



May 7, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Acting Administrator Tavenner
Attention: CMS-0044-P
P.O. Box 8013
Baltimore, MD 21244-8013

Delivered via: <http://www.regulations.gov>

Dear Administrator Tavenner,

The collaborative of associations representing health information technology (HIT) issues for long term and post acute care (LTPAC) providers, professionals, and support services in skilled nursing facilities, nursing facilities, assisted living, home health agencies, hospice, and PACE organizations is pleased to submit comments on the proposed rule to implement the provisions of the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2. This rule proposes Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments.

With the exception of physicians directly employed by PACE organizations, we recognize that LTPAC providers are not eligible for incentive payments and focus our recommendations on this opportunity to improve care in and with our space. We provide care in coordination with other providers that are eligible for Meaningful Use incentives, and as such, our comments also address our relationships with those providers.

We acknowledge and thank ONC and CMS for their efforts to consider LTPAC providers in various initiatives, such as the State HIE Challenge Grants, the Beacon Communities and the S&I Framework initiatives, as well as, in various payment reform demonstration projects. As the various Federal programs become more aligned, it is even more important that HIT and health information exchange (HIE) efforts include all providers.

LTPAC Recommendations:

- We recommend that CMS and ONC continue to acknowledge LTPAC providers an essential component of the health care system and active participants in health information exchange.
- Information exchange requirements should allow an eligible provider to send information to and receive information from other providers regardless of their eligibility status or the type of software utilized.
- The summary of care record to include additional health information that will facilitate care planning and care coordination processes, such as medication reconciliation, which are especially important during care transitions. Such information should include functional status, cognitive status, advance care orders when applicable, and complete medication history.
- Replace the term “disability status” with “functional status” to ensure that the patient receives the most appropriate and effective care to meet his or her needs.
- An expanded definition of e-Prescribing and computerized provider order entry (CPOE) to include medication management in long term and post acute care.
- In the LTPAC setting a discharge summary received from an EP or eligible hospital should be mandated to include all medication including non-prescription medications and supplements from a reconciled medication list.

Proposed Measure: *EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals.*

Recommendation: That the proposed measure apply to information systems capable of information exchange, regardless of their organizational affiliation and vendor.

We strongly support open networks and the requirement that information systems be capable of information exchange regardless of organizational affiliation and vendor. The emphasis should be on the standard messages and message transports so that there are minimal barriers to exchange across these boundaries. The characteristics of the partner and their technology should not be part of this measure. This is especially important for ineligible providers who most likely will not be using Certified EHR Technology but do have a strong interest in standards-based exchange. We recommend that the measure have a numerator of the number of transitions of care where a summary of care record was exchanged and a denominator of the total number of transitions of care. We believe that there should be no threshold; only the reporting of numerator and denominator. In order to improve patient safety in transitions of care, we suggest further investigation on potential barriers that could restrict the exchange of summary documents to non-affiliated providers. To support this with data, we further suggest that the EHRs track the type of care setting patients are transferred to and the number of care summaries sent to each setting type. As systems today track discharge destination by type, we believe this additional data can be collected without adding to the workload of the clinicians.

Proposed Measures: *The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 percent of transitions of care and referrals.*

Recommendation: That the summary of care record should include additional information that will facilitate care planning and care coordination processes, such as medication reconciliation, which are especially important during care transitions.

At a minimum the summary of care record should include the patient name, transferring or referring provider's name and office contact information, problem list, procedures, laboratory test results, medication list, medication allergy list, vital signs, smoking status, demographic information, care plan field, and any care team members and their roles.

We recommend adding:

- Functional status. (See detail below)
- Cognitive status.
- Name and contact information of individual's legally appropriate health decision-maker in the instance that a patient is not capable of making medical decisions.
- Advance care orders. (See detail below.)
- A complete medication history during an episode of care and an active medication list with a detailed administration plan and reconciliation instructions. The latter should include start date, stop date if known, administration instructions, precautions, and last dose administered.

We suggest that the initial use of care summaries as electronic documents progress beyond acting as a repository of care summary documents for viewing, and move to incorporating the information elements into the EHR. The ability to track the origin of the information will become increasingly important with information exchange and as the summary of care record feeds into the full data set of the EHR.

