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U.S. Department of Health and Human Services
Hubert H. Humphrey Building
Suite 729D
200 Independence Avenue, SW
Washington, DC 20201
Attention: 2014 Edition EHR Standards and Certification Criteria Proposed Rule: RIN 0991-AB82

Dear Dr. Mostashari:

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 Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition Proposed Rule (NPRM).

Long-term care, post-acute care, mental, and behavioral health settings are generally outside the incentives and penalties of HITECH. These ineligible providers are essential to providing coordinated care across transitions, part of creating an integrated dynamic longitudinal person centric electronic health record digitized healthcare system. While each care setting has its own characteristic workflow, these comments apply broadly to all the settings.

We have commented on a few specific areas of the Standards and Certification Criteria NPRM:

- Request for Additional Comments, A. Certification and Certification Criteria for Other Health Care Settings
- Request for Additional Comments, C. Disability Status
- Use of the term "longitudinal care"

A. Certification and Certification Criteria for Other Health Care Settings

It is necessary that standards for information exchange apply to all care providers regardless of eligibility for incentives. If not, inconsistencies and gaps will continue to plague healthcare. The lack of standards also drives up the cost of information exchange and the interfaces needed to implement the exchange. In the face of many reductions in Medicare and Medicaid reimbursements to most ineligible providers this will be an unnecessary hardship cost and could possibly affect quality of care. We are also concerned that certification does not become a regulatory unfunded mandate.

As we transition from CCD to CCDA templates, some of the deficiencies of the standard and implementation guide are surfacing. Some of these limitations are being addressed through the S&I Framework and through the IMPACT HIE Challenge Grant. Specifically, the CCD does not address all of the data elements needed for a smooth handoff. We are at the beginnings of RxNORM adoption. Other key areas, like functional status and advance directives are also still having their nomenclature standardized.

The timing and pace of standards adoption is critical for care settings (providers and software vendors) when there are not incentives to support the implementation of the standards. Both vendors and providers believe that standards will provide a higher quality of transitional care and this can be done in a thoughtful, voluntary way. With activities such as the Standards & Interoperability Framework that foster collaboration across care settings, we believe robust and achievable standards will emerge.

One element of this approach is to identify a minimum set of certified standards within those being issued by ONC. This sub-set would be intended for use by all providers whether eligible or ineligible under HITECH incentives. The minimum would ensure exchange of electronic health information with, and integrate such information from other sources; and to protect the confidentiality, integrity, and availability of health information stored and exchanged.

The minimum would apply to all settings. They would be determined by the Standards Committee and published by ONC. This would enable multiple providers to be responsible partners in coordinated care and:
- Ensure patient identity
- Ensure provenance
- Ensure privacy & security
- Ensure standards-based exchange

C. Disability Status

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 patient assessment tool developed as part of CMS' Post-Acute Care Payment Reform Demonstration (PAC-PRD). Similarly, functional status is also found in the nursing home minimum data set, MDS 3.0, and home health outcome and assessment information set, OASIS-C.

"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. We believe that functional status should be collected as part of a standard clinical assessment performed with each care transition utilizing the standards that are emerging through the Standards & Interoperability Framework Longitudinal Care Coordination (LCC) workgroup.

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, there is considerable importance in having the same assessment tool, so that regardless of care setting, all providers are recording the same data elements upon discharge and referral. Therefore, we 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.

Use of the term "longitudinal care"

Longitudinal Care should be reserved for the coordinated, interdisciplinary management of a person's health concerns in accordance with their long term goals, and not limited to a single episode of acute illness or exacerbation.

Thank you for the opportunity to provided comment. Please contact the representatives below for further information or if there are any questions regarding this letter and its recommendations.

Sincerely,
LTPAC Health IT Collaborative

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