



February 6, 2015

Office of the 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: Federal Health It Strategic Plan, 2015-2020

To Whom It May Concern:

The SCAN Foundation (Foundation) appreciates the opportunity to comment on the *Federal Health IT Strategic Plan, 2015-2020*. We are dedicated to advancing a person-centered, coordinated, and easily navigated system of high-quality services for older adults that preserves dignity and independence. A strong health IT system is fundamental to supporting a high-quality person-centered system of care. We commend the Office of the National Coordinator for establishing bold goals to increase the use of health IT across the continuum of care.

Goal 1: Expand adoption of health IT

On page nine, the aim of goal one is described to expand health IT adoption and use, “emphasizing use assistance for health providers serving long-term and post-acute care, behavioral health, community-based, and other populations ineligible to participate in the Medicare and Medicaid EHR Incentives Programs.” Given that long-term care service delivery utilizes a wide range of providers, we recommend clearly stating the types of providers and/or sites of care for whom the assistance is intended. We further recommend that community-based organizations that provided LTSS must be included as a provider type in order to fully expand the use of health IT across the continuum of care.

Goal 2, Objective 2C: Protect the privacy and security of health information

We commend the federal government’s dedication to protecting the privacy and security of individual health information while expanding the use of health IT. One of the outcomes for objective 2C is to increase the reach of education and training information and tools for health IT privacy, security, and cybersecurity. This is an important outcome especially as it applies to HIPAA. A limited understanding

of HIPAA can be a barrier to providers using health IT to better coordinate care. It is important for providers to protect the privacy and security of an individual's health information, but also understand how to share appropriate information across the continuum of care to support person-centered care and coordination of health and LTSS services. We recommend that training and information should be made available to providers to develop an understanding of how they can share information appropriately in the effort to coordinate care while acting in-line with policy and managing their liability. Additionally, we believe individuals should have choice and control over their care to the extent possible. We recommend that when developing the standards for health IT, systems are established that give individuals the opportunity to decide how and to whom their health information is shared. For example, this recommendation would allow the individual to identify the members of their individual care team (doctors, specialists, LTSS, mental health, ect.), and then designate who has access to what information.

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

- Person-centered care: Person-centered care is a term that is growing in use, but has a multitude of definitions. We recommend that the ONC define person-centered care for the purposes of this work in order to establish clear expectations. The Foundation has published two policy briefs on its views related to person-centered care: 1) Achieving Person-Centered Care: The Five Pillars of Systems Transformation (<http://thescanfoundation.org/achieving-person-centered-care-five-pillars-system-transformation>), and 2) Achieving Person-Centered Care Through Care Coordination (<http://thescanfoundation.org/achieving-person-centered-care-through-care-coordination>). We are also currently developing a definition and operational parameters of person-centered care in partnership with an expert advisory panel, and would be happy to share that definition when available later this spring.
- Care team: A key component of person-centered care is inclusion of the individual as an active member of their care team where the individual directs their care to the extent possible. With this in mind, we recommend changing the term "providers" to "care team" in the first paragraph under objective 3A: "Information exchanged and used electronically improves the ability of the providers to make well-informed and coordinated care decisions quickly and safely."
- Self-reported information: Strategy five is written to encourage self-reported outcomes, accommodations, and preferences as a part of the health care and LTSS delivery. Creating a health IT system that allows individuals the opportunity to express their goals, needs, and preferences is in-line with person-centered care. We recommend the development of a health

IT system that collects and manages both quantitative and qualitative data that can be used to inform an individual care plan and evaluate quality of care.

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

Health care and long-term care systems vary in how services and outcomes are documented, often “speaking different languages.” It is important that the evolution of health IT addresses the needs and concerns of each provider type to encourage participation across the continuum of care, particularly minimizing the entry of information multiple times due to multiple and possibly conflicting reporting, billing and quality measurements systems. For example, a community-based LTSS provider may have to communicate with a state agency, federal agency, and/or a health plan depending on the funding source for the service provided all using different data systems and reporting requirements. We recommend identifying the different types of services and their current reporting requirements and mechanisms to develop a plan that leads to creating the most efficient and effective health IT system.

Goal 3, Objective 3C: Improve clinical and community services and population health

A recent report by Avalere Health describes the value of targeting services based on a comprehensive assessment and implementing person-centered care coordination. The research demonstrated that an enhanced health risk assessment used by Medicare plans that assesses medical, social, and functional needs can be used to target individuals for care coordination. This research also analyzed the return-on-investment (ROI) for various care transition and care coordination models when targeted to high-cost individuals, and found that each model studied resulted in a positive ROI. This report can be found at <http://avalere.com/news/avalere-issues-white-paper-on-the-management-of-high-risk-medicare-populati>. We recommend the health IT system incorporate a way to collect data from a comprehensive assessment that includes functional ability in order to support person-centered care coordination.

Thank you for the opportunity to comment on the *Federal Health IT Strategic Plan*. Please feel free to contact the Foundation with any questions.

Sincerely,



Bruce Chernof, MD  
President and CEO