



Submitted via E-mail

December 11, 2016

E-mail: [TOHPublicComments@rti.org](mailto:TOHPublicComments@rti.org)

**RE: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions.**

To Whom It May Concern:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (Alliance) regarding the quality measures to satisfy the IMPACT Act domain of “Transfer of health information and care preferences when an individual transitions.”

By way of background, the Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation’s healthcare system. For more information about our organization, please visit: <http://ahhqi.org/>.

**I. Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings**

The Alliance has two concerns about this measure involving transfer of information at admission, start or resumption of care.

First, it is appropriate to have measures on transfer of information, however this measure holds the receiver of the information (in this case, the home health agency) accountable for transfer of information. In post-acute care in particular, home health agencies receive patients from short-term acute care hospital. It is important to note that the sender of the information does not have a similar measure. The sender (the short-term acute care hospital) should be measured



on whether they have transferred the patient's information.

Second, the measure should allow for transfer from a "licensed independent provider." In some cases, the party sending information may be an APRN or other type of provider. The measure should take this into consideration.

## **II. Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings**

The Alliance has three concerns about this measure involving transfer of information at discharge or end of care.

First, it is appropriate to have a HHA measure for transfer of information at post-acute care discharge. However, information should always be transferred to a party at discharge. At the very least, information should be transferred to the physician who established the plan of care.

Second, the measure should allow for transfer to a "licensed independent provider." In some cases, the party may send information to an APRN or other type of provider. The measure should take this into consideration.

Finally, the term "timely" should be defined for purposes of the measure.

\* \* \*

Thank you for the opportunity to provide these comments. Should you have any questions, please contact me at [tlee@ahhqi.org](mailto:tlee@ahhqi.org) or 571-527-1530.

Sincerely,

A handwritten signature in black ink, appearing to read "Teresa Lee".

Teresa Lee, J.D., M.P.H.  
Executive Director