Alliance for Home Health Quality and Innovation

January 14, 2013

Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Chair, Health IT Policy Committee
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services

Re: Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)

Dear Dr. Mostashari:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") to provide a response to the **Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)**.[1] The Alliance appreciates the opportunity to provide comments on this rule as your office continues to develop the parameters for meaningful use, electronic health records (EHRs), and health information exchange (HIE).

Founded in 2008, the Alliance is a national consortium of home healthcare providers and organizations dedicated to improving patient care and the nation's healthcare system. The Alliance sponsors and supports research and education that demonstrates the value that home-based care can provide across the care continuum. In our capacity representing providers in the post-acute care space, we are keenly aware of the importance of building technological infrastructures that will allow post-acute care providers to work hand-in-hand with other partners to provide high quality, coordinated healthcare services within the healthcare system. The home health community wants to be recognized as a trusted partner in healthcare reform, and building partnerships requires the widespread adoption of data systems that allow for HIE between care settings.

The home healthcare community is committed to a seamless delivery of healthcare services and has the technological capacity to take on a central role in care delivery and care coordination. We support the work of the Standards & Interoperability Framework's Longitudinal Coordination of Care Work Group in working towards HIE and we would second the comments they have submitted in response to your request for comment (RFC). In addition, the Alliance makes the following comments regarding specific items in the RFC:

[1] Available at: http://www.healthit.gov/sites/default/files/hitpc_stage3_rfc_final.pdf.

I. Post-acute care providers, including home healthcare, strongly support the development of Meaningful Use, EHR standards, and HIE guidelines in order to ensure seamless care delivery across care settings and would like to participate in HIE despite the lack of Meaningful Use incentives.

One of the challenges facing long-term and post-acute care (LTPAC) providers is the need for standards in health information exchange. The Department of Health and Human Services (HHS) has recognized the lack of EHR standardization for many post-acute care providers and the barriers this presents in providing seamless healthcare services.[2] The home healthcare community faces significant challenges in the adoption of EHRs because it must work alongside, rather than with, the Meaningful Use Program. Current certifications for EHRs fall under the work of a private sector organization, the Certification Commission for Health Information Technology (CCHIT). Although CCHIT has certified EHR programs unique to LTPAC providers, there are no uniform vocabulary standards required for home healthcare. Additionally, under CCHIT's criteria, there are only three vendors who are certified to provide EHRs for home health.[3]

LTPAC providers, including home health, would greatly benefit from regulatory standards to incentive software suppliers to build EHRs that would comply with the Meaningful Use requirements. While home health has not reached the same level of functionality as other care settings, many providers have electronic medical records (EMRs) and wish to pursue HIE. In fact, in 2007 the Journal of the American Medical Informatics Association reported that as many as 43% of US home healthcare agencies used EMRs.[4] Even so, home health software suppliers have not created systems that would enable HIE and many providers are hesitant to invest due to the lack of standards for data exchange for LTPAC providers. Many existing systems were built to electronically capture the OASIS data set for billing purposes and current vendor solutions for EHRs build on these existing billing systems. Regulatory standards regarding the sending and receiving of electronic health information, even without financial incentives, would encourage technology vendors and software suppliers to build the tools needed for HIE between acute and post-acute care settings. As with Meaningful Use Stage 2 and 3 requirements for eligible providers, the required number of electronic exchanges could be set at a low threshold with plans to increase the number of exchanges in future stages of use.

II. SGRP 101: The computerized provider order entry (CPOE) should include home health and other LTPAC providers as a component of information exchange because LPTAC providers have much to offer hospital and physician partners as data aggregators in medication management.

The Alliance supports the S&I LCC WG's recommendation for a reconciled, electronic medication list. Additionally, we would ask that home health be included as a component of the exchange of medication lists. Home health providers have repeatedly cited medication management and reconciliation as one of

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[2] HHS, *Opportunities for Engaging Long-Term and Post-Acute Care Providers in HIE Activities: Exchanging Interoperable Patient Assessment Information* 35-36 (December 2011). *Available at*: http://aspe.hhs.gov/daltcp/reports/2011/StratEng.pdf.

[3] See https://www.cchit.org/find-cchit, Product: LTPAC EHR, Additional Certification: Home Health. The three vendors are HealthMEDX, AOD Software, and American Data (whose product is currently Pre-Market) as of January 10, 2013.

