Comments for Home Health and Applicable Meaningful Use Standards

As demographics change and the population ages, community based care is in high demand with the need for in-home care options growing every day. As patients transition from a hospital setting, their continued recovery and rehabilitation is key to managing diseases and preventing readmissions. As the saying goes, "it takes a village" and in this case, these patients are at the core of an interconnected community of providers. This network of providers may include physicians, specialists, local health information exchanges, insurance companies, pharmacies, medical equipment suppliers, and others that contribute to the management of a patient's health care and lifestyle needs. Due to the critical need to have all of these external forces working together, ensuring patient data is current, accurate, and accessible is of supreme importance.

As the first line of defense in the delivery of care for many patients, home health agencies serve an important need. How they meet their objectives of providing patient care, however, is markedly different than those within a hospital or other inpatient setting. Home health agencies approach their duties from a unique vantage point. Whether it is the challenge of trying to provide services in physical surroundings that do not compare with that of a hospital or medical practice or the need to work with outside providers to confirm physician orders or fulfill supply requests, home care would not fit the standard health care mold. Consequently, holding home health providers to all of the same meaningful use standard would be ill-conceived. Special consideration should be given to which criteria apply and whether imposing certain standards is wise for their unique circumstances.

Using the recently published comments (http://www.healthit.gov/sites/default/files/generalcertexchangeguidance_final_9-9-13.pdf) about possible post-acute specific meaningful use guidance, it is clear that several items should be considered essential. In fact, several items are already considered mandatory for CCHIT LTPAC certification which would also prove to be useful foundation for post-acute care specific meaningful use standards. Specifically, the noted security standards should be considered critical, especially in a home care environment where patient data is often mobile and not always contained within the secure environment of a health care facility. These essentials should include:

45 CFR §170.314(d)(1) *Authentication, Access Control, and Authorization*	*Requires EHR technology to be capable of authenticating a user, authorizing them, and establishing their ability to access electronic health*
45 CFR §170.314(d)(2) *Auditable Events and Tamper-Resistance*	*Requires EHR technology to be capable of:* *• Recording user actions related to electronic health information in an audit log in addition to when the audit log or the encryption status of electronic health information locally stored on end user devices is disabled or enabled.* *• Being set by default to record actions related to electronic health information in an audit log, and recording audit log status or encryption status.* *• Only enabling specific users to disable an audit log, if possible.* *• Protecting actions and statuses related to the recording of electronic health information, audit log status, and encryption status from being changed, overwritten, or deleted by the EHR technology.* *• Detecting when the audit log has been altered.*
45 CFR §170.314(d)(3) *Audit Report(s)*	*Requires EHR technology to be capable of :* *• Enabling a user to generate an audit report for a specific time period, and* *• Sort entries in the audit log according to the data elements specified in the audit log content standard*
45 CFR §170.314(d)(4) *Amendments*	*Requires EHR technology to be capable of enabling a user to capture a patient's (accepted or denied) request for an amendment to their electronic health information.*
45 CFR §170.314(d)(5) *Automatic Log-Off.*	*Requires EHR technology to be capable of preventing a user from gaining further access to an electronic session after a predetermined time of inactivity.*
45 CFR §170.314(d)(6) *Emergency Access*	*Requires EHR technology to be able to permit an identified set of users to access electronic health information during an emergency.*
45 CFR §170.314(d)(7) *End-User Device Encryption*	*Requires EHR technology to be capable of encrypting electronic health information (following security standards from the National Institute of Standards and Technology) when it is designed to store such information on end-user devices after use on those devices stops.*
45 CFR §170.314(d)(8) *Integrity*	*Requires EHR technology to be able to use secure hashing standards to verify that electronic health information has not been altered.*
45 CFR §170.314(d)(9) *Optional – Accounting of Disclosures*	*Requires EHR technology to be able to record treatment, payment, and health care operations disclosures. The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations.*

In addition to the security elements, the following items are certainly important as home health strives toward greater interoperability. As work progresses on these standards it is important that home health is adequately prepared to receive, digest, and transmit data coming from multiple external sources. More importantly, the push toward standardization positions home health agencies to be better equipped to handle incoming data if there is a level playing field across the health care continuum. The elements important to interoperability include:

