LTPAC HIT Collaborative
Long Term and Post Acute Care Support Services

May 6, 2011

Farzad Mostashari, MD, MPH
National Coordinator for Health Information Technology
Department of Health and Human Services
Hubert Humphrey Building, Room 509F
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: LTPAC HIT Collaborative Public Comments on ONC Federal HIT Strategic Plan 2011 – 2015

Dear Dr. Mostashari:

The Long Term Post-Acute Care (LTPAC) Health Information Technology (HIT) Collaborative, a partnership of leading organizations representing thousands of aging services providers, supplies and technologies, appreciates the opportunity to comment on the Federal Health Information Technology Strategic Plan (2011-2015) recently released by the Office of the National Coordinator for Health Information Technology (ONC).

The LTPAC Health IT Collaborative is very supportive of the goals of this comprehensive strategic plan, and certainly applauds the ONC creating Strategy I.C.3. to support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings. The LTPAC Health IT Collaborative respectfully submits these detailed comments, on where we believe LTPAC has implications to several other goals, strategies and objectives in the Strategic Framework.

COMMENT SUMMARY:

During the unprecedented opportunity to modernize the way health care is delivered in this country, the LTPAC Health IT Collaborative respectfully submits comments on the Federal Health IT Strategic Plan supporting improving the health of all Americans across the entire spectrum of care. With detail and justification presented below, the Collaborative broadly recommends full inclusion of the LTPAC health sector in the Federal Health Information Technology Strategic Plan to improve quality and reduce care disparities through meaningful use and systematic exchange of health information among all providers in all settings.

BACKGROUND:

Long-term and post-acute care (LTPAC) is inclusive of long-term acute care hospitals, inpatient-rehabilitation facilities, skilled nursing facilities, nursing facilities, assisted living, home health agencies and others. It is the most publicly funded health care sector now caring for the fastest growing and most costly segment of the U.S. population. Many elderly LTPAC patients and residents have multiple chronic conditions and co-morbidities that require the coordination of numerous providers, who prescribe multiple medications and diagnostic tests. This population is also known to transition frequently between different levels of care and care settings such as nursing homes and hospitals, hospitals and skilled nursing facilities or skilled nursing facilities and home health agencies.

We fully support the Vision and Mission stated in the Federal Health IT Strategic Plan: a health system that uses information to empower individuals and to improve the health of the population; to improve health and health

care for all Americans through the use of information and technology. Simply put, health IT is a key enabler for improving care, improving health and reducing costs.

Further, we fully support the Federal Health IT Principles:

> **PUT INDIVIDUALS AND THEIR INTERESTS FIRST**
> By their very nature, LTPAC settings are places where people spend more time than in the short-term acute-care settings. Coordinating with acute-care providers, restoring and supporting functional abilities, promoting the healing that shorter stays cannot achieve – these activities put the individual at the center of a multi-disciplinary care team.

> **BE A WORTHY STEWARD OF THE COUNTRY'S MONEY AND TRUST**
> LTPAC settings are generally lower cost settings of care. At the same time, they are highly regulated and have a history of delivering quality care. The evolving healthcare system is looking to these providers as key players in all aspects of improving the value of the money spent on healthcare.

> **SUPPORT HEALTH IT BENEFITS FOR ALL**
> LTPAC serves the frail elderly and other populations needing on-going and/or episodic care. Assuring that individuals at risk receive the benefits of health IT requires the inclusion of LTPAC providers in the planning, implementation and coordination of all Federal health initiatives, including those related to health IT.

> **FOCUS ON OUTCOMES.**
> The LTPAC providers are fully committed to delivering quality care and improving the lives of the individuals served. Moreover, outcomes of patients are directly related to the degree of coordination between care providers, Health IT and health information exchange are key to such coordination and continuing quality improvement within and across care settings.

> **BUILD BOLDLY ON WHAT WORKS**
> The LTPAC community has benefitted from incorporating the many factors affecting a patient's wellbeing, not just their disease, to demonstrate the power that contributions of multiple providers across multiple care settings provide to patients.

> **ENCOURAGE INNOVATION**
> LTPAC has, of necessity, had to innovate with high-value use of health IT. Moreover, LTPAC advocated for interoperability standards relevant to the sector and partnered with CCHIT to create a certification program for LTPAC EHRs. We look to partner with the government in finding further innovative ways to support the acquisition and use of standards-based interoperable health IT.

