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National Coordinator for Health Information Technology
Acting Assistant Secretary for Health
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200 Independence Avenue SW
Washington, DC, 20201

Re: *Office of the National Coordinator for Health Information Technology; Medicare Access and CHIP Reauthorization Act of 2015; Request for Information Regarding Assessing Interoperability for MACRA*

Dr. DeSalvo:

The Long-Term and Post-Acute Care (LTPAC) Health IT Collaborative ("the Collaborative") appreciates the opportunity to provide the following comments on the *Request for Information Regarding Assessing Interoperability for MACRA*. The LTPAC Health IT Collaborative is a public-private group of stakeholder organizations representing associations, providers, policy-makers, researchers, vendors, and professionals with a mission to coordinate the sector and maintain alignment with the national priorities.

The LTPAC Health IT Collaborative members reviewed and discussed the *Request for Information Regarding Assessing Interoperability for MACRA* and our comments, feedback and suggestions are below. In our response to the Request for Information, we provide background information including our assessment of the exchange and use of health information by our members. We also address the questions asked by the Office of the National Coordinator (ONC) on provider population, use of current measures, and future measures.

Background

Since the 2004 Presidential Order to digitize healthcare, the LTPAC Health IT Collaborative has played an important role in encouraging ONC and the Centers for Medicare and Medicaid Services (CMS) to incorporate LTPAC providers into national policymaking and strategy development for health information technology (IT). We appreciate ONC's thoughtful recognition that measuring widespread interoperability cannot be limited to only Meaningful Use (MU)-eligible professionals and hospitals. We offer these foundational considerations as the basis for our comments.

- LTPAC provider organizations[1] require frequent bi-directional communication and health information exchange (HIE) with hospitals and other care professionals for ensuring seamless transitions and coordination of care.
- LTPAC plays a valuable and necessary role in the continuum of care, as discussed in detail in a May 2015, *ONC Brief: Health Information Technology Use & Value Delivered by the Long-Term &*

[1] Skilled Nursing Facilities (SNF), Assisted Living Facilities (ALF), Home Health Agencies (HHAs), Inpatient Rehab Facilities (IRF), and Long Term Acute Care Hospitals (LTCH), as well as associated providers and suppliers of services.

Post-Acute Care Sector.[2] The Brief outlines five Valued Quality Coordination of Care (VQCC) differentials that LTPAC organizations provide to the healthcare delivery system, such as the ability to deploy a multidisciplinary team and coordinate with multiple care-givers to support longitudinal care planning, care delivery, e-assessments, medication management, and discharge planning for the elderly, chronically ill, clinically complex individuals.

- Because Meaningful Use incentive funding was limited to certain acute care hospitals and physicians, LTPAC providers and other associated professionals excluded from the program have much lower, and much more variable, rates of IT adoption and usage (see next section for further discussion on this point). This group will require special considerations and targeted approaches to measuring interoperability and understanding how it contributes to the care of the very diverse population of patients they serve.

Scope of Measurement: Defining Interoperability and Population (page 6)

Overall Assessment of LTPAC Interoperability Today

The Collaborative supports the notion that good information is essential for good care and needs to be accessible from and contributed to by all providers of care, as well as by the patient and their agents. While we believe there is a shift in perception that LTPAC providers have no or limited health IT, we acknowledge that specific capabilities are highly variable among organizations.

- Anecdotally, electronic information exchange and use is still very limited and built opportunistically, using the best available technology. The cost (time, resources) varies as much based on local expertise and infrastructure as on the core capabilities of the providers' health IT.
- Plug-and-play interoperable standards are still in the future. We can achieve limited success by being narrowly focused in our goals, as was seen with e-prescribing. Widespread interoperability is a journey, not a single endpoint.
- LTPAC and other provider types were not eligible for MU incentive funding alongside hospitals and physicians. An unfortunate result of this reality has been a widening gap in information exchange capability between eligible and ineligible provider types. Furthermore, within the LTPAC provider community, IT adoption and use is widely variable, with many small, independent, and rural providers much further behind their corporate peers.
- Providers who were not eligible for MU incentive funding must make judicious use of their own resources in adopting health IT. The timing, pace and costs of acquiring and implementing interoperable health IT must provide high value to justify the resources required. Interoperability is needed for a wide range of health information technology, including but not limited to Electronic Health Records (EHRs).

Recommendation for Defining Interoperability and Population (Page 6)

Even though the health IT adoption in LTPAC is lower and more variable than incentivized eligible hospitals and professionals, measures of interoperability and outcomes must be inclusive of the

[2] http://www.ltpachealthit.org/sites/default/files/ONC%20Brief%20LTPAC%20HIT%20Value%20and%20Use_May%201%202015.pdf

population and consistent with the overall ONC Interoperability Roadmap, not just for the immediate MACRA deadline. Any measure put in place will almost certainly have a long life. Well-chosen measures will create a foundation for the future.

