August 20, 2012

Ms. Rebecca Roper
Program Officer for Health IT
Senior Research Scientist
Agency for Healthcare Research and Quality
Attention: HIT-Enabled QM RFI Responses
540 Gaither Road, Room 6000
Rockville, MD 20850

Re: Request for Information on Quality Measurement Enabled by Health IT

Dear Ms. Roper:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") to provide comments on the **Request for Information on Quality Measurement Enabled by Health IT.**[1] The Alliance appreciates the opportunity to provide information as your office continues to develop plans to foster quality measurement through the use of health information technology (HIT).

Founded in 2008, the Alliance is a non-profit organization committed to research and education focused on the value that home-based care provides to patients in the U.S. health care system. The Alliance is a membership organization comprised of home health care providers and organizations dedicated to improving individual patient care and the nation's health care system. As an organization committed to quality improvement, we support initiatives that will enable home health care providers to better track patient outcomes.

The Alliance's members, which include home health care providers and health IT vendors, are committed to utilizing health information technology in order to measure quality of care. The Alliance has a working group committed to HIT initiatives and developing interoperable electronic health records (EHRs) to better facilitate patient care across the care continuum.

Please see below, for your consideration, the Alliance's responses to questions regarding the Request for Information on Quality Measurement Enabled by Health IT.

[1] Request for Information on Quality Measurement Enabled by Health IT, 77 Fed. Reg. 42738, 42738 - 42740 (July 20, 2012).

Responses to Questions Regarding Quality Measurement Enabled by Health IT

1. **Briefly describe what motivates your interest in clinically-informed quality measures through health information technology. To what extent is your interest informed by a particular role (e.g., provider, payer, government, vendor, quality measure developer, quality improvement organization, standards organization, consumer advocate) in this area?**

   As described above, the Alliance for Home Health Quality and Innovation is a non-profit research and quality improvement organization dedicated to fostering research and education on home health care and its value to the U.S. health care system and its patients. The Alliance serves multiple roles as a result of our diverse membership. The Alliance membership includes both home health care providers and vendors, among others. To date, our membership includes thirteen home health care providers: Addus Healthcare, Almost Family, Amedisys, BAYADA Home Health Care, CareSouth, Encompass Home Health, Gentiva Health Services, Harden Healthcare, Interim HealthCare, LHC Group, Liberty HomeCare & Hospice Services, Metropolitan Jewish Health System, and Senior Home Care. We also have one HIT provider among our membership, Homecare Homebase, an affiliate of Encompass Home Health.

   Our primary interest in clinically informed quality measures enabled by HIT comes from our role as a quality organization. Our long-term strategic plan contemplates provider-led initiatives to improve the quality of care that home health patients receive. For this reason, the Alliance has become more engaged in HIT initiatives that would help providers' better track quality of care, including the work of the Standards & Interoperability Framework to facilitate health information exchange (HIE) among long-term and post-acute providers. In addition, the Alliance is considering steps to standardize the vocabulary used by our member providers to track patient outcomes.

   From a provider perspective, quality measures enabled by HIT have many benefits to those on the front lines of health care, including:

   - Reducing the burden on home health providers, many of whom now are working with only partially electronic OASIS-C forms, by streamlining the reporting process;
   - Offering providers insight into clinical pathways, including which clinical interventions are most likely to improve the quality of patient care;
   - Providing information that allows providers to adjust to variation in practice across regions, especially where providers do not have in-person supervision at all times; and
   - Enabling the development of measures that will apply across settings or the continuum of care (for example, pain, activities of daily living (ADL) and IADL function could be standardized across settings to allow providers to better identify points for intervention, transition, and deterioration or risk).

2. Whose voices are not being heard or effectively engaged at the crucial intersection of health IT and quality measurement? What non-regulatory approaches could facilitate enhanced engagement of these parties?

The home health community, as a whole, has had difficulty generating HIT-enabled quality measures because home health care providers are not eligible for the Meaningful Use incentives available to other providers under the American Recovery and Reinvestment Act of 2009 (Recovery Act).[2] For this reason, many home health care providers often have not been included in policy discussions about standards for HIT. An example of this is the fact that there are currently no federal standards for home health certified electronic health records (EHRs). *See* **Question 3** below.

Despite the lack of federal incentives, home health care has committed itself to measuring quality of care with the existing data set required under federal law. The primary data set and recording tool for home health care providers is the Outcome and Assessment Information Set (OASIS). Home health care providers must report OASIS-C data at the beginning of care, as an assessment, when a patient transfers to a hospital (TIF), resumes care with the agency, and when a patient is discharged from home health care. The amount of data that home health care providers collect is one of the most robust data sets of the spectrum of federally required data sets in the U.S. healthcare system.