The Federal Health IT Strategic Plan recognizes the importance of LTPAC providers and their role in delivering safe and effective care; their importance in assuring continuity of care and successful transitions from acute episodes of care to long-term health and vice versa. The following comments build on what is contained in the Strategic Plan and further extend it to better meet the needs of the large population that LTPAC serves.

DETAILED COMMENTS:

During the unprecedented opportunity to modernize the way health care is delivered in this country - the LTPAC HIT Collaborative respectfully submits these comments on the Federal HIT Strategic Plan supporting improving the health of all Americans across the entire spectrum of care:

GOAL I: Achieve Adoption and Information Exchange through Meaningful Use of Health IT
- Suggest include in the Federal HIT Strategic Plan support for healthcare services associated with consumer care including the personal care needs, infusion, nutrition, rehabilitation, as well as durable medical equipment. With the success of the CMS PACE program (Program of All Inclusive Care for the Elderly), venues of care such as Community Based Care including Adult Day Care and Assisted Living will also have increased needs to be included in the health information exchange viewing, continuing and updating the consumer centric longitudinal plan of care.

OBJECTIVE I.A: Accelerate adoption of Electronic Health Records (EHR)

STRATEGY I.A.7: Align federal programs and services with the adoption and meaningful use of certified EHR
- We applaud the ONC for planning to include methods to encourage providers that are not eligible for the incentive programs such as post acute and long term care to achieve meaningful use of IT as well.

OBJECTIVE I.B: Facilitate information exchange to support meaningful use of EHR
- Suggest "including long-term and post-acute care settings" with any example of provider settings.
- Suggest clarifying "services" to be IT services (e.g. authentication, access, etc.) to differentiate "services" that are provided as part of consumer care such as transportation, personal care, PT, OT, Speech, Rehabilitation etc. This will distinguish the difference in "Health" and "Information Technology" services in HIT.

STRATEGY I.B.I: Foster Business models that create health information exchange
- Health Information Exchange strategies include the LTPAC community.
- The ONC Direct engages a variety of providers in Health Information Exchange. Ensure that LTPAC providers are included in Direct Projects to benefit these vulnerable populations in future meaningful use criteria.
- It is not readily apparent in the Strategic Plan that LTPAC is part of the Direct Project.

OBJECTIVE I.C: Support health information technology adoption and information exchange for public health and populations with unique needs

STRATEGY I.C.2: Track health disparities and promote health IT that reduces them
- Long Term care organizations are resource poor settings, add them to the list mentioned in this STRATEGY "including small practice settings…"

STRATEGY I.C.3: Support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings

The Federal HIT Strategic Plan notes ONC is working with SAMHSA and HRSA to address the policies and standards concerning the unique needs of behavioral health IT adoption and information exchange. The LTPAC Health IT Collaborative supports the inclusion of the unique needs of behavioral health identified in the strategic plan and offers these recommendations below supporting the unique needs of the LTPAC community:

- Support for effective care delivery which maintains healthcare quality outside of the hospital and acute care setting where most of the elder population – both Medicare and Medicaid beneficiaries as well as "dual eligibles" reside.
- Policies, standards, and incentives for vital links between healthcare providers to be encouraged to accelerate the care process outside current settings being incentivized [eligible hospitals, CAH, eligible professionals].
- Policies, standards, and incentives to provide sustained effective care for the large numbers of vulnerable populations in settings outside acute systems.
- Policies, standards, and incentives to develop communication between providers eligible for EHR incentive payments to establish and maintain connections supporting data exchange with those outside agencies who are NOT EHR incentive payment eligible to support consumer centric care across the continuum that includes the longitudinal care planning being discussed by HIT Policy Committee for inclusion in the future stages of Meaningful Use.
- Support for effective electronic health information exchange with ALL health professionals involved in delivering LTPAC needs of the consumer including *include Home Care services such as Care Management, Private Duty, and Skilled Nursing - and also the personal care needs, infusion, nutrition, rehabilitation, PT, OT, Speech therapy as well as durable medical equipment providers.*
- Support for Longitudinal assessments across the continuum which identify the patient's story. It is unclear how the Virtual Lifetime Electronic Health Record facilitates longitudinal assessment.
- Health information exchange from LTPAC facilities to hospitals and vice versa to facilitate better transitions to meet unique needs.
- Support for services or service delivery structure to the current EHR that provide a means to track unique needs of patients transitioning between settings. This includes patient care services – not just medical decision making.
- Support for the concept of a problem that is not disease specific or a medical problem; examples of other issues that need to be addressed include transportation, personal care, activities of daily living (ADLs), financial issues which are barriers to sustained effective care beyond acute care and often result in hospitalizations, re-hospitalizations and greater medical costs.
- Support for health care delivery for of ALL levels of care and prevention – not just support for traditional health care delivery episodes of care "check in to check out" or "admission to discharge".

