April 30, 2009

**Harry Reynolds, Jr,**
**Chairman, National Committee on Vital and Health Statistics**

**Re: "Meaningful Use" of Health Information Technology should include effective electronic exchange of health information with Long-Term Care, Aging and Support Services Providers**

Dear Dr. Reynolds:

The collaborative of associations representing long-term care, aging and support services with respect to health information technology (HIT) would like to thank you for organizing the public hearing on "Meaningful Use" of HIT, April 28-29. We appreciate the opportunity to submit a written statement and offer comment on "Meaningful Use" of HIT to support implementation of Sections 4101 and 4102 in American Recovery and Reinvestment Act (ARRA) of 2009 from the perspective of the long-term care continuum of services.

As you may know, long-term care is the most publicly funded health care and treats the most costly segment of the increasingly aging US population. Our collaborative has worked to ensure that long-term care providers (skilled nursing facilities, assisted living, home health entities and others) were included in the ARRA HIT provisions because fully including this substantial segment of the health care community in interoperable electronic health records (EHRs) is critical to reforming the health care system. Long-term care patients and residents have multiple chronic conditions and co-morbidities that require them to have multiple providers and to transitions between different care settings. We are pleased with the law's emphasis on interoperability and the exchange of health information across different health care settings as it will greatly benefit the long-term care population. Health care expenditures for nursing facility (NF) combined with home health services represent the third highest expenditures in our country, following hospitals and physicians services. Total health expenditures made on behalf of individuals who receive these long-term care services are even higher when taking into account the annual costs of the hundreds of thousands of hospital stays, millions of physician visits, medication orders, and services delivered by other health care professionals. For example, three million patients per year receive Medicare and Medicaid services in NFs. Each year, episodes of care that include NF services is about 450,000 hospital stays, and millions of physician encounters, medication orders, and Speech, Occupational and Physical Therapy visits. Forty percent of Medicare hospital discharges go to post-acute care, including 17% to NFs. Forty percent of hospital re-admissions of NF patients are considered "inappropriate" and result in about $2 billion of unnecessary hospital costs per year (80% of which is paid by Medicare, with Medicaid paying the remaining balance). In addition, the Medicare and Medicaid hospital costs have increased due to unnecessary hospital re-admissions of long-term care patients due to the failure of hospitals to exchange timely and necessary health information from the initial hospital[1]. Effective electronic health information exchange with long-term care providers reduces such errors, improves quality, supports the continuity of care, and reduces costs.

For the above reasons, our collaborative representing thousands of long-term care providers serving tens of millions individuals, believes that the "**meaningful use" of certified health information technologies (including EHRs) by acute care providers must include the electronic exchange of health information with long-term care providers.** Failure to include the health information exchange on behalf of patients who receive post-acute or long-term care under Sections 4101 and 4102 will diminish the anticipated benefits of health information exchange, and will lead to missed opportunities to improve quality, increase efficiencies, and decrease costs. Finally, failure to include the long-term care providers in the exchange of health information will hinder the advancement of health care reform. In order to achieve this goal, HIT systems in **ALL** health care settings must have the ability to exchange health information with long-term care providers. This goal can be achieved by implementing HITSP interoperability standards developed.

[1] Jencks SF, Williams MV, Coleman EA, Rehospitalizations Among Patients in the Medicare Fee-for-Service Program, NEJM, 2009; 360:1414-28. Available on-line at: http://content.nejm.org/cgi/content/abstract/360/14/1418.

This is a *necessary* but not *sufficient* condition to make the health information actually flow across settings. **Such seamless flow of health information and "meaningful use" can only be achieved if long-term care providers are included as active partners in the ARRA-funded planning and implementation HIT projects** aiming at facilitating the exchange of health information. In fact, the long-term sector is ready to embrace electronic health records, with almost 100% of nursing homes and home health agencies having electronic billing and electronic reporting of federally-required health and functional status assessments (i.e., the MDS and OASIS). These assessment requirements have enabled 20% (or more) of nursing facilities and more than 61% of home health agencies to implement electronic information systems functionalities equivalent to an Electronic Health Record (including physician orders, medication orders/drug dispensing, laboratory/procedures information)[2,3,4]. Furthermore, adoption of HITSP-accepted assessments standards by CMS as it goes forward with new patient assessment requirements for nursing homes, home health agencies, and other provider settings will accelerate the adoption and use of interoperable EHRs by these providers, and will help improve safety, quality and continuity of care, and reduce unnecessary costs.

Regarding the certification process and measuring "meaningful use" moving forward, we believe that a setting-specific certification approach is too slow and may not maximize opportunities to support Sections 4101 and 4102 of ARRA. CCHIT certification could be accelerated by identifying core functional, privacy, security, and interoperability criteria that must minimally be met by all certified products, regardless of health care setting. As time permits, setting-specific certification criteria could be identified. This could lead to tiered certification: 1) minimally necessary criteria; and 2) advanced criteria. Part of the core functional and interoperability criteria should include the requirements that certified products be able to: a) produce and exchange HITSP-compliant transfer/discharge documents based on the Continuity of Care Document (CCD); b) generate and track reports regarding the number/percentage of times such reports were produced, electronically sent, and to whom/which settings the reports were sent; c) receive HITSP compliant CCD-based transfer/discharge documents; and d) generate and track reports regarding the number/percentage of times such reports were electronically received, and from whom/which settings the reports were received. Process measures related to health information exchange are needed to measure "meaningful use" and assess the effects of these policies. An example of a type of measure may include the number and/or percentage of times certain documents (e.g., transfer documents) are electronically exchanged using HITSP standards. This type of measure could be automatically generated and reported if CCHIT required that certified products track and generate reports based on the number of documents (by type) electronically exchanged and track the receiving providers and their settings (e.g., NF EHR, PHR, etc.).

Implementing our recommendations would ensure attaining a meaningful use of HIT, as required by ARRA, achieving a meaningful return on ARRA funds invested, and meeting the ARRA goal that each person in the U.S. has an EHR by 2014. We would be happy to meet with you in person to discuss our recommendations further, if needed, and we look forward to including these recommendations and comments that reflect long-term care providers' perspective in your Committee's report.

Sincerely,

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[2] Fazzi R, Ashe T, Doak L. Part I Insights From Philips National Study on the Future of Technology and Telehealth in Home. Available on line at: http://www.ctel.org/documents/Philips_2008_Home_Telehealth_Study_Slides.PPT#327,17,Barriers have slowed telehealth adoption.

[3] Resnick HE, Manard BB, Stone RI, Alwan M. Use of Electronic Information Systems in Nursing Homes: United States, 2004. In *Journal of the American Medical Informatics Association (JAMIA).* Available on line at: http://www.jamia.org/cgi/reprint/16/2/179.pdf.

[4] "Nursing Home and Home Health HIT Use Appears to be At Least Comparable to that of Physician Offices and Hospitals," available at http://aspe.hhs.gov/daltcp/reports/2009/HITlitrev.htm