ONC's Available Data Sources and Potential Measures and Measures Based upon National Survey Data

Comments on Provider Population (Page 9)

The Collaborative supports ONC's efforts to include users of health information beyond the scope of Meaningful Use (MU). Physicians who practice in nursing facilities face unique challenges, similar to but distinct from the challenges facing hospital-based physicians. Because MU applies to these physicians regardless of their primary practice setting, many have adopted certified EHR technology in their practice, which oftentimes cannot integrate with LTPAC facility EHR, because LTPAC providers were not required to adopt *certified* products. This divergence has complicated the ability of LTPAC physicians to seamlessly coordinate the care for their patients. The Collaborative maintains that any effort to encourage interoperability and adoption of technology must consider the unique challenges faced by LTPAC physicians, provider organizations and partners.

Almost all Medicare admissions to post-acute care providers come from a hospital. This is recognized in the Meaningful Use requirement for eligible hospitals to send care summaries when patients are discharged. However, this exchange has been less than ideal: there were operational requirements beyond the mandated standards, there were timing mismatches as providers implemented the needed technology, and the use of the technology is largely disconnected from the actual care delivery processes. We must learn from this experience and focus on drawing the maximum value and use of established, available technologies.

Use of Survey-Based Measures (page 13)

1. Survey all providers using standard questions

   To fully understand the range and capability of information exchange and use along the continuum of care, a broad and comprehensive survey of LTPAC and affiliated providers is needed. The survey should include standard questions across all care settings and provider types to establish a common ground for comparison. ONC should partner with industry to sponsor and conduct a national survey, similar to their partnership with the American Hospital Association on the national, annual hospital-focused survey.

   The survey should assess health information exchange (HIE) and use (is it used or not, within an organization and with others, and for what purposes) as well as the technologies used. The theory of standards-based interoperability should not blind us from seeing what already has been implemented. Historically, numerous standards are proposed and have limited adoption while only a very few become widespread.

Finally, the biggest drivers of adoption are economic – those which provide both monetary and non-monetary value. The survey should also seek to understand both the drivers and barriers to adoption.

2. Surveys (AHA Hospital Survey and NCHS Physician Survey)
   The referenced surveys do not cover long-term and post-acute care providers or their affiliated care partners, with the exception of long-term care hospitals and inpatient rehabilitation facilities.

   The NCHS National Study of Long-Term Care Providers has limited information on use of electronic health records and the exchange of information for adult day services and residential care communities, but does not collect any IT-related information for most LTPAC provider types. Expanding this national study could provide more complete information for improved policy making. (Please see our previous comments and recommendations on surveys above.)

   In addition to the surveys mentioned by ONC in the RFI, there are several surveys currently underway by academic researchers, provider groups, and others. We call specific attention to these two as potential data sources for ONC:

   - Alexander GL, Madsen RW, Miller EL, Schaumberg MK, Holm AE, Alexander RL, Wise KK, Dougherty ML, and Gugerty B. (2016). A National Report of Nursing Home Information Technology: Year One Results. Journal of the American Medical Informatics Association. DOI: http://dx.doi.org/10.1093/jamia/ocw051 First published online: 23 April 2016.

   - LeadingAge/CAST has developed a 7-Stage EHR Adoption Model for LTPAC. Data from vendors about where their provider clients are with respect to the 7 Stages were collected through the CAST EHR Initiative update. They expect to release their findings as the CAST 2016 LTPAC EHR Matrix at the LTPAC Health IT Summit in June, 2016. http://www.leadingage.org/EHR.aspx

3. Use of Survey for developing measures of information exchange and use
   Surveys are a useful tool for measuring information exchange and use. As stated previously, we would encourage consistent questions across all provider types. Additionally, surveys can be an excellent method for identifying best practice use cases and promoting their adoption.

EHR Incentive Program Measures (Page 13-16)

Consistent measures regardless of setting/provider type (as appropriate and relevant). Good measures of interoperability and interoperability-sensitive outcomes are needed and will require public and private collaboration and investment.

The Meaningful Use interoperability objective to send a C-CDA Care Summary at transitions of care was expected to encourage exchange and use. While it has increased the technical capability to exchange, it does not appear to have increased use. **The LTPAC Health IT Collaborative encourages research on where this objective is providing value to improved care and what has enabled that improvement.**

Identifying Other Data Sources to Measure Interoperability (Page 16-17)

1. Build on Current Mandates – IMPACT Act of 2014

   The IMPACT Act strives for consistent assessment elements, data elements and quality measure across post-acute and long-term care providers. Ideally there will also be consistency with acute care hospitals and physician practices. This will be an important area for interoperability and it should be measured.