GOAL II: Improve care, improve population health, and reduce health care costs through the use of health IT

 In the spirit of capturing the power of including all aspects of a consumer's life in the fabric of "healthcare delivery", we would also like to suggest adding on Page 22 under the "Spotlight on Health Outcomes" under reducing cost – a successful story about an individual served by a PACE program. An elderly individual was having repeated monthly hospital admissions for several chronic and unmanaged illnesses. After joining the PACE program and receiving a social work visit and home health assessment, it was also determined the patient had COPD and no air conditioner, as well as two dogs with fleas. The fleas were biting her, and causing her to have infected sores that in turn affected her chronic illnesses; she would need to be admitted to an acute care facility for treatment. Subsequently, PACE bought an air conditioner and had the individual's dogs dipped for flea control. Since then the patient has not been admitted in two years after the intervention. In this case when the person did the home visit - key information was obtained that lead to improved quality of care and unnecessary service delivery.

> **OBJECTIVE II.A: Support more sophisticated uses of EHRs and other health IT to improve health system performance**
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> > **STRATEGY II.A.1: Identify and implement best practices that use EHRs and other health IT to improve care, efficiency, and population health.**

- Consider enhancing current language to "Clinical decision support (CDS) systems are tools that leverage EHRs to improve clinical processes – ADD NEW – "across ALL venues of care including LTPAC, behavioral health, and emergency care settings".
- Usability is a critical issue that needs to be addressed in this GOAL so that systems providing clinical decision support provide consistent messaging and alerting across the continuum from acute care to long term and post-acute care.

OBJECTIVE II.D: Support new approaches to the use of health IT in research, public and population health, and national health security

STRATEGY II.D.1: Establish new approaches to and identify ways health IT can support national prevention, health promotion, public health, and national health security.

- Include a plan to integrate LTPAC. Include clinical decision support systems integrated across the continuum to consistently support meaningful use by all care providers, not just providers currently eligible for the EHR Incentive Program.
- Collaboration with LTPAC providers to define supporting strategies, policy and standards needed regarding risk assessment and clinical decision support in a long-term or post-acute care setting.
- Support for a link between quality and core processes important across the continuum which include medication reconciliation, care transitions, change of condition, and risk identification.
- Support for health records associated with the longitudinal care plan and outcomes of care in various care settings that capture the essence of an individual's life in the community which are vital to the continuum of care. A more specific plan should be included for including these records in the near term meaningful use plans. This is particularly important for populations served by LTPAC.
- Support for family histories which are a vital and rich part of the longitudinal care plan and unique assessment of the nursing home and long term or post-acute care environment.
- Support for standards and vocabularies associated with the longitudinal care plan which include LTPAC standards which are different than acute care environment, integrating these disparate sources is vital for continuity of care. We encourage some dialogue about these as part of the continuum of care being developed in the strategic plan [OASIS, MDS].
- Support for quality outcomes across the continuum.

GOAL III: Inspire Confidence and Trust in Health IT

OBJECTIVE III.A: Protect confidentiality, integrity, and availability of health information

STRATEGY III.A.4: Identify health IT system security vulnerabilities and develop strategic solutions

- Include a specific cogent plan for adoption and widespread use of evidence based practices in LTPAC, to avoid delaying the dissemination of best practice resources to some providers and outlying facilities.
- Support for more language around person centered care, medical homes, patient ownership and empowerment with IT.
- Support for capturing the needs of the people residing in long term care environments or served by post-acute care providers, and a plan to build out the system to protect these consumers and their information.

GOAL IV: Empower Individuals with Health IT to Improve their Health and the Health Care System

OBJECTIVE IV.C: Integrate patient-generated health information and consumer health IT with clinical applications to support patient-centered care

STRATEGY IV.C.3: Encourage the use of consumer health IT to move toward patient-centered care.