The OASIS-C data set has great potential to enable home health care providers to track quality measures electronically, but there are still issues with accessing the data. After a decade of submitting over 100 variables on each patient, home health care providers are still not able to access this data as it is reported. Instead, providers must contract with outside organizations to aggregate the data from private national databases. For some home health providers, the cost associated with such data services presents an obstacle toward evaluating the data and applying them toward quality measurement and improvement. Removing these restrictions on accessing the data would do much to enable home health providers to track quality goals.

Home health providers are also faced with multiple technological challenges in the area of HIT and quality measurement across care settings. The variation among the data sets required for submission by acute care and long-term post acute care providers presents a significant obstacle to tracking cross continuum care. Data sets vary between the OASIS-C measures, MDS, IRF-PAI and others. The terms and standards across these measures are somewhat similar, but not identical. For example, the hospital data set measures report hospital re-admissions over a 30-day period, not a 60-day period as is reported in the OASIS data set.

[2] *See* Medicare and Medicaid Programs; Electronic Health Record Incentive Program, 75 Fed. Reg. 44314, 44314 – 44588; *also at* 42 C.F.R. 412, 415, 422 et. al, Medicare and Medicaid Programs, Electronic Health Record Incentive Program; Final Rule.

These discrepancies between measurements in the various reporting tools require providers to crosswalk these data sets into one, streamlined EHR in order to share data. The Alliance supports the work of the Office of National Coordinator's Health Information Technology community-led effort, the Standards & Interoperability Framework (S&I Framework). The S&I Framework's Longitudinal Coordination of Care Work Group in particular has included a limited Use Case for pressure ulcers that would enable providers to share information between acute and post-acute care settings. This effort alone for this limited data set has taken more than two years.

The home health community is very interested in engaging in this space. However, some providers lack the funding to pursue EHRs. Others may have funding but in the absence of standards for EHRs in home health, they are hesitant to invest in such systems for fear that the environment is too unstable. Providers would benefit from meaningful guidance on the merits of HIT-enabled quality measurement and information on how to begin the process.

3. **Some quality measures of interest have been more difficult to generate, such as measures of greater interest to consumers, measures to assess value, specialty-specific measures, measures across care settings (i.e., measures enabled by health information exchange), and measures that take into account variations in risk. Describe the infrastructure that would be needed to ensure development of such measures.**

Home health care providers would need multiple levels of infrastructure in order to participate fully in quality measurement enabled by HIT, including federal standards that would be voluntarily adopted by vendors and LTPAC providers, technological infrastructure, and agreement on measures for a cross-continuum assessment.

First and foremost, the Alliance supports voluntary standards for health information exchange akin to what is required for hospitals and physicians under Meaningful Use. As the environmental snapshot, *Quality Measurement Enabled by Health IT*, illustrates, home health care is not fully equipped with EHRs that enable home health providers to work with other health care providers in the spectrum of patient care.[3] The snapshot reports that only 29% of home health care agencies have a basic EHR, as of 2007.[4] The low level of adoption for EHRs among home health care providers is consistent among many long-term care providers, with home health holding one of the highest rates of adoption.[5]

It is noteworthy that in that same year (2007), almost half (41%) of home health or hospice care had electronic medical records (EMRs) with an additional 15% of providers planning to

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[3] Krisine Martin Anderson, et al., *An Environmental Snapshot—Quality Measurement Enabled by Health IT: Overview, Possibilities, and Challenges*, Agency for Healthcare Research and Quality (AHRQ), 6 (July 2012), http://healthit.AHRQ.gov/HealthITENabledQualitymeasurement/Snapshot.pdf.

[4] *Id*.

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

adopt EMRs within the following year.[6] The Alliance contends that the reason that home health is slowly gaining more robust EMR systems but not EHR systems is due both to a lack of regulatory support for technological standards across the care continuum and a lack of physical infrastructure to implement those systems (largely due to limited individual agency capital).

These two problems are interrelated in that EHR vendors have been reluctant to create the physical systems necessary to build an EHR that will work with long-term post acute (LTPAC) providers because currently there are neither federal standards nor financial incentives for long-term and post-acute care under Meaningful Use.

