

February 6, 2015

Karen DeSalvo, MD, MPH, MSc
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Suite 729-D
Washington, D.C. 20201

RE: Draft Federal Health IT 5-year Strategic Plan

Dear Dr. DeSalvo:

The Federal Health IT 5-year Strategic Plan (the Plan) identifies the federal government's health IT goals for the next five years and sets measurable objectives to achieve them. The Visiting Nurse Associations of America (VNAA) appreciates the opportunity to provide input on the Plan and to recommend ways to support and encourage the use of health IT by home health and hospice agencies, including VNAA's nonprofit members.

VNAA is a national organization that supports, promotes and advances mission driven, nonprofit providers of home and community-based healthcare, hospice and health promotion services to ensure access and quality care for their communities. As safety net providers, VNAA members provide care to all patients regardless of their ability to pay or the severity of their illness and serve a mixture of Medicare, Medicaid, privately insured and uninsured patients.

VNAA members provide high quality, patient-centered care at home as well as offer support for family caregivers. They serve the most clinically complex and vulnerable patients who are by definition homebound and who will benefit from having closely integrated health exchange between all members of the care team. Two of the most significant challenges in health care delivery today are reducing unnecessary hospital admissions and improving management of patients with chronic conditions. Home health, including home-based palliative care and hospice, plays a critical role in coordinating care for vulnerable patients and provides medically necessary care to prevent a hospitalization, as well as to prevent unnecessary readmissions to the hospital. Home health providers work with physicians and hospitals, and play an important role in helping keep patients in their homes longer. Through health information exchange, providers will be able to receive and share information in real time and help to realize the goals of new payment models and enhanced care coordination.

Home health and hospice providers have been in the vanguard of health IT adoption, devoting already-stretched resources to incorporate health IT into their practice and using new technology to improve patient care and to make the coordination of a patients care seamless across all settings. Our member's experiences show the positive impact of health IT both on improving patient outcomes and reducing preventable costs like readmissions. These providers have accomplished

this without benefiting from the financial and technical assistance that was made available through ARRA for a subset of providers.

The current state of health information technology, telehealth and mobile health applications in home care is complex. At a high level, home care and hospice providers routinely use electronic health records to manage patient care but confront significant challenges related to the interoperability of these records with the hospital and physician provider offices operating in their communities. Barriers to interoperability are both technical and political. Systems are not yet capable of speaking to each other, health information exchange is nascent in many places, and some providers continue to treat patient data as proprietary and resist sharing it with providers outside of their system or accountable care organization.

There are many ways to promote the use of health IT by long-term supports and services and post-acute providers. In particular, home health and hospice providers need additional financial and technical support in order to expand their capacity, invest in needed health IT systems, and maintain the work force needed to fully adopt health IT. Below, we offer specific comments on areas where the Plan could be strengthened to advance our shared goal of a truly interoperable health IT system.

Goal 1: Expand Adoption of Health IT

- ***Objective 1A: Increase the adoption and effective use of Health IT products systems and services***

While many home health and hospice providers already use health IT, not all do. Post-acute providers were not included in the Meaningful Use Incentive Program and have not had access to the same financial resources, technical assistance and support as other providers. In addition, there are few EHR products designed to capture the unique workflow of hospice providers in particular. The result is slower adoption among post-acute care providers and limited ability to compile and share health information electronically across the continuum of care. We recommend a specific strategy focused on educating and supporting long-term supports and services and post-acute providers. Elements of this strategy include technical assistance, direct community- and provider-level support, and the development and dissemination of best practices specific to post-acute providers. Federal policy should also encourage the design of products for post-acute care providers by offering certification criteria, and developers and vendors should look particularly to hospice providers to build high-quality products to meet their needs. As more providers across the care continuum use health IT, developers and vendors must meet the challenge of building innovative products that support all aspects of health care delivery

Another disincentive toward adoption among many post-acute care providers is the growing information silo between health care systems and independent providers. This occurs for two primary reasons: 1) lack of interoperability across different EHR vendors, and 2) business practices by health systems that treat patient data as proprietary. There is less of an incentive to invest in HIT and HIE when providers know there will be significant barriers to fully utilizing the technology. We encourage CMS to expedite standards for interoperability and require all providers to share data with other others, regardless of whether the providers are within the same system, ACO or other governance structure. We further expand on this recommendation in our comments on Goal 2: Objective 2A below.

