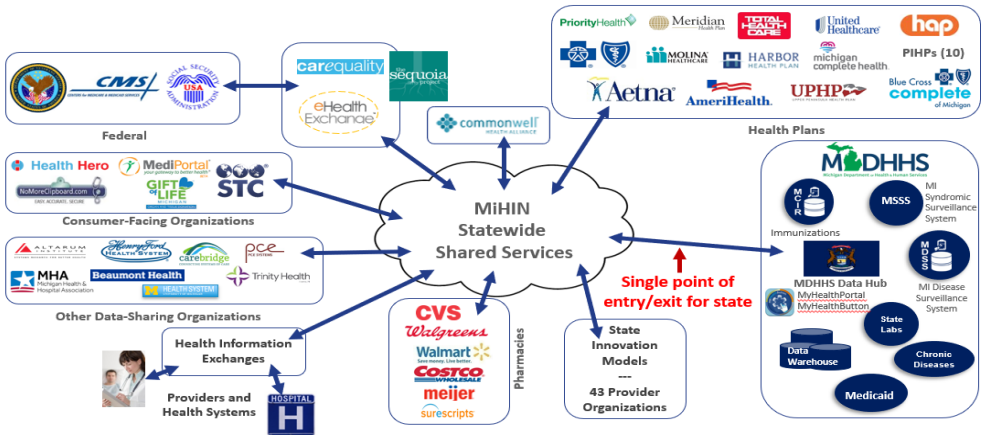


Diagram 2. Michigan Hub Model



ADT Routing

Under the ADT Hub model, a provider or organization is merely required to send information to the statewide ADT Hub. MiHIN is then able to send the information anywhere it needs to go. Routing can be determined by named providers, named health plans, patient zip codes, or active care relationships—which are often referenced throughout CMS as established care relationships.

The latter is applicable if an organization lists an active care relationship with a patient and routing functions as described below:

When a patient is admitted to a hospital, transferred, or discharged, an ADT notification is created by the hospital's electronic health record (EHR) system. The hospital EHR system sends the ADT notification through a trusted organization to MiHIN.

MiHIN then looks up the patient and providers who are on that patient's care team using the Active Care Relationship Service (ACRS). ACRS contains information on which providers (e.g. attending, referring, consulting, admitting, primary care physician) are interested in that patient's health.

MiHIN also looks up the providers in the statewide Health Directory to obtain the delivery preference for each of those providers and to determine the electronic endpoint and transport method by which the providers wish to receive ADT notifications (e.g. via Direct Secure Messaging, Health Level Seven (HL7) over LLP) for their patients.

Based on the provider's delivery preferences, MiHIN notifies each provider who has an active care relationship with a patient upon the following ADT events:

- Patient is admitted to the hospital for inpatient or emergency treatment
- Patient is discharged from hospital
- Patient is transferred from one care setting to another
- Patient's demographic information is updated by a participating hospital

Statewide Success and Acclaim

MiHIN's ADT Hub has been successful throughout the state and is one of the most robust use cases to date. In Michigan, on average, one ADT message is exchanged per person per week, resulting in approximately 10 million messages per week, 40 million messages per month, and 480 million messages per year.

While the quantity of messages exchanged is telling, MiHIN has spent most of its focus on fostering the exchange of quality ADT messages. Through its work, both in Michigan and nationally, MiHIN has worked alongside the users of ADT information themselves to perfect the process of setting up a framework, normalizing the data to ensure its usability, enriching the data with supplemental information, and scaling the use case across communities, cities, and eventually states.

To date, 38 health systems and 154 hospitals participate in MiHIN's ADT Hub. Health systems are listed under **Appendix A** and hospitals are listed as **Appendix B**, following this letter.

Scalability and Public Health Benefits

As previously mentioned, utilizing an ADT Hub model creates a scalable network for exchanging information: one that can scale downwards to a local level or outwards to a national framework.

As national interoperability secures its place as a top priority in the health IT landscape, scalability will be key to foster robust sharing that supports the U.S' increasingly mobile population.

This proven model can mimic the public health benefits Michigan has witnessed on a state level to a national level, and it provides numerous benefits that span beyond mere event notification.

For example, if Michigan scales its ADT hub model to a national level, the hub could track imperative COVID-19 data in real-time and better inform a national response. Earlier this year, the federal government released a letter to hospitals, requiring tracking of pertinent COVID-10 data. MiHIN has been actively working to support national efforts by determining how ADTs could be used to meet federal requirements to:

- Track trends in emergency department and intensive care unit volumes
- Track ventilator usage
- Provide real-time monitoring of total capacity

Currently this information is input on a manual basis that is both an inefficient use of provider or administrator time, and it lacks the real-time tracking that is necessary during crises like this. Utilizing ADT messages as a solution would alleviate these burdens.

Additionally, the ability to utilize ADT messages to support public health initiatives is not restricted to public health crises. ADT messages can support a variety of functions, including:

- Care coordination, including post-discharge coordination
- Syndromic surveillance for public health, if patient identifiers are removed
- A foundational piece for higher quality, better patient matching
- Tracking for opioid overdoses and other death monitoring
- Support for Patient Centered Data Home
- Utilization of an alert & query model to automate event notifications and support additional queries, giving providers access to the additional information they need at the point of care
- Support for Patient Right of Access
- Support for notifications to family members

Additional Information on MiHIN's ADT Hub is publicly available using links below:

MiHIN ADT Use Case

Admission Discharge Transfer Notifications Use Case Summary

Admission Discharge Transfer Notification Implementation Guide

Admission Discharge Transfer Notification Static Definitions
Admission Discharge Transfer Notifications HL7 Vocabulary Tables