In fact, the only certifying body that currently provides a home health care EHR certification is the Certification Commission for Health Information Technology (CCHIT). CCHIT (https://www.cchit.org/) is the only body to provide standards for long-term and post-acute care (LTPAC) EHRs. However, of vendors carrying a LTPAC certification from CCHIT, there are only two with sub-specialty certifications in home health: AOD Software and HealthMEDX, LLC. The presence of these certifications indicates that the LTPAC community is willing to pursue quality measures enabled by HIT; however, the low rate of adoption bears witness to the fact that vendors are hesitant to build the infrastructure that would allow home health care providers to fully engage in HIE.

Finally, measures for cross-continuum assessment would require an agreement that the measures would have a common language, regardless of setting. For example, it is critical that when health care providers discuss measures focused on fall risk, pain, functional status, weight gain, and the like, that the providers are talking about the same measures and these measures are translated into the same language. Providers need to agree on both on the descriptive or evaluative language and the computer language to build these programs.

An example of the current disconnect is the recent review of the OASIS-C data set, which included a provision for providers who identify a patient as “frail.” The “frail” designation did not rely on the agreed-upon elements of establishing frailty that are used in other care settings. This is an example of where CMS could provide leadership and guidance.

To remedy some of these inconsistencies, the Alliance is considering community-led initiatives to address standardized vocabulary for EHRs. Anecdotal evidence suggests that vendors would need at least 1 ½ - 3 years to build products with a standard vocabulary, as well as a significant financial investment on the part of the vendors. The fact that providers are not yet fully equipped to implement this infrastructure is a major obstacle for home health providers who wish to track quality measures via HIT.

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[6] Anita Bercovitz, Manisha Sengupta, & Patricia Jamison. “Electronic Medical Record Adoption and Use in Home Health and Hospice,” U.S. Department of Health and Human Services, Cenders for Disease Control and Prevention, *NCHS Data Brief* (Sept. 2010), http://www.cdc.gov/nchs/data/databriefs/db45.pdf.

The Alliance supports the community choosing voluntary standards and then adoption of those standards across the care continuum. Absent standards, communications will continue to be siloed and will be a barrier toward achievement of health information exchange. Furthermore, true innovations in the delivery of health care, such as through the development of accountable care organizations, may be hindered if standards are not developed and adopted.

4. **What health IT-enabled quality measures, communication channels, and/or technologies are needed to better engage consumers either as contributors of quality information or as users of quality information?**

   There is a great opportunity to increase patient involvement in their care by providing patients access to their personal health information. Many insurance companies and health systems currently allow patients to download their patient information and share with their providers across settings. The Department of Veterans Affairs' Blue Button Initiative[7] is a great example of where patients have been empowered by HIT and assisted providers in tracking quality across settings. Patients can download their health record into a text or PDF file and bring that same information to their provider.

   The design of the Blue Button program provides a model that could be applied across patient settings outside of the VA program. If the federal government required or endorsed a consistent language for patient health information, then patients could bring information to the providers and providers could track quality measures for individual patients across settings.

   It would also improve the quality of patient care if patients had immediate access to their patient records at discharge. When a patient is referred to home health, there is often a significant delay in providing that patient's records to the home health agency. If the patient had immediate access to their record, they could take that information with them to the agency, avoid costly mistakes, and improve the quality of their health care transition.

   Implementing a standardized patient health record would allow the patient to obtain their own health records and share it between entities. However, providers and their information systems will still need standardized continuity of care documents (CCD), standardized clinical terms (e.g., SNOMED-CT) and standards for interoperability (e.g., HL7) to efficiently use a patient's personal health record information.

5. **How do we motivate measure developers to create new health IT-enabled quality measures (which are distinct from existing measures which were retooled into electronically-produced quality measures) that leverage the unique data available through health IT? Please provide examples of where this has been successfully. What**

[7] *See* http://www.va.gov/bluebutton/.

new measures are in the pipeline to leverage data available through health IT?

In terms of measures that are not HIT-enabled but would be a value add for providers, the National Quality Forum (NQF) has completed the framework for multiple chronic conditions.[8] This set of measures would enable long-term care providers to better manage multiple chronic conditions and identify interventions that improve the cost and quality of care for some of Medicare's most costly beneficiaries.

Additionally, NQF has also endorsed National Voluntary Consensus Standards for Home Health Care.[9] Although these standards have some overlap with the data collected by the OASIS-C data set, they are not the same and are not currently captured by existing HIT.

Although these measures exist already for use (or adaptation) into HIT systems, the creation of *new* HIT-enabled quality measures may require investment in research to develop the evidence base needed to establish such measures. The Alliance supports investment in research that may ultimately lead to the development of new quality measures that are HIT-enabled. AHRQ's leadership in this area could be useful. For example, AHRQ could provide education to provider communities on various approaches to pursue creation of new HIT-enabled quality measures.

