Can I use Direct Messaging to send a C-CDA Summary of Care document to my hospital partner?

No, not right now. Not all EHRs can make C-CDA Summary of Care documents and not all hospitals are ready to get C-CDA Summary of Care documents. Over the next year hospitals will need partners, like nursing facilities, who can send a C-CDA Summary of Care document when a resident is sent to the hospital for care. Many groups are working now to make this happen.

Why don't I get a C-CDA Summary of Care document for every resident who comes from a hospital?

Hospitals do not have to send a C-CDA Summary of Care document for every person who is sent to a nursing facility now, but by the end of 2019, they will have to.

NY–RAH

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DIRECT MESSAGING AT A GLANCE

A Guide for Nursing Facilities

New York–Reducing Avoidable Hospitalizations
www.nyrah.org

Answering Questions about Direct Messaging and the C-CDA Summary of Care document

What is Direct Messaging?

Direct Messaging is one way hospitals can electronically send protected health information (PHI) to nursing facilities. PHI is information about a resident's health and the medical care they have been given, and by law it must be kept private. Direct Messaging is a service that uses the Internet to send PHI.

Is the information sent by Direct Messaging safe?

Yes. It is sent over a closed network that others cannot see, like a secure email message.

What do Direct Messages look like?

Direct Messages look like emails, and go to Direct Messaging accounts that look like other email accounts. The messages have a PDF attached, and that is called a Consolidated Clinical Document Architecture (C-CDA) Summary of Care document.

Why can't I use my facility's Electronic Health Record (EHR) to send and get Direct Messages?

Nursing facility EHRs are not built to send or get Direct Messages or C-CDA Summary of Care documents right now.

What is in the C-CDA Summary of Care documents?

They have a resident's name, gender, care team, care plan, medications list, immunizations, allergies, diagnosis, vitals, lab values, procedures, smoking status, hospital course, and discharge instructions. The hospital's EHR makes the C-CDA Summary of Care document after the resident has left, so it has the very latest information. It is more accurate than the New York State PRI and the paper discharge summary that goes with the resident when they leave the hospital.

When does the hospital send the C-CDA Summary of Care documents to the nursing facility?

Hospitals usually send them from six to 24 hours after the resident has gone to the nursing facility.

Who at my facility should get the Direct Messages?

The Admissions department—not administrators or IT staff—should check for new Direct Messages and give the C-CDA Summary of Care document to the resident's care team.

> Protected health information is information about a resident's health and the medical care they have been given, and by law it must be kept private.

Can C-CDA Summary of Care documents be saved to the EHR?

Yes. When the C-CDA Summary of Care gets to the nursing facility, it should be saved to the EHR, or printed out and placed in the paper chart so that it will be part of the resident's medical record and other clinicians can read it.

My nursing facility gets C-CDA Summary of Care documents hours, and even a day after the resident gets to the facility. Can the document still be used?

Yes. If the C-CDA Summary of Care document arrives after the resident has been admitted, clinicians can still use it for medication reconciliation since it has a record of the medications that the resident was put on at the hospital.

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