45 CFR §170.314(b)(1) ***45 CFR §170.314(b)(2)*** *Transitions of Care*	*These two certification criteria require EHR technology to be, at a minimum, capable of: A) electronically creating and receiving summary care records with a common data set in accordance with the Consolidated Clinical Document Architecture (CCDA) standard; and B) electronically exchanging in accordance with the Direct transport specification.*
45 CFR §170.314(b)(4) *Clinical Information Reconciliation*	*Require EHR technology to allow a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list.*
45 CFR §170.314(b)(5) *Incorporate Laboratory Tests and Values/Results*	*Requires EHR technology designed for an ambulatory setting to be capable of electronically receiving, incorporating, and displaying clinical laboratory tests and values/results in accordance with the HL7 Version 2.5.1 Implementation Guide: S&I Framework Lab Results Interface (LRI) and with laboratory tests represented in LOINC®.*
45 CFR §170.314 (b)(7) *Data Portability*	*Requires EHR technology to be able to electronically create a set of export summaries for all patients, formatted in accordance with the CCDA.*
45 CFR §170.314(c)(1)-(3) *Clinical Quality Measures*	*Requires EHR technology to be capable of capturing, exporting, importing, calculating, and electronically submitting the information necessary for clinical quality measures.*
45 CFR §170.314(e)(1) *View, Download, and Transmit to 3rd Party*	*Requires EHR technology to be capable of providing secure online access to health information for patients and authorized representatives to electronically view, download their health information in accordance with the CCDA standard, and transmit such information in accordance with the Direct transport specification.*
45 CFR §170.314(e)(2) *Clinical Summaries*	*Requires EHR technology to enable a user to create a clinical summary in accordance with the CCDA standard in order to provide it to a patient.*

Finally, one of the key factors of quality patient care is having access to accurate and timely clinical decision support tools. Much like the widely used drug and allergy interaction messaging, having medical knowledge information available for patient education purposes would certainly be critical. Therefore the following items are relevant to home health:

45 CFR §170.314(a)(8) *Clinical Decision Support*	*Provides the option for EHR technology to be certified to the HL7 Context-Aware Knowledge Retrieval Standard ("Infobutton") standard to electronically retrieve linked-referential clinical decision support information from content/knowledge resources.*
45 CFR §170.314(a)(15) *Patient-Specific Education Resources*	*Requires EHR technology to be able to use "Infobutton" standard to electronically retrieve patient-specific education from content/knowledge resources.*

At this writing, without further understanding about the exact role home health would play in disseminating certain details for public health reporting, the items listed below may not be applicable to all home health providers. In many cases the home health providers may not be in the best position to report on certain patient demographic data that is beyond their scope of practice. These items may be more aligned for reporting by physicians or hospitals who are guiding the treatment or ordering certain diagnostic tests, etc.

45 CFR §170.314(f)(2) *Transmission to Immunization Registries*	*Requires EHR technology to be able to electronically generate immunization information for electronic transmission using the HL7 2.5.1 Implementation Guide for Immunization Messaging, Release 1.4, and using the HL7 Standard Code Set CVX - Vaccines Administered vocabulary standard.*
45 CFR §170.314(f)(3) *Transmit Syndromic Surveillance to Public Health Agencies*	*Requires EHR technology to be able to electronically generate syndromic surveillance information for electronic transmission to public health agencies using the HL7 2.5.1 standard and, for the inpatient setting, a specific implementation guide.*
45 CFR §170.314(f)(4) *Transmit Lab Results to Public Health Agencies*	*Requires EHR technology to be capable of electronically generating reportable laboratory test values and results information for electronic transmission to public health agencies using the HL7 Version 2.5.1 Implementation Guide for Electronic Laboratory Reporting to Public Health as well as SNOMED CT® and LOINC®.*
45 CFR §170.314 (f)(6) *Optional -Transmit to Cancer Registries*	*Requires EHR technology to be able to electronically generate cancer case information for electronic transmission using the HL7 Clinical Document Architecture, Release 2.0, Implementation Guide for Ambulatory Healthcare Provider Reporting to Central Cancer Registries and SNOMED CT® and LOINC®.*

Finally, two of the referenced criteria do not appear to be applicable to home health providers. Specifically, the items that may require further consideration are as follows:

Criteria	Description	Comments
45 CFR §170.314(b)(3) *E-Prescribing*	*Requires EHR technology to be capable of electronically creating prescriptions and prescription-related information and electronically transmitting such information using the NCPDP SCRIPT version 10.6; with medications represented in RxNorm.*	Within a home health setting, the responsibility for prescribing medications is not applicable. Clinicians or Therapists would be responsible for executing the medication list ordered by a provider with prescribing
45 CFR §170.314(b)(6) *Transmission of Electronic Laboratory Tests and Values/Results to Ambulatory Providers*	*Requires EHR technology designed for an inpatient setting to be able to generate laboratory test reports for electronic transmission to ambulatory provider's EHR systems in accordance with the HL7 Version 2.5.1 Implementation Guide: S&I Framework LRI and with laboratory tests represented in LOINC®.*	While receiving the lab results of a patient is important for a home health agency, transmitting them to an ambulatory provider would typically not be necessary. The provider is typically the ordering authority and would be receiving the results at the same time as the home health agency. The onus of transmitting these results should be on the laboratory.