- ***Objective B: Increase user and market confidence in the safety and safe use of health IT products, systems and services***

No comments.

- ***Objective 1C: Advance a national communications infrastructure that supports health safety, and care delivery***

Home health and hospice providers often travel great distances to support clients in their homes and communities. Telehealth and remote patient monitoring, as well as remote access to patient records, enhances providers' ability to develop and adhere to a care plan, and the ability of homebound home health and hospice patients to interact with their providers and receive high quality care at home rather than in the hospital. This is especially true in rural settings where access to cellular data and broadband is often unreliable or unavailable.

To realize the full potential of telehealth and remote patient monitoring, high-speed and wireless broadband is vital. VNAA strongly supports a national communications infrastructure that supports the delivery of care.

Goal 2: Advance Secure and Interoperable Health Information

- ***Objective 2A: Enable individuals, providers and public health entities to securely send, receive, find, and use electronic health information***

Home health and hospice providers rely on accurate and complete patient records to best manage a patient's care and ensure the care plan is implemented. Interoperable health information facilitates more efficient care and earlier interventions. It can help identify patients in distress; allow family caregivers to consult with a provider instead of heading to the emergency department; and provide follow up monitoring that can help prevent readmissions. For example, emerging technologies allow a home health nurse to transmit images—such as with wound care—to specialists or providers for an on-the-spot assessment rather than arranging for an office visit or a specialist nurse to visit the patient. Basic video conferencing allows patients and caregivers to show members of the home health team virtually how they are doing that day and enable the teams to make better decisions about the right time for their next visit.

More complete medical records also facilitate program integrity efforts and ease administrative burden on providers, CMS and the Medicare Administrative Contractors (MACs). For example, in order to be eligible for home health services, a Medicare beneficiary must meet a number of criteria. Evidence that the individual meets the criteria must be included in the patient's records with some of it specifically required to be in the referring physicians' records. Today, home health agencies must request copies of portions of the referring providers' medical records to demonstrate compliance with the eligibility rules during audits. Interoperable medical records reduce the administrative burden on both the home health agencies requesting the records and the referring physicians providing the records. The time the MAC (or other auditor) waits to receive the complete records is reduced. In addition, home health agencies will be able to check the records on their own and identify problems earlier, before an audit process is even launched. We also anticipate that more complete medical records will facilitate CMS' efforts to identify fraudulent referrals for home health services.

In order to achieve the promise of efficient health IT, systems must be interoperable. Standards must be in place for all members of a care team to securely send and receive information about a patient across different EHR systems. In regions with heavy penetration by a single EHR software, or in the case of a hospital-led demonstration project, small providers are often pressured to purchase the same EHR as everyone else. For small providers and/or those who have already invested significant resources in a certified EHR, it may be financially out of reach to purchase a new program. Interoperability ensures that all authorized providers can securely access a patient's information even if they use a different system.

For these reasons, VNAA supports a federal requirement that all Medicare and Medicaid participating providers engage in the exchange of interoperable patient data with all appropriate providers consistent with HIPAA and any other federal and state privacy rules.

We recognize that there are barriers to true interoperability, including some technological standards that still need to be developed. But it is important to note that there are also strong incentives by vendors and some providers to keep their software and EHRs proprietary for market purposes. Providers may be influenced by financial incentives that are not always appropriately aligned with the broader policy goals to provide cost-effective and high-quality patient care. The federal government should play a strong role in breaking these perverse incentives to ensure that a patient's data is accessible by all members of the care team regardless of the software platform they use.

- ***Objective 2B: Identify, prioritize, and advance technical standards to support secure and interoperable health information***

VNAA recommends that future standards and technical specifications integrate unstructured data into clinical records. Unstructured data such as patient or caregiver-generated information is important to all members of the care team to understand what a patient's goals are and to truly put the patient in the center of the care. Data from other community-based organizations, such as Meals on Wheels or church providers, complement health records and shows the full range of services a homebound patient needs and will assist providers in recognizing and addresses the social determinants of health. It is critical that EHRs be able to capture and share these data, and that all providers on the care team have access to the information.

VNAA also recommends continued development of standards for documenting care coordination and care transitions.

