Social Security Administration Health IT Partner Assessment – Participating Facilities and Available Content Form

Overview

Thank you for your interest in partnering with the Social Security Administration (SSA). Since 2008, we have been working to enable the electronic exchange of health information. We can improve the speed and consistency of disability determinations with the use of health information technology (health IT). Health IT enables us to reduce the amount of time we need to make a disability determination by allowing us to electronically request and receive health records. With health IT, we are able to receive health records within minutes or hours as compared to weeks or months in the traditional process. Health IT also allows us to analyze the data in health records electronically. We currently are exchanging health information electronically with numerous organizations and are working to bring on additional organizations moving forward.

1.0 Value Proposition

These health IT innovations will improve service to the public, streamline processes, assist our state Disability Determination Services (DDS) partners, and reduce our burden on the health care industry. As a partner in Social Security's health IT initiative, you can expect to attain benefits on the basis of several key value drivers. Below are some of the potential benefits of collaborating with Social Security.

Potential Benefits to Partners:

- Reduced administrative costs and labor time for locating, printing, copying, and mailing paper records
- Reduced uncompensated care as faster disability determinations give patients faster access to Medicare and Medicaid benefits
- Automated payment from Social Security
- Increased revenue by having the ability to respond to a higher number of Social Security requests for records
- Improved patient satisfaction

Potential Benefits to the Public:

- Faster and more consistent disability decisions
- Quicker access to monthly cash benefits and financial peace-of-mind
- Earlier access to medical insurance coverage
- Fewer consultative examinations
- Decreased burden to secure and provide medical records
- Earlier access to other social service benefits

2.0 Process Overview

Before deciding to move forward with a health IT partnership, Social Security needs to understand whether your organization can electronically provide the substantive medical information that enables us to make disability determinations. The first step in this process is to tell us about your organization and its characteristics. Upon completing the Introductory Questions and Content Checklist contained within the following tabs, you should expect contact from SSA's New Partner Committee to review your responses and answer any questions you might have. Once the responses are reviewed, validated, and completed, Social Security will conduct careful analysis to determine if your organization is ready to begin a health IT partnership with the SSA.

High-level Evaluation Process:

1.1 Potential partner organization completes partner assessment form

1.2 SSA New Partner Committee meets for initial review of evaluation templates

1.3 Committee meets with potential partner for initial review and follow-up questions

1.4 Potential partner completes revisions and submits final form

1.5 Committee assesses completed responses to determine readiness for potential partners

1.6 Committee decides on whether to proceed with partnership

1.7 Committee communicates results and next steps to partner organization

Overall Engagement Process:

2.1 Develop and review project plan

2.2 Demonstrate Clinical Document Architecture (CDA) or Consolidated CDA (CCDA) capabilities and verify medical content

2.3 Analyze participating facility lists

2.4 Conduct interoperability testing (connectivity and end to end tests)

2.5 Complete production implementation

3.0 Document Overview

As mentioned in the Process Overview, we require completed responses to the Introductory Questions and Content Checklist templates found in this document. Each section contains a high level overview and detailed definitions.

1. The Introductory Questions
    a. are contained within a single tab
    b. contain definitions that help to clarify terminology across the entire workbook
    c. pose questions related to general characteristics, composition, and high-level technical capabilities related to your organization's health IT readiness
2. The Content Checklists
    a. are spread across two tabs: 2-Clinical Documents and 3-CDA/CCDA Structured Document
    b. is designed to provide a basic understanding of your organization's available EHR content. We intend to evaluate your completed Content Checklist in terms of both potential accessibility of health information and the content value of your EHR for our disability determination process

Questions pertaining to each section will be addressed by the New Partner Committee as they arise. We suggest that you complete this template with an internal team that consists of representatives within your organization that span functional areas including project management, application development, and clinical health informatics.

4.0 Conclusion

Please note that your submission of this document will go through several rounds of review, and any questions that arise during the process of completing this document will be addressed by a representative from the New Partner Committee. Questions and completed documents should be submitted to ssa.hit.information@ssa.gov. The burden estimate for completing this form is approximately 5 hours per respondent. All of the information SSA receives from potential partners is non-confidential and resides solely with us, and we comply with the agency's retention period for recordkeeping requirement of seven years. Participation is voluntary, and any organization that expects to partner with us must complete this form.