   The IMPACT Act of 2014 calls for a defined set of consistent assessment elements across providers and setting types, as well as consistent quality measures across those providers. The first of these go live in October of 2016, with additional elements over the subsequent three years. CMS is preparing to unveil a website that will list data standards that correspond with the cross-setting standardized assessment elements. This will be a step towards interoperability as IT vendors can be encouraged to utilize these standards in their EHR products. As these types of standards are developed and published, they will support wider information exchange, use and re-use. This will be an important area for interoperability and it should be measured. *(It is important to note that the IMPACT Act requires the data elements to be standardized and interoperable—there is no requirement for providers to use electronic means to exchange the data.)*

   By October 1, 2018, the IMPACT Act mandates that a quality measure for "Communicating the Existence of and providing for the transfer of health information and care preferences" be specified. While providers are not required to meet this quality measure using electronic means, the effort by CMS to standardize what data is to be transferred will be a major step toward standardizing the workflow of transferring data, and in using it in care delivery.

   Efforts to encourage more use of the mandated assessments, converting the standard MDS and OASIS into C-CDA documents, are just now becoming implemented with a few health information exchange organizations. ONC should study and learn from these organizations, and if applicable, encourage the adoption of any identified best practices.

2. Health Information Exchange Participation

   LTPAC provider participation and engagement in HIE varies greatly on many factors, including local market forces and cost structures. For example, while some communities provide support for LTPAC providers and may offer no/low-cost subscriptions with no/low-cost charges for LTPAC providers, others charge considerable fees for HIE participation with little or no special consideration for LTPAC. Some HIEs are offering hybrid payment models, wherein some services

are free, to provide the data needed by others, and other services (which more directly benefit the LTPAC provider) have associated charges. **Nonetheless, measuring the types of use and information included in the exchanges would provide insight into the adoption of HIE services by a wide range of provider types.**

The recent letter to State Medicaid Directors, which expanded the availability of federally-matched funds for connecting MU-eligible providers with other providers, is an example of the type of support LTPAC providers need. We applaud this opportunity, and we encourage ONC to analyze how this additional funding helps the government achieve its goals around interoperability.

HIE-sensitive clinical outcome measures should focus on results rather than methods. We believe this is needed and important for supporting local innovation while achieving national goals.

Automated technical measures (of volume and data quality) will provide an opportunity to monitor the flow of information. This has been very helpful in assessing the adoption of e-prescribing and should be extended to other types of exchange.

3. Admission/Discharge/Transfer (ADT) Notification Services

Knowing where an individual is receiving care in near-real time is an important aspect of managing a population. As payment shifts to population health, ADT notification is a core capability. These services are offered by a range of organizations, from some that only provide this notification to more broad-based HIEs that offer this as an additional service. LTPAC and other non-MU providers participate in these notification services. Measuring the providers who are connected this way and the type of notification provided would provide a quantitative view of this exchange and use.

4. New Payment Models and Outcomes that are Sensitive to Interoperability

New payment models reward coordination of services and reuse of information. They will drive exchange and use, though the technologies will likely be highly variable.

The many types of Value Based Payment, including the Comprehensive Care for Joint Replacement Model (CJR), are leading to increased care coordination and collaboration among providers. Information exchange and use is a key element of these partnerships. The performance of the providers in these arrangements will depend on their communication capabilities and is expected to drive increased electronic exchange and use of health information.

The various measures of hospital admissions and readmissions should also be an outcome sensitive to the quality and quantity of information being exchanged and used. The information must be timely and complete to be useful for managing a care transition.

5. Other Emerging and Potential Types of Data Sources:

The **Comprehensive Shared Care Plan** (CSCP) shows great promise for coordinating care in accord with patient preferences. The current pilots need to be encouraged to further expand their implementation and to serve as a test bed for policy and standards development. At this time, we see this as a research and development effort, not yet ready for widespread adoption. We should measure progress toward this capability.

Medication management is a clinically important area that can benefit from good information across care providers. This is an area which has particular importance to frail individuals with multiple chronic conditions and a large number of medications. The IMPACT Act requires medication reconciliation to be measured beginning October 1, 2018, for most LTPAC providers. Use of antipsychotics, opioids and antimicrobials are all important classes of drugs to manage well and their management aligns with national priorities.

Public health reporting programs offer an opportunity to build on consistent standards including disease registries, immunization registries, and syndromic surveillance. We can learn from the experience with the Minimum Data Set[3] (MDS) submissions: initially, States were responsible for developing their own MDS submission infrastructure and were developing multiple different ways to submit data. Eventually the federal government assumed responsibility for all MDS submissions. Having a single method and consistent technology for submitting the MDS, and other PAC assessment instruments, simplified the process for providers and their technology vendors. That said, any change in technology would require sufficient time and resources for providers to implement.

The LTPAC HIT Collaborative appreciates the opportunity to share our comments on the *Request for Information Regarding Assessing Interoperability for MACRA* and we look forward to working with you on any of the issues highlighted in these remarks.

Best Regards,

LTPAC Health IT Collaborative

Submitted electronically on behalf of the LTPAC Health IT Collaborative by:

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[3] The Minimum Data Set -(MDS) is a federally mandated assessment instrument for skilled nursing facilities.