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National Coordinator for Health Information Technology
Chair, HIT Policy Committee
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: Health Information Technology; HIT Policy Committee: Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)

January 14, 2013

Dear Dr. Mostashari:

We appreciate the opportunity to comment on the HIT Policy Committee's *Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)*. The National Transition of Care Coalition supports the Office of the National Coordinator for Health Information Technology's (ONC) efforts to make it possible for health care providers to better manage patient care through secure use and sharing of health information.

The National Transitions of Care Coalition (NTOCC) is a non-profit organization of leading multidisciplinary health care organizations and stakeholders dedicated to providing solutions that improve the quality of health care through stronger collaboration between providers, patients, and family caregivers. The organization was formed in 2006 to raise awareness about the importance of transitions in improving health care quality, reducing medication errors, and enhancing clinical outcomes among health care professionals, government leaders, patients and family caregivers.

As you are aware, patients —particularly the elderly and individuals with chronic or serious illnesses— face significant challenges when moving from one care setting to another within our fragmented health care system. Poor communication during transitions from one care setting to another can lead to confusion about the patient's condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. These failures create serious patient safety, quality of care, and health outcome concerns.

NTOCC believes that the capacity for health information technology (HIT) to improve communication and information sharing will help address the threats to safety and quality of care during care transitions. In order for HIT to make a difference in transitions of care, the technology must incorporate several crucial elements, including standardized processes, mandatory performance measures, and established accountability for these processes among the health care providers coordinating an a patient's care. NTOCC believes that interoperability among the

various technology systems—such as the administrative systems, medical record systems, diagnostic tools, transcription and security, and others—is critical for effective transitions of care. Without addressing each step, the promise of HIT’s affect on overall transitions of care improvement will not be realized.

NTOCC applauds the Committee’s focus on care coordination during times of transitions in the Stage 3 Meaningful Use Recommendations. To that end, NTOCC offers the following comments on these objectives and measures:

SGRP 204A

NTOCC supports the objective in Stage 2 to “provide patients with the ability to view online, download, and transmit (VDT) their health information within four business days of the information becoming available to the EP.” We strongly support the proposed enhancement in Stage 3 to make this information available within 24 hours. NTOCC has long advocated that central to ensuring an effective transition from one care setting to another is the communication of clear, accurate and timely information between providers, patients and family caregivers. In today’s health system, most patients and family caregivers are not encouraged to play an active role when a transition in their care occurs, even though they are often the only constants throughout the transition. NTOCC strongly believes that patients and family caregivers should be empowered to take an active role when a transition in their care occurs. To do this, patients and family caregivers must have the necessary information and tools to effectively manage their own health. Making health information available to patients within 24 hours ensures that patients and their caregivers can work with their providers to make timely and accurate decisions about their follow up care.

SGRP 302

NTOCC supports the objective and believes that every time a patient is exposed to a new care setting or level of care, medication reconciliation should be completed by a member of the care team, and providers in the new setting should receive key information about this patient’s plan of care. In fact, NTOCC has [developed a list](#) of suggested common/essential data elements for medication reconciliation.

NTOCC recommends that this objective should make clear that reconciliation should be performed for all medications, including over the counter and other nutritional supplements/herbals and the system should not rely solely on claims.

SGRP 303

NTOCC strongly supports the transfer of key demographic and clinical information to the next setting of care. We appreciate the inclusion of documentation of an individual’s family caregiver (name, role, and contact information) in the summary of care record. Family caregivers play a vital role in the care team and any system that seeks to improve care coordination must ensure the health providers have access to these individuals and are aware of their role in the patient’s care plan.

In regards to “setting specific goals” within the summary of the care record, NTOCC urges the Committee to include patient and clinical goals, as both of these have a significant impact on health outcomes. As with so much of the health care system, goals for transitions of care are in

silos—each department worrying only about their piece of the puzzle, often with little regard to patient and family caregiver goals taken into account. As ONC works to support patient-centered and collaborative care, NTOCC strongly believes that providers should clearly document patient and family caregiver’s preferences to care and health goals.

Finally, NTOCC supports the proposed future objective detailed in **SGRP 304** that a more detailed care plan would be transmitted between settings. NTOCC looks forward to working with the Committee in future rulemakings to expand on the essential elements that should be shared as part of the plan of care.

SGRP 305

NTOCC appreciates the addition of the objective to include process measures that the provider (or facility) receiving the patient “acknowledges receipt of external information and provides referral results to the requesting provider”. NTOCC has long advocated that in order for health care information technology to be effective, clearly defined communication models and tools need to be implemented along with shared accountability across providers sending patient information and providers receiving patient information.

All too often, patients and their families are lost in the communication gap between providers, and NTOCC strongly supports ONC’s work “to close the loop” on patient information transfer. NTOCC encourages the ONC to keep in mind for future rulemaking that the sending provider must be available to the receiving provider for any questions and clarifications regarding the patient’s plan of care after the handoff and that the sending healthcare provider must remain responsible for patient’s care until the receiving provider has acknowledged that he/she can effectively assume the care of the patient.

We appreciate this opportunity to submit comments. Please feel free to contact Lindsay Punzenberger, NTOCC’s Policy Director, at 202-466-4721 or lpunzenberger@vennstrategies.com.

Sincerely,



Cheri Lattimer
Executive Director