Again, thank you for your interest in partnering with Social Security. We look forward to hearing from you soon.

Social Security Administration Health IT Partner Assessment – Participating Facilities and Available Content Form

1.0 INTRODUCTION

The ~~Social Security Administration~~ (SSA) has implemented a health information technology (health IT) process with numerous large healthcare providers. With this health IT process, we have successfully demonstrated that we can electronically exchange health information with providers in a production setting. As the first step in determining your readiness to partner with SSA, please complete the general overview questions beginning with section 1.2 Identifying Your Entity as well as the Clinical and ~~CDA~~ CCDA Structured Document Questionnaires found in worksheets 2 and 3.

1.1 DEFINITIONS

~~1.1.1~~ **Health Information Exchange (HIE) / Facility Identification:** Any healthcare entity that will partner with SSA must provide a list of all participating facilities/provider groups within the partnering HIE. When your patient applies for disability, this information is used to determine which of the patient's treating facilities reside within your HIE.

1.1.2 Electronic Health Record (EHR) System: The EHR is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR has the ability to generate a record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

1.1.3 Beacon Communities: The Beacon Community Cooperative Agreement Program through the Office of the National Coordinator will provide funding to communities to build and strengthen their health IT infrastructure and exchange capabilities to demonstrate the vision of the future where hospitals, clinicians and patients are meaningful users of health IT, and together the community achieves measurable improvements in health care quality, safety, efficiency, and population health.

1.1.4 Virtual Lifetime Electronic Record (VLER): VLER is an initiative of the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to create a unified lifetime electronic health record for Armed Services members. As a common access point for all patient records, VLER contains administrative, medical, and health benefits information throughout the life of a Service member, eliminating the need to bring paper copies of medical records from one medical facility to the next.

1.1.5 Disability Determination Services (DDS): Disability Determination Services are state agencies that review disability claims for the Social Security Administration.

1.1.6 Narrative Data in a ~~CDA~~/CCDA Structured Document: A document or data in the narrative block of a ~~CDA~~/CCDA Structured Document section regardless of whether information is also conveyed in ~~CDA~~/CCDA entries.

1.1.7 Coded Data in a ~~CDA~~/CCDA Structured Document: Documents or data which are fully encoded into ~~CDA~~/CCDA header or entries.

1.1.8 Standards Based Structured Documents: A stand alone document that contains discrete data elements. A standards based structured 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.

1.1.9 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~~/CCDA wrapper (HITSP/C62, HL7 Unstructured Document, or CCDA (R1.1 or R2.1) Unstructured Document). (~~CDA Definition: http://www.hl7.org/implement/standards/cda.cfm~~)

1.2 IDENTIFYING YOUR ENTITY

Organization or Group Name: _____

Website URL: _____

The following section allows you to identify the type of entity that best describes your organization. Please only select one type.

Entity Types	
Health Information Exchange (HIE): Including Regional Health Information Organizations	☐
Hospital: Including hospitals, medical groups and/or networks	☐
Physician Group:	☐
Integrated Physician Network:	☐

Other: Please specify	☐

The following section allows you to identify the characteristics that best describe your organization. Select all that apply.

Entity Composition		
Composition		**Comments**
Multi-Disciplinary Hospital	☐	
Ambulatory Center	☐	
Integrated Network	☐	
Physician Group	☐	
Rehabilitation Hospital	☐	
Cancer Center	☐	
Dialysis Center	☐	
Children's Hospital	☐	
Behavioral Health Facility	☐	
Community Health Center	☐	
ER Clinic	☐	
Hospital Specialty Other	☐	
Other: Please Specify	☐	

If your organization contains separate organizations, facilities and/or provider groups, please provide a list of the primary organizations that account for the majority of volume for Medical Evidence of Record (MER) requests.

Participating Organizations, Providers and Facilities					
Name	**City**	**State**	**Physician / Organization Count** Note: for physician groups / ambulatory centers	**EHR Vendor(s) / Application**	**Estimated Annual SSA Requests**

Questions	Comments
Describe your current electronic data exchange capabilities.	
Describe your strategic plan / roadmap for interoperability.	
Do you have an agreement to exchange medical data across the Nationwide Health Information Network with other Federal agencies? If so, please specify agency and program. (such as ~~VLER, C-HIEP,~~ ONC, State HIE, ~~Beacon~~)	
List all structured documents that can be interoperably transmitted to or with the SSA. (e.g. ~~HL7/CCD, HITSP/C32,~~ CCDA R1.1 Operative Note, CCDA R2.1 Discharge Summary)	
Is there anything else about your organization that the SSA should understand when considering you as a future partner (e.g. special patient population characteristics, provider type uniqueness, experience in electronic health records, strategic goals).	