Proposed Objective: *Record whether a patient 65 years old or older has an advance directive.*

Recommendation: The summary of care record should include an advance directive or that, in a care transition, that the sending entity communicates advance care orders regarding CPR, Mechanical Ventilation, and Enteral/Parenteral Feeding Technologies.

At transitions of care, sending facilities should provide a summary of care document with advance directive information. This should include a copy of the current order in the sending facility regarding CPR and Mechanical Ventilation, or, if no advance care order exists, the indication of the absence of the advance care order. Furthermore, we suggest that when developing Meaningful Use Stage 3, that standard vocabularies and value sets be developed for advance care orders using the “Medical Orders for Life-Sustaining Treatment (MOLST)¹” paradigm.

Stage 2 Proposed Objective: Concept of “disability status”

Recommendation: Replace the term disability with functional status.

If the primary goal is to improve care coordination, we suggest that recording “disability status” is not the most effective way to achieve that goal. The term “disability status” is vague and often subjective. A patient with a physical infirmity may not consider himself disabled. “Functional status,” is a more precise, comprehensive and objective measure for describing the patient’s status. Functional status is found in the Continuity Assessment Record and Evaluation (CARE) Tool, a standardized patient assessment tool developed as part of CMS’ Post-Acute Care Payment Reform Demonstration (PAC-PRD).

“Functional status” data are far more useful in terms of ensuring that the patient receives the most appropriate and effective care to meet his or her needs. There is considerable value in standardization, so that regardless of patient care setting, all providers are using the same terminology and recording the same data elements upon discharge and referral. This kind of standardization could help erode some barriers to interoperability, particularly where the transferring entity is an eligible hospital or provider with complex Certified EHR Technology and the receiving entity is not an eligible provider and does not benefit from financial incentives to acquire and use health information technology. While the CARE tool is not in use yet, it has been tested in multiple setting types, including short-term acute-care hospitals (Eligible Hospitals) and can be a source of standardized components. Standardization is important because patients utilizing LTPAC may utilize several settings including SNF and home health and sometimes an episode in the hospital and then back into a SNF, for example. If eligible hospitals and providers capture the same information regarding “functional status” that is captured in the CARE Tool, care transitions, especially those where the recipient facility is an LTPAC entity, will be more efficient and coordinated.

Furthermore, we believe that functional status should be collected as part of a standard clinical assessment performed with each care transition utilizing the same vocabulary and value sets as those created for the CARE tool. The following questions are included in the CARE Assessment Instrument and list their corresponding LOINC ID:

Does the patient have any impairment with hearing, vision, or communication?	52621-0
Understanding Verbal Content (excluding language barriers)	52622-8
Expression of ideas and wants	52623-6
Ability to See in Adequate Light (with glasses or other visual appliances)	52624-4

¹ http://www.health.ny.gov/professionals/patients/patient_rights/molst/

Ability to Hear (with hearing aid or hearing appliance, if normally used)	52625-1
Indoor mobility (ambulation): did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?	52546-9

We support the inclusion of cognitive and functional status but recognize that the standardized assessments (e.g. CARE assessment instrument) which create this capacity are not yet sufficiently mature to require for Stage 2. However, we would like to formally recommend that subsequent stages of Meaningful Use include standardized vocabularies and value sets for cognition, mood and affect, and functional capacity including all basic activities of daily living (ADLs), as well as, assistive devices, gait assessment, fall history, and skin integrity; as this will advance alignment of assessment data across the care continuum.

Proposed Objective:

Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.

Recommendation: An expanded definition of e-Prescribing and computerized provider order entry (CPOE) to include medication management in long term and post acute care.

The three way exchange (prescriber-facility-pharmacy) of electronic prescription (eRX) in LTPAC is still exempt in terms of CMS requirement for all licensed nursing facilities, skilled and non-skilled. The standards needed for eRX in the LTC setting require an NCPDP SCRIPT version higher than 10.6. NCPDP SCRIPT version 10.6 should be adopted as the LTC industry standard by Office of e-Health Services so that eRX networks are certifying with the necessary requirements for the LTC setting.