- There are some types of technologies being implemented in long term care, but these are mostly disparate systems which are not integrated well with other systems. For example, many nursing homes contract with physical therapy and rehabilitative resources which have vital health records which are not electronically stored in the medical record but are used mostly as financial tracking systems. Understanding how these systems can be integrated to facilitate better care processes using standardized languages that the whole healthcare team could understand would benefit the patients and improve quality. We recommend that the strategic plan include more details about types of technology used in LTPAC and the skills/capabilities needed for ALL disciplines of users.
- Suggest greater clarification of what stakes exist in the LTPAC community including technology and data standards to enable the business model and innovation in LTPAC.

GOAL V: Achieve Rapid Learning and Technological Advancement

OBJECTIVE V.B: Broaden the capacity of health IT through innovation and research

STRATEGY V.B.2: Make targeted investments in health IT research.

- These strategies seem very narrow; we recommend expanding to include prevention.
- There needs to be greater clarification for how the electronic health record should flow outside the acute care setting to LTPAC settings.
- Workflows, patient interactions, and goals in the LTPAC setting are unique with a longitudinal focus, drawing conclusions from hospital care and critical access will limit understanding and applications of how IT affects workflow and interactions in LTPAC.
- Include a plan for EHR across continuum of care including LTPAC to be able to gather and send quality information (accidents, infections, medication errors, falls, wounds, etc.) in the common formats authorized by the Patient Safety and Quality Improvement Act of 2005 as shown the National Quality Forum project: http://www.qualityforum.org/projects/commonformats.

IN CONCLUSION:

The LTPAC Health IT Collaborative wishes to thank the ONC for their hard work in creating the Strategic Plan for HIT, for the inclusion of LTPAC providers in this strategic plan and for this opportunity to participate in a public comment process. During the unprecedented opportunity to modernize the way health care is delivered in this country, the LTPAC Health IT Collaborative again wants to express our support of the Vision and Mission stated in the Federal Health IT Strategic Plan supporting the 3 AIMS of CMS to create a health system that uses information to empower individuals, to improve the health of the population and to improve health and health care for all Americans through the use of information and technology.

As represented in the PACE success story under Goal II earlier in this document, without coordination of care incorporating every aspect of this patient's life into the assessment of what was happening in her life, not just her disease, a solution would not have been found. This solution saved THOUSANDS in Medicare dollars. This is the POWER of incorporating long term care into the overall framework of healthcare. By incorporating the many factors that affect a patient and their wellbeing, not just their disease, PACE success story exemplifies the contributions of multiple providers across multiple care settings who provide to these individuals. The LTPAC Health IT Collaborative stands committed to assisting HHS and ONC in the evolution of this framework to improve healthcare for all Americans and make it a reality that health IT is a key enabler for improving care, improving health and reducing costs.

Respectfully submitted by these LTPAC Health IT Collaborative contributors,

- American Association of Nurse Assessment Coordinators (AANAC) ~ Ingrid Serio, 303-758-7647, iserio@aanac.org
- American Health Care Association/National Center for Assisted Living (AHCA/NCAL) ~ Peter Gruhn, 202-898-2819, pgruhn@ahca.org
- American Health Information Management Association (AHIMA) ~ Michelle Dougherty, 312-233-1914, michelle.dougherty@ahima.org
- American Medical Directors Association (AMDA) ~ Lorraine Tarnove, 800-876-2632, ltarnove@AMDA.com
- Alliance for Nursing Informatics (ANI) ~ Gregory L. Alexander PhD, RN, 573-882-9346, alexanderg@missouri.edu
- American Society of Consultant Pharmacists (ASCP) ~ Lynne Batshon, 703-739-1300 ext 141, Lbatshon@ascp.com
- Golden Living, LLC ~ John F. Derr, 479-926-1807, john.derr@goldenliving.com
- LeadingAge (Formerly AAHSA) ~ Barbara Manard, 202-508-9435, bmanard@LeadingAge.org
- LeadingAge Center for Aging Services Technologies (CAST) ~ Majd Alwan, 202-508-9463, Malwan@LeadingAge.org
- Health Information and Technology Systems Society (HIMSS) Nursing Informatics Task Force ~ Robin Raiford, 972-375-8755, robin.raiford@allscripts.com
- National Association of Home Care and Hospice/Home Care Technology Association of America (NAHC/HCTAA) ~ Richard D. Brennan, Jr., 202-547-7424, rdb@nahc.org
- National Association for the Support of Long Term Care (NASL) ~ Annessa Kirby 703-549-8500, annessa@nasl.org
- National PACE Association (NPA) ~ Shawn Bloom, 703-535-1518, ShawnB@npaonline.org