[4] Helaine E. Resnick and Majd Alwan, *Use of health information technology in home health and hospice agencies: United States, 2007*, JAMIA (April 30, 2010). *Available at*: http://jamia.bmj.com/content/17/4/389.full.pdf+html.

the critical elements of care that they use as providers to prevent unnecessary re-hospitalizations during a post-acute care episode.

LTPAC providers can offer other providers in the healthcare system critical information about medication within the patient's setting or residence. As "eyes in the home," home health clinicians in particular work with the patient within their residence to identify which prescription drugs the patient is taking and what behaviors or additional pharmaceuticals may affect the effectiveness of those drugs. For example, a home health clinician collects information on the patient's prescribed medications, identifies incidences of poly-pharmacy, and identifies over-the-counter or herbal medications that may interfere with the effectiveness medication. Much of this data is currently collected through the OASIS data set and many providers electronically capture this data within their EMRs. Being able to exchange medication reconciliation information with the hospital, primary care physician, and other providers would improve patient outcomes significantly and likely reduce avoidable hospitalizations.[5]

III. SGRP 303: The Alliance:

- **A. supports the measure to expand the electronic transfer of summary of care records to 30% under the parameters provided by the S&I Framework's Longitudinal Coordination of Care Work Group (LCC WG);**
- **B. supports the use of the IMPACT data set to support transitions of care between home healthcare and other providers;**
- **C. supports the development of the LAND and SEE interfaces to enable LTPAC providers to send and receive information with other care settings;**
- **D. encourages the development of new sub-data sets to the IMPACT data set to capture information on the top 20 illnesses affecting home healthcare patients; and**
- **E. supports the LCC WG's recommendation to expand the 48- hour care plan to encompass a longer-range plan of care.**

The proposed measure under SGRP 303 asks eligible providers (EP), eligible hospitals, or CAH to transition patients to the home with the exchange of a "summary of care" record 65% of the time (with 30% of referrals transferred electronically). This measure presents a challenge for home healthcare providers, many of whom who may not be not equipped to receive the transfer of electronic information from an eligible provider, hospital or CAH. We are hopeful that the LAND & SEE tools arising out of the Massachusetts IMPACT project will eventually enable home health providers to send and receive data with these key stakeholders in the care continuum.[5] Under this scenario, we support the measure under SGRP 303.

The Alliance also agrees with the LCC WG's recommendation to use the IMPACT data set to identify the elements needed to support care transitions between home healthcare providers and other settings.

[5] The Alliance strongly supports the Massachusetts IMPACT project's current work towards building the "LAND" (Internet-based "Local" Application for Network Distribution) and "SEE" (Surrogate EHR Environment) interfaces which would allow providers using paper records or EMRs to trade information with other healthcare partners (project homepage located at http://mehi.masstech.org/what-we-do/hie/impact/land-and-see). We are hopeful that this project will enable LTPAC providers to send and receive data, although it should be noted that this project is still being tested and may not be publicly available for two to five years.

We would encourage the LCC WG that expansion of the existing IMPACT data set should include sub-data sets on the top twenty illnesses affecting home health patients.[6] Please see below two relevant charts with the lists of illnesses affecting home health patients below, listed by MS-DRG and ICD-9 codes respectively.

Clinical Profile of Home Health Users

Chart 3.1: Top 20 Most Common Diagnosis Related Groups (DRGs) for Beneficiaries Discharged from Hospital to Part A Home Health Episodes, 2010

MS-DRG	Number of Home Health Part A Claims, 2010	Percent of Total Home Health Part A Claims, 2010
Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	211,779	10.77%
Heart Failure & Shock w MCC	46,134	2.35%
Septicemia or Severe Sepsis w/o MV 96+ Hours w MCC	44,685	2.27%
Heart Failure & Shock w CC	36,375	1.85%
Hip & Femur Procedures except Major Joint w CC	31,145	1.58%
Kidney & Urinary Tract Infections w/o MCC	29,279	1.49%
Intracranial Hemorrhage or Cerebral Infarction w CC	29,052	1.48%
Simple Pneumonia & Pleurisy w CC	27,884	1.42%
Chronic Obstructive Pulmonary Disease w MCC	27,569	1.40%
Cellulitis w/o MCC	26,490	1.35%
Simple Pneumonia & Pleurisy w MCC	26,015	1.32%
Syncope & Collapse	22,047	1.12%
Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders w/o MCC	21,776	1.11%
Chronic Obstructive Pulmonary Disease w CC	21,486	1.09%
Nutritional & Misc Metabolic Disorders w/o MCC	20,694	1.05%
Spinal Fusion except Cervical w/o MCC	18,669	0.95%
Renal Failure w CC	18,617	0.95%
Major Small & Large Bowel Procedures w CC	17,963	0.91%
Major Small & Large Bowel Procedures w MCC	17,687	0.90%
Medical Back Problems w/o MCC	16,926	0.86%
Total for Top 20 MS-DRGs	**712,272**	**36.23%**