6. **Describe how quality measurement and ``real-time'' reporting could inform clinical activity, and the extent to which it could be considered synonymous with clinical decision support.**

Real-time reporting of HIT-enabled quality measures would have a very positive impact on the lives of patients and the cost of providing patient care. In particular for home health care providers, real-time reporting would improve care transitions between acute care hospital discharge and the home health care admission. This would allow for better insight into the effectiveness of clinical pathways and allow providers to determine which processes and interventions provided the best outcomes to patients.

Real-time reporting would also allow providers and health systems to identify variations in practice or timing and to track their correlation with patient outcomes. Quality measurement could incentivize providers to better streamline their processes and efficiency. Many demonstration projects rely on the measurement of quality data to identify the successes and weaknesses of particular interventions. Electronic tracking of various measures would allow providers the opportunity to aggregate data and identify best practices and pitfalls of existing models of care.

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[8] *See* http://www.qualityforum.org/Projects/Multiple_Chronic_Conditions_Measurement_Framework.aspx.
[9] *See*http://www.qualityforum.org/Publications/2010/10/National_Voluntary_Consensus_Standards_for_Home_Health_Care_—_Additional_Performance_Measures_2008.aspx.

Additionally, many programs or drug regimens that are started in the acute care setting could be continued seamlessly in the home setting through appropriate "real time" sharing of information. When patients are receiving clinically appropriate care at home, rather than in the hospital, there is the potential to reduce cost of care and enable the patient to be at home, where they generally prefer to receive care.

7. **Among health IT-enabled quality measures you are seeking to generate in a reliable fashion, including the currently proposed Meaningful Use Stage 2 measure set, what types of advances and/or strategies for e-measure generation if pursued, would support more efficient generation of quality measures?**

   Please see **Question 3**. Federal standards for EHRs are needed in order to motivate vendors to develop EHRs that are standard and interoperable across care settings. The Alliance supports development of federal standards in this area that would be voluntarily adopted by vendors and LTPAC providers. The Alliance supports the work of community-led groups such as the S&I Framework and the LTPAC Health IT Initiative as means to develop such standards with the federal government.

8. **Many EHR, HIE, and other health IT vendors are developing software code to support measures. Tools such as the Measure Authoring Tool (MAT) were created to improve efficiencies in the process of creating and implementing eMeasures. What additional approaches might be used to enable consistent, accurate, and efficient quality measurement when using health IT?**

   As the home health care community is still developing EHRs (*see* **Question 3**), the Alliance is open to working with AHRQ to disseminate information on how MAT can be used to foster development of HIT-enabled quality measures in the home health community.

9. **How do you see the establishment and adoption of data standards impacting the future of health IT-enabled quality measurement? For what types of quality measures should a combination of natural language processing and structured data be considered?**

   The Alliance strongly supports the establishment and adoption of data standards in order to enable the future of HIT-enabled quality measures (*see* **Question 3**). The Alliance supports development of federal standards that would be voluntarily adopted by vendors and LTPAC providers. We support the work of community-led groups such as the S&I Framework and the LTPAC Health IT Initiative as means to develop such standards with the federal government; however, key to this effort is a streamlined means of sharing measure results or points for clinical decisions across care settings.

   Natural language processing, although sometimes easier to produce, may limit the ability to validate, consolidate and produce appropriate outcomes. There is a clear need to document genuinely the assessment of patients, as well as the care plans provided to those

patients. However, gathering data in a structured fashion generally allows for better clinical decision support, reporting of conditions and outcomes, and better statistical analysis of the care delivery model.

10. **Much support has been voiced for the need of longitudinal data in quality measurement. What are the strengths and weaknesses of different information architectures and technologies to support health IT-enabled quality measurement across time and care settings? How can data reuse (capture once, use many times) be supported in different models? What examples might you provide of successful longitudinal health IT-enabled quality measurement (across time and/or across multiple care settings)?**

    Longitudinal data in quality measurement is key to acknowledge cross-setting needs and to affect system-wide improvements in the health care system. Reuse of data is especially beneficial to save costs and improve quality of patient care. In many cases, the patient is required to submit to multiple tests, venipuncture, x-rays or exams simply because HIT systems cannot standardize the systems to share the results of these tests. For example, allowing care providers to share the results of an MRI, or enabling emergency departments to use test results from a prior care setting would prevent delays in accessing care (while waiting for test results), save costs that would otherwise be incurred for unnecessarily duplicative tests or services, and improve patient care. For home health care especially, longitudinal data can be used to track patient care that has an impact on IPPS measures relating to joint replacement and 90-day post discharge complications. Information exchange of longitudinal data between post-acute care providers and hospitals in such cases would greatly improve the ability to communicate and collaborate in pursuing improved patient care.