The LTPAC HIT Collaborative supports an expanded definition of e-Prescribing and CPOE to include medication management in LTPAC. This includes collecting source data regarding a patient’s active medication orders and utilization history. Engaging the consultant pharmacists, facility and home health nurses and the physicians to reconcile a single active medication list electronically is difficult when these three practitioners do not practice in the same location. Interoperability and data exchange among the three systems have their own unique issues for system development and adoption. To further complicate the matter performing medication reconciliation, resulting in a single source of a true active medication list needs to include drug name, dose, form, route of administration, frequency of administration, indication, special precautions or administration instructions if applicable and stop date. For facility based care, including NF, Domiciliary, LTAC, and IRF, this medication list will be documented in the Initial encounter in the setting and with each subsequent encounter where new medication instructions are provided and upon any care transitions where the physician or non-physician provider is present to provide a billable service. For home based care, including Skilled Services provided by Nursing, Rehabilitation, or Social Work, or with Hospice, the Physician would provide Medication Management as defined above and included on the Initial Physician Plan of Care and any updates to that plan of care as provided by the agency and required by CMS. The physician would include a Gcode indicating successful medication management in LTPAC for each visit or certification included in the denominator.

The LTPAC HIT Collaborative supports the intent of the rule to ensure that receiver facilities have access to data necessary to start care in a timely fashion in a “platform agnostic” fashion. We support standards based exchange. Closed referral systems created on common HIT platforms which do not share data outside their “walled garden” does not preserve patient choice nor optimize the investment in HIT infrastructure created by the CMS incentive program. We propose that the performance metric be based on fulfillment of requests for summary documents including the consolidated CDA by LTPAC facilities and programs through a Health Information Exchange. The numerator would be successful fulfillment of an electronic query for CDA document published by the acute care hospital and made by LTPAC provider, the denominator would be requests for CDA documents by LTPAC facilities. This process would ensure publication of relevant clinical data to the HIE and allow for nonaligned providers collaborating around a single patient to receive current data.

In addition, we recognize that a reduction in hospital readmissions in 30 days will require more than a complete medical summary document. The physician provider is a critical determinant of who can appropriately continue to receive medical care in the nursing facility or at home and who requires updated assessments or medically intensive treatments in the hospital. To fully inform physicians in the skilled nursing facility, the meaningful use program needs to be extended to address the barriers to physician eligibility addressed above. Therefore, we request full support for Meaningful Use Stage 1 and 2 eligibility based on medication management in the LTPAC setting.

***Proposed Objective:** The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.*

We do not believe that OTC medicines will be routinely electronically prescribed and propose to continue to exclude them from the definition of a prescription. However, we encourage public comment on this assumption.

Recommendation: In the LTPAC setting a discharge summary received from an EP or EH should be mandated to include all medication including non-prescription medications and supplements from a reconciled medication list hopefully supplied by the patient and managed by a pharmacist or nurse.

Medication reconciliation allows providers to confirm that the information they have on the patient's medication is accurate. This not only assists the provider in their direct patient care, it also improves the accuracy of information they provide to others through health information exchange.

If an EHR feeds the active medication list from eRX and medication history (claims based RX history) not from reconciled medication list outlined in the section from pages 104-105, then the active medication list is produced from potentially two inaccurate electronic sources. If OTCs are excluded from the definition of prescriptions, then how will they be included in the active medication list? We must begin to think about the work flow of the prescriber who will be writing for prescription including drug interaction alerts that will check for new prescriptions written against the active medication list.

In the LTPAC setting a discharge summary received from an EP or EH should be mandated to include all medication including non-prescription medications and supplements from a reconciled medication list.

Conclusion

While LTPAC providers are involved in various CMS and ONC initiatives and demonstration projects, we continue to urge that Federal HIT and HIE programs become more aligned and include all providers in the health care system. LTPAC provides care in coordination with eligible providers, and as such, our recommendations focus on improving care in and with our space. Additionally, the LTPAC HIT Collaborative supports the development of clinical quality measures for care transitions, as well as, care delivery and outcomes in LTPAC. We believe there needs to be process measure for effective care transitions to include the provision of clinically relevant data to the receiver facility and receiver physician upon all care transitions. We believe the comments provided above enhance the relevance of the clinical data upon transition.

Thank you for the opportunity to provide comments on the proposed regulation. The Long Term and Post Acute Care Health IT Collaborative has also provided feedback on the Office of the National Coordinator for Health Information Technology's (ONC) Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition Proposed Rule (NPRM).

Please contact the representatives below for further information or if there are any questions regarding this letter and its recommendations.

Sincerely,
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