Source: Avalere Health, LLC analysis of Medicare Standard Analytic Files, 2010
Data for beneficiaries with a Part A home health episode and a prior short-term acute care hospital stay in 2010.
Note: CC is complication or comorbidity. MCC is major complication or comorbidity.

[6] *See* Avalere Health LLC, *Home Health Chartbook*, "Clinical Profile of Home Health Users" Chart 3.1, 3.2 (September 2012). Available at: http://ahhqi.org/images/pdf/home-health-chartbook.pdf.

Clinical Profile of Home Health Users

Chart 3.2: Top 20 Primary International Classification of Diseases, Version 9 (ICD-9) Diagnoses for Home Health Claims, 2010

ICD-9 Diagnosis	Number of Home Health Claims, 2010	Percent of Total Home Health Claims, 2010
Diabetes Mellitus	728,297	10.44%
Essential Hypertension	515,637	7.39%
Care Involving Use of Rehabilitation Procedures	458,550	6.57%
Other Orthopedic Aftercare	451,057	6.47%
Other and Unspecified Aftercare	429,673	6.16%
Heart Failure	379,612	5.44%
Chronic Ulcer of Skin	260,700	3.74%
Chronic Bronchitis	195,723	2.81%
Late Effects of Cerebrovascular Disease	191,813	2.75%
Osteoarthritis and Allied Disorders	184,325	2.64%
Cardiac Dysrhythmias	130,038	1.86%
Disorders of Muscle, Ligament, and Fascia	126,698	1.82%
Symptoms Involving Nervous and Musculoskeletal Systems	123,612	1.77%
Other Deficiency Anemias	101,513	1.46%
Other Complications of Procedures, Not Elsewhere Classified	92,919	1.33%
Other Forms of Chronic Ischemic Heart Disease	90,136	1.29%
Fitting and Adjustment of Other Device	83,509	1.20%
Other Cellulitis and Abscess	80,269	1.15%
Other Disorders of Urethra and Urinary Tract	71,650	1.03%
Other Cerebral Degenerations	71,222	1.02%
Total for Top 20 Primary ICD-9 Diagnoses	**4,766,953**	**68.33%**

Source: Avalere Health, LLC analysis of Medicare Standard Analytic Files, 2010

Lastly, the Alliance supports the LCC WG's suggestion that Meaningful Use incorporate a more extensive care transitions plan from the hospital and that an expanded narrative section allow the receiving care setting to have more information to care for their patient.

IV. SGRP 304: The Alliance supports the reuse of the S&I Framework's Transitions of Care Consolidated C-CDA in developing care transitions.

The Alliance supports the LCC WG's recommendation to reuse the S&I Framework's Transitions of Care Work Group's Consolidated-CDA to the extent that the C-CDA supports an interoperable, longitudinal care plan accessible by LTPAC providers.

With specific reference to the priority use case for patients going from hospital or nursing service and receiving home health services, it is critical for patient outcomes and measuring 30-day rehospitalizations that the use case involves data points on the following:

- Inpatient hospital discharge dates;
- Whether the patient was hospitalized or rehospitalized;
- Diagnosis and reasons for hospitalization or rehospitalization; and
- List of medications prescribed the hospital and/or nursing service.

It is the Alliance's understanding that the C-CDA incorporates this information and additional information that would improve the amount of patient data available to receiving home healthcare providers. The broad data set in the C-CDA will allow for home health providers to better track the quality of home healthcare and identify 30-day readmission rates with more accuracy. For this reason, we support the recommendations of the S&I Framework to reuse the C-CDA in developing an electronic, shared care planning and collaboration tool that will work across care settings.

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Thank you again for the opportunity to comment. Should you have any questions, please contact me at 202-239-3671 or tlee@ahhqi.org.

Sincerely,

Teresa L. Lee, JD, MPH
Executive Director