1.3 PREPARED BY:

Title: _____

Name: _____

Address: _____

City: _____ **State:** _____**Zip:** _____

Phone Number(s): _____

E-mail: _____

Primary Contact (if different from Preparer)

Title: _____

Name: _____

Address: _____

City: _____ **State:** _____**Zip:** _____

Phone Number(s): _____

E-mail: _____

Social Security Administration Health IT Partner Assessment – Participating Facilities and Available Content Form

2.0 Identifying Available Clinical Documents

The following section allows you to identify the types and formats of clinical documents that are currently generated within your organization. Please check all that apply.

For each report type, fill in the table according to the following instructions

~~CDA/~~CCDA -Templated Structured Document Type column
Please indicate in the ~~CDA/~~CCDA -Templated Structured Document Type column any additional formats that your organization supports for a specific clinical document.

~~CDA/~~CCDA -Templated Structured Document: Narrative / Coded Data columns
Enter a 'Y' in either or both of the Narrative or Coded Data columns to indicate whether your organization generates documents that contain Narrative and/or Coded Data clinical content according to ~~CDA/~~CCDA specifications.

HITSP/C62, HL7 Unstruc Doc, CCDA Unstruc Doc, TXT, PDF, DOC, RTF, TIF, JPG, PNG, GIF columns
Enter a 'Y' in each column where your organization generates a clinical document in the indicated format Use the Other column to indicate formats that are not listed in the table.

* If you have indicated that you have a Summary of Care report in the ~~CDA/~~CCDA -Templated Structured Document format column and indicate 'Y' in either or both the Narrative / Coded Data columns, please fill out the information in section 3 (worksheet 3-~~CDA~~-CCDA Structured Document).

Report Type	~~CDA/~~CCDA - Templated Structured Document			HITSP/C62 HL7 Unstruc Doc CCDA Unstruc Doc	Native Unstructured Document								Other	Comments
	Format	Narrative	Coded Data		TXT	PDF	DOC	RTF	TIF	JPG	PNG	GIF		
Summary of Care*														
Discharge Summary														
Consultation														
History & Physical														
Lab														
Pathology														
Operative Notes														
Doctor to Doctor														
Inpatient Progess Notes														
Outpatient Progress Notes														
Emergency Room Notes														
Procedure Notes														
Audiometry/Audiology														
Audiograms														
Psychology Reports														
Mental Status Evaluation														
Neuropsychological Testing														
Psychological Testing														
Cardiac Reports														
Angiogram														
Cardiac Catheterization														
Doppler Test														
Electrocardiograph, electrocardiogram (EKG/ECG) result/interpretation														
EKG/ECG Tracing Image														
Echocardiogram result/interpretation														
Stress Testing (exercise, pharma)														
Holter monitor														
Neurology														
Electroencephalogram (EEG)														
Electromyogram/nerve conduction (EMG)														

Myelogram															
Ophthalmology/Optometry															
Visual Acuity															
Visual Fields															
Radiology (Interpretations Only; No Images)															
CT															
MRI															
PET															
X-Ray															
Respiratory															
DLCO Study															
Pulmonary Function Study															
Spirometry Test result/interpretation															
Spirometry Tracing Image															
Surgical Diagnostics															
Bone Marrow (Biopsy/Aspiration)															
Colonoscopy															
Endoscopy															
Additional Procedures															
Ultrasound (exclude Doppler)															
Genetic Testing															
Physical Exam															

Social Security Administration Health IT Partner Assessment – Participating Facilities and Available Content Form

3.0 Identifying ~~CDA/~~CCDA Structured Document capability

Please fill out this worksheet if you have indicated that your organization has a Summary of Care report in the ~~CDA/~~CCDA-Templated Structured Document format column and indicated 'Y' in either or both the Narrative / Coded Data columns in worksheet 2-Clinical Documents.