11. **What are the most effective means by which to educate providers on the importance of health IT-enabled quality measurement and how clinical information is used to support health IT-enabled quality measurement and reporting? How can providers be better engaged in the health IT-enabled quality measurement process?**

    Please see **Questions 2 and 3**. The provider members of the Alliance are aware of the need and importance of HIT-enabled quality measurement and its relationship with clinical quality improvement. There are other obstacles beyond lack of education that make it difficult for home health care providers to fully engage in this space.

12. **What is the best way to facilitate bi-directional communication between vendors and measure developers to facilitate collaboration in health IT-enabled measure development?**

    Please see **Questions 2 and 3**. Providers and vendors are interested in pursuing collaborations that will yield HIT-enabled measure development. However, because there are multiple vendors and providers, in order to truly facilitate bi-directional communication and disseminate advances in such measure development, it is critical to standardize the

message formats across the industry and then adopt these standards in order to share data appropriately.

The cost of data collaboration and development of standards based measures may be cost-prohibitive for some home health care providers. Many providers and vendors who are able to afford these systems are hesitant to invest when the standards are not clear.

Continuing to demonstrate and promote the value of HIT-enabled measure development is the best way to facilitate collaboration.

13. **To what extent do you anticipate adopting payment models that use quality measurement informed by electronic clinical records (as opposed to exclusively using claims data)? What strategies are you pursuing to gain access to clinical data and test the reliability of health IT-enabled clinical outcome measures? How do you anticipate sharing quality measure results with consumers and other stakeholders?**

The home health care community would like to participate in payment models that use quality measurement, informed by electronic records. As hospitals and physicians begin to take on the requirements of Meaningful Use, it will become more critical for home health providers to be able to partner with these providers in order to provide higher-quality long-term care and avoid unnecessary hospital re-admissions.

Currently, home health care as an industry has already begun to encounter payment models that require outcomes reporting (such as Accountable Care Organizations and bundled payments models). The industry meets these reporting requirement by manually abstracting data and creating reports. The demand for electronic programs that will aggregate this data far outstrips the current capacity of vendors to generate systems to program these reports. Many providers are also reluctant to invest in programming when the requirements may change frequently.

14. **What tools, systems, and/or strategies has your organization been using to aggregate information from various EHRs and other health IT for use in quality measurement? What strategies is your organization pursuing to move toward greater automation in quality measurement?**

The Alliance is fully committed to, and supports, an EHR that would enable home health care providers to track quality measures across the continuum of care. Home health, in particular, is uniquely equipped to address care transitions and to be a liaison between acute care and a patient's primary care physician.

At this point, however, home health's technological infrastructure is generally limited to the capture of OASIS-C data when a patient enters home health care and is assessed, and when a patient is discharged from home health care. This limited technological infrastructure does present opportunities for home health to track quality measures, as it has with the

Home Health Quality Initiative, in which the Alliance participated as a member of the Executive Committee.

The Alliance for Home Health Quality and Innovation was actively involved in the Centers for Medicare & Medicaid Services' initiative, the Home Health Quality Improvement (HHQI) National Campaign. The 24-month HHQI grassroots campaign began January 2010 and was led by the home health community. The campaign included partnerships with other provider groups such as hospitals and physicians' offices.

The Alliance, as well as several of its members, served on the Steering Committee with West Virginia Medical Institute (WVMI) in preparation for the campaign. During the 2010-2011 HHQI campaign, the Alliance made recommendations to the CMS Office of Clinical Standards and Quality. During the campaign, the Alliance also served as a Local Area Network for Excellence (LANE). LANEs served as the central hub of HHQI campaign activity in local areas, with multiple opportunities to create awareness, provide encouragement and facilitate communication among agencies. At this time, however, the campaign is on hiatus. The Alliance is committed to further work in this area when the campaign begins again.

15. Please describe scalable programs, demonstrations, or solutions (domestic or internationally) that show material progress toward quality measurement enabled by health IT.

At this juncture, the home health community is still building infrastructure that may be a prerequisite for programs, demonstrations and solutions relating to quality measurement and HIT. We are, however, interested in working with AHRQ to identify programs and projects that would be feasible given the current systems that are in place.

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

Sincerely,

Teresa L. Lee, JD, MPH
Executive Director