**Addendum to the Supporting Statement for Form SSA-680**
**Social Security Administration**
**Health IT Partner Program Assessment –**
**Participating Facilities and Available Content Form**
**OMB No. 0960-NEW**

**SSA's New Partnering Program Evaluation Form SSA-680 Contents**

All of the information SSA receives from potential partners will reside solely with us. Any healthcare entity that expects to partner with us must complete the form, which specifically provides information about the following:

**Introductory Questions for identify the partner organization:**

- Health Information Exchange (HIE): Including Regional Health Information Organizations
- Hospital: Including hospitals, medical groups and/or networks
- Physician Group
- Integrated Physician Network
- Identification identify the characteristics that best describe the organization
- Names Addresses and Physician counts for each organization
- Explanation of current health IT electronic data exchange capabilities
- Opportunity to disclose any other data exchange relationship with other Federal entities
- List of document types that the organization can share electronically

**Identifying the Partners Available Clinical Documents**

- Identify the types and formats of clinical documents that are currently generated within the organization
- The documents by report type are listed and format, structure, and characteristics of the documents can be selected.
    - STRUCTURED STANDARDS BASED DOCUMENTS: A stand-alone document that contains discrete data elements. A structured standards based document shall have narrative text and discretely coded data. Examples include documents such as Procedure Note, History and Physical, Discharge Summary, Continuity of Care Record, etc.
    - UNSTRUCTURED DOCUMENTS: A stand-alone document that does not contain discrete data elements. Examples include natively formatted documents such as TIF, PDF, TXT, JPG, etc. Unstructured documents may also be encapsulated in a CDA wrapper (HITSP/C62 and HL7 Unstructured Docs). (CDA Definition: http://www.hl7.org/implement/standards/cda.cfm)

**Identifying the Continuity of Care Document (CCD) Capability:**

- Identification of the Provider Entity
- Problem Summary Documentation
- Medication Summary Documentation
- Medical Encounter Summary Documentation
- Medical Note Information (Admission and Discharge Summaries, Emergency Room Visit notes, etc.)

- Procedure Summary Information (All interventional, surgical, diagnostic, or therapeutic procedures or treatments)
- Physical Exam Data
- Functional Status Data
- Treatment Data
- Lab Data
- Support Contact Information Data (individual(s) providing assistance, consult, counsel to patient)
- Data within each of these areas needs to be classified by:
  - STRUCTURED DATA IN A CONTINUITY OF CARE DOCUMENT (CCD): A document in the narrative block of a CCD section tied to a specific structured entry by a reference.
  - UNSTRUCTURED DATA IN A CCD: A document in the narrative block of a CCD section without an association to a structured entry.