For each row in sections 3.1 through 3.21, please indicate the availability and the format of the specific information in your EHR.
- "Y" in any applicable columns if your organization has the information in the specific format; or
- If your organization does not have information available, please indicate with a "Y" in the "Not Available" column.

NOTE: Check all that apply.
NOTE: **Do not** enter any information in cells shaded gray.

Please see the Introductory Questions worksheet for definitions of Narrative and Coded Data. If a row is left blank, then we will assume that information is not available in an electronic format.

The following data elements are of particular value to the Social Security Administration for use in the disability determination process. Providing all or some of these elements may not guarantee conformance to any specific HIT content standard. It is the provider's responsibility to provide these data elements in the context of and in conformance with a recognized HIT content standard.

3.1 ENTITY IDENTIFICATION

Electronic Content	~~CDA/~~CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
HIE Name (if applicable)				
Facility Name				
OID (Object Identifier)				
Street Address				
City				
State				
Zip				
Assigned Provider ID				
Name of Affiliated Sites				

3.2 PROBLEMS: All relevant clinical problems at the time the document is generated.

Electronic Content	~~CDA/~~CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Condition Name				
Diagnosis Code				
Provider Name				
Date - Start				
Date - End				
Prognosis Value (CCDA R2.1 only)				
Prognosis Date (CCDA R2.1 only)				

3.3 ENCOUNTERS: Any healthcare encounters pertinent to the patient's current health status or historical health history. An encounter can be any documented hospitalization (acute, rehab, nursing facility, or long-term care), office or clinic visit, emergency room visit, home health visit, or any treatment or therapy (physical, occupational, respiratory, or other), or any interaction, even remote (non face-to-face), between the patient and the healthcare system or a healthcare provider.

Electronic Content	~~CDA/~~CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Date - Start				

Date - End				
Encounter Provider				
Type/Activity				
Facility Location				

3.4 PROCEDURES: All interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated.

Electronic Content	~~CDA/~~CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Facility Location				
Procedure Code				
Treating Provider				
Date				
Procedure Type				
Audiometry/audiology				
--Audiograms				
Cardiac				
--Angiogram				
--Cardiac Catheterization				
--Doppler Test				
--Electrocardiograph, electrocardiogram (ECG)				
--Tracing image				
--Echocardiogram				
--Stress Testing (exercise, pharma)				
--Holter monitor				
Electroencephalogram (EEG)				
Electromyogram/nerve conduction				
Genetic Testing				
Ophthalmology/Optometry				
--Visual acuity				
--Visual fields				
Psychology Reports				
--Mental Status Evaluation				
--Neuropsychological Testing				
--Psychological Testing				
Radiology (Interpretations Only; No Images)				
--CT				
--MRI				
--PET				
--X-Ray				
Myelogram				
Respiratory				
--DLCO Study				
--Pulmonary Function Study				
--Spirometry Test				
--Tracing Image				
Surgical Diagnostics				
--Bone Marrow (Biopsy/Aspiration)				
--Colonoscopy				
--Endoscopy				
Ultrasound (exclude Doppler)				

3.5 PROCEDURE FINDINGS: All clinically significant observations confirmed or discovered during the procedure or surgery. (CCDA R1.1/2.1 only)

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Condition Name				
Diagnosis Code				
Provider Name				
Date - Start				
Date - End				

3.6 COMPLICATIONS: All problems that occurred during the procedure or other activity. The complications may have been known risks or unanticipated problems. (CCDA R1.1/2.1 only)

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Condition Name				
Diagnosis Code				
Provider Name				
Date - Start				
Date - End				

3.7 POSTPROCEDURE DIAGNOSIS: All diagnoses discovered or confirmed during a procedure. (CCDA R1.1/2.1 only)

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Condition Name				
Diagnosis Code				
Provider Name				
Date - Start				
Date - End				

3.8 LABS: Observations generated by laboratories, imaging procedures, and other procedures.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Lab Results				
Pathology Reports				
Provider Name				

3.9 FUNCTIONAL STATUS: The patient's physical state, status of functioning, and environmental status at the time the document was created.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Activities of Daily Living (ADL)				
Minimum Data Set				
Social Functioning (Capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals).				
Cognitive Status (CCDA R1.1 only)				
--Condition Name				
--Diagnosis Code				
--Provider Name				