- ***Objective 2C: Protect the privacy and security of health information***

VNAA strongly supports the strategies in this objective to maintain the privacy and security of health information. We urge that the Plan add an additional strategy of educating post-acute providers about their rights and responsibilities regarding the privacy and security of their EHRs and provide the resources necessary to aid small providers to make informed choices in their EHRs.

Goal 3: Strengthen Health Care Delivery

- ***Objective 3A: Improve health care quality, access, and experience through safe, timely, effective, efficient, equitable, and person-centered care***

VNAA members are engines of innovation, actively engaged in Accountable Care Organizations (ACOs),

bundled payment demonstration projects and innovations designed to resolve breakdowns in care for patients with multiple chronic conditions. VNAA champions the transition to value-based payments that incentivizes and rewards high quality, efficient care across the continuum of care, and our members are leaders in care coordination and transitions.

Concord Regional VNA in Concord, N.H. is partnering with the Dartmouth-Hitchcock Medical Center, Medical Center Primary Care Providers to provide medication reconciliation for 204 Medicare beneficiaries with chronic medical conditions. First year results show a decrease in hospitalization rates from 27 percent to 24 percent and an increased patient satisfaction rate from 81 percent to 87 percent.

Sutter Care at Home in Fairfield, Calif. is using an Integrated Care Model for patients with chronic conditions. Two years after implementation, acute care hospitalizations decreased from 29 percent to 14 percent, nurse turnover rates decreased from 20 percent to 6 percent and patient experience scores also increased.

The Visiting Nurse Service of New York (VNSNY) in New York, N.Y. is partnering with Mount Sinai Hospital in New York City to develop a hospital to home care program for patients following cardiothoracic surgery with the purpose of preventing 30-day readmissions. In a three-month period, 131 Mount Sinai patients included in the program were admitted to VNSNY and all 131 avoided SNF admissions.

VNA of Somerset Hills in Basking Ridge, N.J., partnering with a primary care group in a telehealth initiative, is providing a program to identify symptom severity in COPD and CHF patients for early interventions. This program yielded a zero percent 30-day readmission rate for the 27 patients enrolled.

While VNAA is optimistic about the ability of delivery system reforms to drive high value healthcare, we believe that there is still much work to be done. Today, vulnerable patients often receive care that is fragmented and sometimes inefficient. Interoperable electronic health records, telehealth and remote monitoring support home health agencies and hospice providers in coordinating care and helping patients understand and maintain their health. Health IT is foundational to realizing the promise of delivery system reform.

- ***Objective 3B: Support the delivery of high value health care***

VNAA supports the federal government's work to align quality and other reporting requirements. We strongly support the use of health IT to simplify participation in care delivery models and the reporting requirements across programs for quality and claims information. In this objective, the Plan should provide strong technical assistance to providers to help them succeed in innovative models and encourage coordinated management for their populations.

We also support the outcome of facilitating clinical reporting and feedback to providers to improve population health.

- ***Objective 3C: Improve clinical and community services and population health***

Home health agencies and hospice providers routinely integrate individual health information from multiples sources to better treat patients. As noted above, we strongly support the sharing and integration of all data that are relevant to treating the patient, including non-medical data.

VNAA supports promoting data collection and building clinical decision support tools for long term and post-acute providers. Our providers already identify individuals and communities that are underserved and/or at risk for timely health interventions. Using health IT to coordinate all preventive and social services, they can better facilitate coordination and implementation of comprehensive care delivery.

Goal 4: Advance the Health and Well-Being of Individuals and Communities

- ***Objective A: Empower individual, family and caregiver health management and engagement***

Many homebound patients rely on a complex network of caregivers and medical professionals to manage their care. Home health and hospice providers work with patients and their caregivers to identify their own goals and participate in informed shared decision making. Health IT empowers both individuals and caregivers to participate in the care plan and to work their providers to better understand their health information.

VNAA supports the dissemination of health IT tools and education resources for individuals to enable them to understand their health information and their care plan. We support health IT policies and technologies that allow designated caregivers and patient representatives access to health information and health education. Working together, this will allow individuals and their care team to better manage their health and result in better outcomes.

- ***Objective B: Protect and promote public health and healthy, resilient communities***

No comments.

Goal 5: Advance Research, Scientific Knowledge, and Innovation

No comments.

Thank you for the opportunity to provide input. I would be glad to answer any questions you might have about these comments.

Sincerely,



Tracey Moorhead
President and CEO

Cc: Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services