I would like to thank the committee members for their outstanding work.

I am an internist/geriatrician and spend half of my time providing post-hospital care to individuals at a high intensity skilled nursing facility. The remainder of my time is spent on transitions of care and the integration of care within a Pioneer ACO and working with the ONC S&I Framework, HL7 and the IMPACT Challenge Grant to define and standardize the essential clinical information needed to support transitions and longitudinal coordination of care.

My remarks address the "Why", the "What" and the "How" of LTPAC EHR certification:

"Why" do we need LTPAC EHR certification? Health care has changed fundamentally and will continue to change as our population ages and individuals accumulate an increasing burden of chronic conditions. Instead of brief encounters with the health care system for an acute illness, more and more individuals have, and will have, episodes of acute illness superimposed on chronic conditions. The result is more complex care, provided in multiple sites by multiple clinicians across longer episodes of care and this is increasing.

These individuals increasingly encounter two fundamental health care processes. The first is the transition of clinical responsibility from one clinician or clinical team to another with the information required to safely and efficiently exercise that responsibility, also known as a transition of care. Each exchange from site to site or team to team is a transition. Each level of increasing clinical complexity generates additional transitions as acute conditions are superimposed on more and more chronic conditions: each combination requiring more participants and more sites of care. Failed transitions are a leading cause of adverse events. (Gandhi, et al., 2000).

The second process is the exchange of a longitudinal care plan to align care across multiple sites and providers and thereby reduce the risks of omissions and duplications. The literature documents the adverse events that result from inadequate coordination of care (Lu, et al., 2011). Poor transitions of care and failures to coordinate care result in frequent, avoidable, adverse events and billions of dollars a year of avoidable health care costs (Gandhi et al., 2003. Forster, et al., 2003. van Walraven, et al., 2002). LTPAC EHR certification would set the foundation for these two essential processes.

The 2012 Medicare Chart Book identified 14% of Medicare beneficiaries who have six or more chronic conditions, receive care in multiple sites from multiple, often unaffiliated, providers, and experience many transitions of care. They account for 46% of all Medicare spending and for 70% of all Medicare 30-day readmissions. 70% have one or more ED visits per year, 63% have one or more hospital admissions per year. Importantly, 41% go on to receive care in LTPAC sites. In fact, the total amount spent on LTPAC care for these patients exceeds the amount spent on acute hospital care. Because of their complexity, engagement with multiple providers, and care in multiple sites, these patients are at highest risk for failed transitions and poorly coordinated care. This is the "why".

The "What". Both transitions and care coordination require the exchange of essential clinical information, but very few LTPAC providers share a common EHR platform with their acute care partners, nor is it likely that this will become a widely adopted model. It is far more likely that LTPAC providers will share care with several acute care partners all using different IT platforms. The electronic exchange of standardized, interoperable clinical information between different IT platforms becomes the essential tool for care integration between and among acute and LTPAC providers.

And the importance of this cross platform exchange is not limited to LTPAC but applies as well to the management of any complex patient receiving care from multiple sites whether acute and acute or acute and LTPAC.

Thanks to the work of scores of national organizations (see attachment), there are data elements which can now serve as a national standard for transitions of care and longitudinal coordination of care. The HL7 Domain Analysis Work Group, the ONC Longitudinal Coordination of Care Work Group, ASPE and others have nearly completed the final stages of HL7 ballot reconciliation for these data elements which will be available for reference as certification standards early in 2014. At a minimum, EHR certification for both EPs and LTPAC sites should include the capacity to send and receive these standardized data elements to support transitions and care coordination.

Finally, Section 3, "How" to promote adoption of these standards, this is less clear.

Where is the business case for vendors to built IT systems to meet these proposed standards, and for LTPAC sites to acquire these systems? There are no MU incentives. Although some "at risk" provider organizations may fund the certified technology needed to support these exchanges, this is unclear that this will be sufficient to drive the creation and widespread adoption of these capabilities.

It may take CMS to build off the increasing focus by NQF, TJC and other quality standards organizations on transitions and longitudinal care. Were CMS to adopt a quality standard requiring the electronic exchange of these essential clinical data elements, that standard alone would create the business case for the adoption of certified LTPAC EHRs. And if adoption were tied to quality incentives that provided the opportunity to partially defray the cost of implementation, these new quality metrics would accelerate the adoption.

In conclusion: we need improved transitions and longitudinal coordination of care, we have available standards for LTPAC EHR certification; and we need to find the engine to power this transformation. LTPAC EHR certification is a necessary next step. Thank you for the work you are doing to move this forward

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Appendix

Participants

- New York eHealth Collaborative (NYeC)
- Healthix
- Continuum of Care Improvement Through Information New York (CCITI NY)
- Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Centers for Disease Control (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Department of Defense and Veterans Administration
- Massachusetts eHealth Institute (MeHI)
- Lantana Consulting Group
- AHIMA LTPAC HIT Collaborative

- HIMSS Continuity of Care Model
- Multiple EHR Vendors
- American College of Physicians
- NY's eMOLST
- Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
- Substance Abuse, Mental Health Services Agency (SAMHSA)
- Administration for Community Living (ACL)
- Aging Disability Resource Centers (ADRC)
- National Council for Community Behavioral Healthcare
- National Association for Homecare and Hospice (NAHC)
- Longitudinal Coordination of Care Work Group (ONC S&I Framework)
- Transfer of Care & CCD/CDA Consolidation Initiatives (ONC's S&I)
- Electronic Submission of Medical Documentation (esMD) (ONC S&I)
- ONC Beacon Communities and LTPAC Workgroups
- Assistant Secretary for Planning and Evaluation (ASPE)
- Geisinger: Standardizing MDS and OASIS
- Centers for Medicare & Medicaid Services (CMS)(MDS/OASIS/IRF-PAI/CARE)
- DoD and VA: working to specify Home Health Plan of Care dataset
- AHIMA LTPAC HIT Collaborative
- HIMSS: Continuity of Care Model
- **INTERACT** (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers)
- Transfer Forms from Ohio, Rhode Island, New York, and New Jersey