--Date - Start				
--Date - End				
Assessment Scale				
--Assessment Scale Supporting Info				
Medical Equipment (CCDA R2.1 only)				
--Equipment Name				
--Equipment Code				
--Facility				
--Provider Name				
Self-Care Activities (ADL and IADL) (CCDA R2.1 only)				
--Date				
--Result Type				
--Ability Value				
--Provider Name				
Sensory Status (CCDA R2.1 only)				
--Date - Start				
--Date - End				
--Sensory Status Problem Type				
--Mental and Functional Status Response Value				
--Provider Name				
--Assessment Scale				
--Assessment Scale Supporting Info				

3.10 VITAL SIGNS: Relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Type				
Date				
Interpretation				
Value				
Reference Range				

3.11 MEDICAL EQUIPMENT: A patient's implanted and external medical devices and equipment that their health status depends on, as well as any pertinent equipment or device history.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Equipment Name				
Equipment Code				
Facility				
Provider Name				

3.12 MEDICATIONS: A patient's current medications and pertinent medication history.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Product Name				
Product Code				
Dosage Details				
Reason				

Date - Start				
Date - End				
Provider Name				

3.13 PHYSICAL EXAM: Direct observations made by the clinician.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Ambulation/balance				
Apgar Score				
--Color 10M Post Birth				
--Heart Rate 10M Post Birth				
--Muscle Tone 10M Post Birth				
Burns				
Edema/Inflammation/Swelling/ Tenderness				
Growth Chart				
Motor Function				
Muscle Atrophy				
Muscle Weakness/Strength				
Range of Motion				
Sensory Loss				
Skin Lesions (Extent)				
Speech				
Weight Bearing Status				

3.14 MENTAL STATUS: Observations and evaluations related to a patient's psychological and mental competency and deficits. (CCDA R2.1 only)

Cognitive Status				
--Cognitive Function Finding Date				
--Cognitive Function Finding Value				
--Cognitive Function Finding Ref Range				
--Provider Name				
Assessment Scale				
--Assessment Scale Supporting Info				

3.15 PLAN OF CARE: Data that defines pending orders, interventions, encounters, services, and procedures for the patient.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Interventions				
Encounters				
Procedures				

3.16 SOCIAL HISTORY: Data defining the patient's occupational, personal (e.g. lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity and religious affiliation.

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Social History Name				
Social History Code				
Social History Observed Value				
Social History Observation Date				

3.17 ASSESSMENT AND PLAN: The clinician's conclusions and working assumptions that will guide treatment of the patient and pending order. (CCDA R1.1/2.1 only)

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Plan of Care Name				
Plan of Care Code				
Plan of Care Status				
Date - Start				
Date - End				

3.18 HISTORY OF PAST ILLNESS: The history related to the patient's past complaints, problems, or diagnoses. It records these details up until, and possibly pertinent to, the patient's current complaint or reason for seeking medical care. (CCDA R1.1/2.1 only)

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Condition Name				
Diagnosis Code				
Provider Name				
Date - Start				
Date - End				

3.19 NOTES

Electronic Content	~~CDA~~/CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Admission Summaries/H&P				
Emergency Room (ER)				
Discharge Summaries				
Consults (Inpatient and/or Outpatient)				
Doc-to-Doc Letters				
Neonatal				
Operative Report				
Outpatient				
Office Notes				
Clinic Notes				
Mental/Behavioral Health Notes				
Progress Notes				
Physical/Occupational Therapy Notes				

Other, e.g. telephone notes, medication notes				

3.20 TREATMENT

Electronic Content	~~CDA/~~CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Antineoplastic Therapy				
Blood Transfusions				
Dialysis				

3.21 Support/Contact Information: individual(s) providing assistance, consult, counsel to patient

Electronic Content	~~CDA/~~CCDA Struc Doc Delivery Method		Not Available	Comments
	Narrative	Coded Data		
Support/Contact Name				
Address				
Phone Number				
Relationship, e.g., sister				

3.22 TERMINOLOGY

Terminology	Available	Not Available
LOINC		
ICD 9-CM		
ICD 10-PCS		
ICD 10-CM		
SNOMED CT		
CPT4		
HCPCS-LEVEL-II		
International Classification of Function (ICF)		
Other (Please Specify)		

3.23 PREPARED BY:

Title: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number(s): _____